OREGON BULLETIN

Supplements the 2009 *Oregon Administrative Rules Compilation*

Volume 48, No. 1
January 1, 2009

For November 17, 2008–December 15, 2008

Published by
BILL BRADBURY
Secretary of State

INFORMATION AND PUBLICATION SCHEDULE

General Information

The Administrative Rules Unit, Archives Division, Secretary of State publishes the *Oregon Administrative Rules Compilation* and the *Oregon Bulletin*. The *Oregon Administrative Rules Compilation* is an annual publication containing the complete text of the Oregon Administrative Rules at the time of publication. The *Oregon Bulletin* is a monthly publication which updates rule text found in the annual compilation and provides notice of intended rule action, Executive Orders of the Governor, Opinions of the Attorney General, and orders issued by the Director of the Department of Revenue.

Background on Oregon Administrative Rules

ORS 183.310(9) defines "rule" as "any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency." Agencies may adopt, amend, repeal or renumber rules, permanently or temporarily (up to 180 days), using the procedures outlined in the *Oregon Attorney General's Administrative Law Manual*. The Administrative Rules Unit assists agencies with the notification, filing and publication requirements of the administrative rulemaking process. Every administrative rule uses the same numbering sequence of a 3 digit agency chapter number followed by a 3 digit division number and ending with a 4 digit rule number. (000-000-0000)

How to Cite

Citation of the Oregon Administrative Rules is made by chapter and rule number. Example: Oregon Administrative Rules, chapter 164, rule 164-001-0005 (short form: OAR 164-001-0005).

Understanding an Administrative Rule's "History"

State agencies operate in a dynamic environment of ever-changing laws, public concerns and legislative mandates which necessitate ongoing rulemaking. To track changes to individual rules and organize the rule filing forms for permanent retention, the Administrative Rules Unit has developed for each rule a "history" which is located at the end of the rule text. An administrative rule "history" outlines the statutory authority, statutes implemented and dates of each authorized modification to the rule text. Changes are listed in chronological order and identify in abbreviated form the agency, filing number, year, filing date and effective date. For example: "OSA 4-1993, f. & cert. ef. 11-10-93" documents a rule change made by the Oregon State Archives (OSA). The history notes this was the 4th filing from the Archives in 1993, it was filed on November 10, 1993 and the rule changes became effective on the same date. The most recent change to each rule is listed at the end of the "history."

Locating the Most Recent Version of an Administrative Rule

The online OAR Compilation is updated on the first of each month to include all rule actions filed with the Secretary of State's office by the 15th of the previous month, or by the previous workday if the 15th is on a weekend or holiday. The annual printed *Oregon Administrative Rules Compilation* contains the full text of all permanent rules filed through November 15 of the previous year. Subsequent changes to individual rules are listed in the OAR Revision Cumulative Index which is published monthly in the *Oregon Bulletin*. Changes to individual administrative rules are listed in the OAR Revision Cumulative Index by OAR number and include the effective date, the specific rulemaking action and the issue of the *Oregon Bulletin* which contains the full text of the amended rule. The *Oregon Bulletin* publishes the full text of permanent and temporary administrative rules submitted for publication.

Locating Administrative Rules Unit Publications

The *Oregon Administrative Rules Compilation* and the *Oregon Bulletin* are available in electronic and printed formats. Electronic versions are available through the Oregon State Archives Web site at http://arcweb.sos.state.or.us. Printed copies of these publications are deposited in Oregon's Public Documents Depository Libraries listed in OAR 543-070-0000 and may be ordered by contacting: Administrative Rules Unit, Archives Division, 800 Summer Street NE, Salem, OR 97310, (503) 373-0701, Julie.A.Yamaka@state.or.us

2008–2009 Oregon Bulletin Publication Schedule

The Administrative Rules Unit accepts rulemaking notices and filings Monday through Friday 8:00 a.m. to 5:00 p.m at the Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310. To expedite the rulemaking process agencies are encouraged file a Notice of Proposed Rulemaking Hearing specifying hearing date, time and location, and submit their filings early in the submission period to meet the following publication deadlines.

Submission Deadline	Publishing Date
December 15, 2008	January 1, 2009
January 15, 2009	February 1, 2009
February 13, 2009	March 1, 2009
March 13, 2009	April 1, 2009
April 15, 2009	May 1, 2009
May 15, 2009	June 1, 2009
June 15, 2009	July 1, 2009
July 15, 2009	August 1, 2009
August 14, 2009	September 1, 2009
September 15, 2009	October 1, 2009
October 15, 2009	November 1, 2009
November 13, 2009	December 1, 2009

Reminder for Agency Rules Coordinators

Each agency that engages in rulemaking must appoint a rules coordinator and file an "Appointment of Agency Rules Coordinator" form, ARC 910-2003, with the Administrative Rules Unit, Archives Division, Secretary of State. Agencies which delegate rulemaking authority to an officer or employee within the agency must also file a "Delegation of Rulemaking Authority" form, ARC 915-2005. It is the agency's responsibility to monitor the rulemaking authority of selected employees and to keep the appropriate forms updated. The Administrative Rules Unit does not verify agency signatures as part of the rulemaking process. Forms are available from the Administrative Rules Unit, Archives Division, 800 Summer Street NE, Salem, Oregon 97301, (503) 373-0701, or are downloadable at http://arcweb.sos.state.or.us/banners/rules.htm

Publication Authority

The *Oregon Bulletin* is published pursuant to ORS 183.360(3). Copies of the original Administrative Orders may be obtained from the Archives Division, 800 Summer Street, Salem, Oregon, 97310; (503) 373-0701. The Archives Division charges for such copies.

TABLE OF CONTENTS

APPROVAL OF CLEANUP AT ODOT — FORMER HIGH COUNTRY DISPOSAL SITE REDMOND, OREGON

PROJECT LOCATION: 124 NE Hemlock Avenue, Redmond, Oregon
DECISION: On November 4, 2008, the Department of Environmental Quality issued a No Further Action (NFA) determination based on results of site investigation and remedial activities performed at the former High Country Disposal site, at 124 NE Hemlock Avenue, in Redmond, Oregon. DEQ has determined that no further action is required because the site no longer poses a risk that exceeds the acceptable risk level defined in ORS 465.315.
HIGHLIGHTS: The former High Country Disposal site was purchased by the Oregon Department of Transportation (ODOT) as part of the acquisition of right-of-way for the construction of the US97 Redmond reroute project. The site was a waste collection and post-consumer recycling facility. It was used for vehicle storage and maintenance, and storage of recyclables at the site. It was also used as a transfer station for used motor oil. The site occupies 2.48 acres.

Based on soil sampling, ODOT removed about 125 cubic yards of petroleum-contaminated soil. Sampling following removal of this material indicated that residual contamination was below acceptable risk levels. Groundwater at this site is approximately 250 feet below ground surface, and it is assumed not to have been impacted by this surface soil contamination.

DEQ issued a public notice regarding its decision on October 1, 2008. Public comments were requested by October 31, 2008. No comments were received. The NFA determination was issued following the close of the public comment period.

NO FURTHER ACTION DETERMINATION ODOT — BASQUE MAINTENANCE STATION DRYWELL REMOVAL, BASQUE, OREGON

DECISION: On November 4, 2008, the Department of Environmental Quality (DEQ) issued a No Further Action determination regarding excavation and offsite disposal of contaminated soil from a drywell at the Basque Maintenance Station operated by the Oregon Department of Transportation (ODOT). This determination is based on approval of investigation and remedial measures conducted to date. Public notification is required by ORS 465.320. DEQ issued a public notice on May 1, 2008 requesting public comments by May 31, 2008 regarding its intention to issue the No Further Action determination. No comments were received.
HIGHLIGHTS: ODOT's Basque Maintenance Station is located in Malheur County on Highway 95, approximately 30 miles north of the Nevada border. ODOT removed a drywell from this facility in September-October 1997. In 2007, ODOT requested that DEQ review sample results and other information to determine whether a No Further Action determination could be issued.

The drywell consisted of a 4-foot diameter, 12-foot long vertical concrete pipe. ODOT excavated approximately 30 cubic yards of contaminated soil and backfilled the excavation with clean native soil. The contaminated soil and concrete were taken to the Burns-Hines Landfill for disposal. Sample results collected following excavation indicated that residual contamination does not exceed safe levels.

PROPOSED CONDITIONAL NO FURTHER ACTION DETERMINATION, FORMER K-LINES SITE, PARCEL D, 17387 SW 63RD AVENUE, LAKE OSWEGO, OREGON

COMMENT PERIOD: January 1 to January 30, 2009
COMMENTS DUE: January 30, 2009
PROPOSAL: The Oregon Department of Environmental Quality (DEQ) proposes to approve the cleanup of contaminated soil and groundwater and issue a conditional no further action determination (NFA) for the former K-Lines Site, Parcel D.
HIGHLIGHTS: Several phases of environmental testing have been performed at the site, identifying petroleum constituents, chlorinated solvents, and heavy metals contamination to soil and groundwater from past industrial activities. More than 285 tons of contaminated soils were removed from two underground storage tank locations, a drywell, and from beneath a steam cleaning operation. Oxygen releasing compound was applied to several areas of residual contamination to accelerate degradation of contaminants. A limited amount of contaminated soil remains at the site, and contaminants are present in groundwater at the site and beneath the neighboring Hale property to the southwest (at 17550 and 17650 SW 65th Avenue, Tax Lots 800 and 500). The K-Lines Site owner purchased and recently redeveloped the Hale property. Remaining site risks will be adequately addressed by deed restrictions that will restrict future site excavation and groundwater use at the re-developed K-Lines and Hale property sites.

DEQ recommends that the remedy be approved and no further action required at the site.
HOW TO COMMENT: The project file is available for public review. To schedule an appointment call (503) 229-6729. The DEQ project manager is Loren Garner, (503) 229-6900. Written comments should be sent to Loren Garner, DEQ, 2020 SW Fourth Avenue, Suite 400, Portland, OR 97201 by January 30, 2009. A public meeting will be held to receive comments if requested by 10 or more persons or by a group with a membership of 10 or more.
THE NEXT STEP: DEQ will consider all public comments before making the final decision.

CHANCE TO COMMENT ON… APPROVAL OF REMEDIAL ACTION AND PROPOSED CONDITIONAL NO FURTHER ACTION FORMER RASMUSSEN PAINT FACILITY (ECSI #153)

COMMENTS DUE: February 2, 2009
PROJECT LOCATION: 12655 SW Beaverdam Road, Beaverton, Oregon
PROPOSAL: Pursuant to Oregon Revised Statute, ORS 465.320, and Oregon Administrative Rules, OAR 340-122-100, the Department of Environmental Quality (DEQ) invites public comment on its proposal to approve a remedial action and issue a conditional no further action (NFA) for the former Rasmussen Paint facility (ECSI File #153). Because institutional and engineering controls are required to ensure protectiveness for current and future likely site use, the site will remain on the Confirmed Release, and will be added to the Inventory of Hazardous Substance sites.
HIGHLIGHTS: Solvent-based paint was manufactured at the 0.44-acre site from the 1960s until 1989. Underground storage tanks (USTs) containing solvent were removed in 1989, and a total of 208 cubic yards of contaminated soil were removed and treated on-site with DEQ approval. Rasmussen Paint continued operating at the site until 2004. The building was remodeled and site is now leased for storage and office use. The property is located in the City of Beaverton Regional Center-Transit Oriented District and is currently zoned for mixed commercial and residential use.

In March 2006, an independent lead- contaminated soil removal was conducted in a former paint wash ditch area. The ditch area previously had discharged to a tributary of Beaverton Creek. Soil was excavated to a depth of about 3 feet. Approximately 22.13 tons of lead-impacted soil was excavated and disposed of as hazardous waste at the Waste Management landfill in Arlington, Oregon. Additional investigations were conducted in 2007 and 2008 to assess soil and groundwater conditions at the site, in addition to sediment in Beaverton Creek near the former site-related discharge.

Residual soil and groundwater contamination is present at the site. A risk screening determined that soil and groundwater containing concentrations above risk-based standards for occupational exposure were limited, and that the site did not present a significant risk to site workers because impacted areas of covered by gravel fill or asphalt. Sediment samples indicated potential site-related impacts to Beaverton Creek. However, there appear to be other local sources,

including a former sanitary sewer plant that shared a common drainage with the site.

Based on the results of the risk evaluation DEQ has determined that no further action is required to address site contamination under certain conditions. To ensure that the site remains protective of human health, the proposed NFA will be conditioned on the following: 1) residential use is prohibited unless vapor barriers are installed and/or other DEQ-approved remedial actions are completed; 2) any soil excavated on the property would have to be sampled according to a DEQ-approved soil management plan and managed appropriately; 3) The gravel fill and paved areas will be maintained to prevent direct contact with underlying soil, and 4) any excavation would be managed under an appropriate health and safety plan. DEQ's determination does not relieve potential future liability for impacts to Beaverton Creek.

These conditions will be memorialized in an Easement and Equitable Servitude (E&ES) between the site owner and DEQ, and recorded with Washington County.

HOW TO COMMENT: To access additional detail on the site, please view the DEQ Staff Report in DEQ's Environmental Cleanup Site Information (ECSI) database on the Internet at http://www.deq.state.or.us/lq/ECSI/ecsiquery.asp. Enter 153 in the "Site ID" box and click "Submit" at the bottom of the page. Next, click the link labeled 153 in the Site ID/Info column. Next, click on the staff report under Site Documents. You can review the administrative record for the proposed conditional no further action at DEQ's Northwest Region office located at 2020 SW 4th Avenue, Suite 400, Portland, Oregon. For an appointment to review the files call (503)229-6729; toll free at (800)452-4011; or TTY at (503)229-5471. Please send written comments to Mark Pugh, Project Manager, DEQ Northwest Region, 2020 S.W. Fourth Ave., Suite 400, Portland, Oregon, 97201 or via email at: pugh.mark@deq.state.or.us. DEQ must receive written comments by 5 p.m. on February 2, 2009.

DEQ will hold a public meeting to receive verbal comments if 10 or more persons, or a group with membership of 10 or more, requests such a meeting. Interest in holding a public meeting must be submitted in writing to DEQ. If a public meeting is held, a separate public notice announcing the date, time, and location of any public meeting would be published in this publication.

DEQ is committed to accommodating people with disabilities at our hearings. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ Communications and Outreach at (503) 229-5696 or toll free in Oregon at (800) 452-4011. People with hearing impairments may call DEQ's TTY number, (503)229-5471.

THE NEXT STEP: DEQ will consider all public comments received by the deadline. In the absence of comments, DEQ will issue a conditional No Further Action for the site.

REQUEST FOR COMMENTS PROPOSED NO-FURTHER-ACTION DETERMINATION FOR THE FORMER CHEVRON BULK PLANT IN CORVALLIS

COMMENTS DUE: 5 pm, February 2nd, 2009

PROJECT LOCATION: 1225 SE 3rd Street, Corvallis, OR

PROPOSAL: Pursuant to ORS 465.320 and Oregon Administrative Rules (OAR) 340-122-465, the Oregon Department of Environmental Quality (DEQ) requests public comment on its recommendation that no further action is required for investigation or cleanup of petroleum contamination at the Former Chevron Bulk Plant in Corvallis, OR (ECSI No. 1749).

HIGHLIGHTS: The Former Chevron Bulk Plant operated as a petroleum fuel distributor from 1921 to 1981. Operations consisted of storage and transfer of gasoline, diesel, kerosene, and lubricating oils and due to historical releases of these products, soil and groundwater beneath the site were contaminated. The Site was decommissioned in 1981 by removing all storage tanks, piping, transfer equipment, and structures. Soil and groundwater assessment activities began in 1989 and continued to 2006.

In 1991, approximately 4,300 cubic yards of petroleum-contaminated soil was excavated from the central portion of the site. The majority of the soil was disposed off site at a landfill and the remaining soil was treated and beneficially reused as on site fill. Soil contamination remains in a small area in the central portion of the Site. Soil sampling results confirmed that the remaining contamination in soil is below DEQ screening levels and that the soil contamination does not pose a risk to people occupying the site.

Groundwater monitoring took place at the Site from 1989 to 2006. Petroleum contamination in groundwater has significantly decreased since 1989 from natural degradation processes. Residual contaminant levels in groundwater are below applicable screening values and residual groundwater contamination does not pose a risk to on site and off site occupants.

HOW TO COMMENT: A Staff Report presenting details about the site and cleanup activities was prepared by DEQ, which supports the decision to approve the No-Further-Action determination. The staff report is available for review, electronically, by contacting the DEQ project manager, Bryn Thoms at 541-687-7424 or at thoms.bryn@deq.state.or.us, or the report can be viewed in person at the DEQ Eugene office by appointment. The Eugene office address and contact information is presented to the right.

Comments on the proposed determination need to be received by the Eugene Office, attn: Bryn Thoms, by 5 pm on February 2nd, 2009. Fax or email comments are acceptable.

THE NEXT STEP: Upon completion of the comment period, the comments will be addressed. Once the comments have been adequately addressed, the DEQ may approve, modify, or deny the no-further-action determination for assessment and/or cleanup of the Former Chevron Bulk Plant.

ACCESSIBILITY INFORMATION: DEQ is committed to accommodating people with disabilities. Please notify DEQ of any special physical or language accommodations or if you need information in large print, Braille or another format. To make these arrangements, contact DEQ Communications & Outreach (503) 229-5696 or toll free in Oregon at (800) 452-4011; fax to 503-229-6762; or e-mail to deqinfo@deq.state.or.us.

People with hearing impairments may call DEQ's TTY number, 541-687-5603.

REQUEST FOR COMMENTS PROPOSED NO FURTHER ACTION DECISION FOR MIDLAND MARKET, MIDLAND, OREGON

COMMENTS DUE: January 30, 2009 by 5:00 p.m.

PROJECT LOCATION: 10505 Highway 97, Midland

PROPOSAL: Pursuant to Oregon Revised Statute (ORS) 465.315, the Oregon Department of Environmental Quality (DEQ) is proposing to issue a risk-based no further action (NFA) determination for Midland Market site located at 10505 Highway 97 in Midland, Oregon.

HIGHLIGHTS: The Leaking Underground Storage Tank (LUST) Program has reviewed site assessment activities performed at the site. Concentrations of petroleum products detected in the soil are below applicable risk based pathways for the site.

HOW TO COMMENT: The project file may be reviewed by appointment at DEQ's Eastern Regional Office at 700 SE Emigrant, Suite #330, Pendleton, OR 97801. Summary information and a copy of the *"Site Investigation Report"* are available in DEQ's LUST database http://www.deq.state.or.us/lq/tanks/lust/LustPublicLookup.asp under LUST No. 18 98 0034.

To schedule an appointment to review the file or to ask questions, please contact Katie Robertson at (541) 278-4620. Written comments should be received by January 30, 2009 and sent to Katie Robertson, Project Manager, at the address listed above. Upon written request by ten or more persons or by a group with a membership of 10 or more, a public meeting will be held to receive verbal comments.

THE NEXT STEP: DEQ will consider all public comments received before making a final decision regarding the "No Further Action" recommendation.

REQUEST FOR COMMENTS
PROPOSED NO FURTHER ACTION DECISION FOR
WORDEN TRUCK STOP, WORDEN, OREGON

COMMENTS DUE: January 30, 2009 by 5:00 p.m.
PROJECT LOCATION: 19777 S. Hwy 97, Worden
PROPOSAL: Pursuant to Oregon Revised Statute (ORS) 465.315, the Oregon Department of Environmental Quality (DEQ) is proposing to issue a no further action (NFA) determination for Worden Truck Stop site located at 19777 S. Hwy 97 in Worden, Oregon. The site is also proposed for de-listing from the Confirmed Release List and Inventory of Hazardous Substances.
HIGHLIGHTS: The Site Assessment Section has reviewed site assessment activities performed at the site. Concentrations of petroleum products detected in the soil are below applicable risk based pathways for the site. Surficial stained soil was excavated and transported off site for disposal.
HOW TO COMMENT: The project file may be reviewed by appointment at DEQ's Eastern Regional Office at 700 SE Emigrant, Suite #330, Pendleton, OR 97801. Summary information and a copy of *"Site Investigation Report"* are available in DEQ's Environmental Cleanup Site Information (ECSI) database http://www.deq.state.or.us/lq/ecsi/ecsi.htm under Site ID 3530.

To schedule an appointment to review the file or to ask questions, please contact Katie Robertson at (541) 278-4620. Written comments should be received by January 30, 2009 and sent to Katie Robertson, Project Manager, at the address listed above. Upon written request by ten or more persons or by a group with a membership of 10 or more, a public meeting will be held to receive verbal comments.
THE NEXT STEP: DEQ will consider all public comments received before making a final decision regarding the "No Further Action" and de-listing recommendations.

NOTICES OF PROPOSED RULEMAKING

Notices of Proposed Rulemaking and Proposed Rulemaking Hearings

The following agencies provide Notice of Proposed Rulemaking to offer interested parties reasonable opportunity to submit data or views on proposed rulemaking activity. To expedite the rulemaking process, many agencies have set the time and place for a hearing in the notice. Copies of rulemaking materials may be obtained from the Rules Coordinator at the address and telephone number indicated.

Public comment may be submitted in writing directly to an agency or presented orally or in writing at the rulemaking hearing. Written comment must be submitted to an agency by 5:00 p.m. on the Last Day for Comment listed, unless a different time of day is specified. Written and oral comments may be submitted at the appropriate time during a rulemaking hearing as outlined in OAR 137-001-0030.

Agencies providing notice request public comment on whether other options should be considered for achieving a proposed administrative rule's substantive goals while reducing negative economic impact of the rule on business.

In Notices of Proposed Rulemaking where no hearing has been set, a hearing may be requested by 10 or more people or by an association with 10 or more members. Agencies must receive requests for a public rulemaking hearing in writing within 21 days following notice publication in the *Oregon Bulletin* or 28 days from the date notice was sent to people on the agency mailing list, whichever is later. If sufficient hearing requests are received by an agency, notice of the date and time of the rulemaking hearing must be published in the *Oregon Bulletin* at least 14 days before the hearing.

**Auxiliary aids for persons with disabilities are available upon advance request*. Contact the agency Rules Coordinator listed in the notice information.

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Board of Chiropractic Examiners
Chapter 811

Rule Caption: Amends continuing education rule for minor surgery certified chiropractic physicians adding a new option.

Date:	Time:	Location:
1-22-09	9:30 a.m.	Western States Chiropractic College 2900 NE 132nd Ave. Portland, OR 97230

Hearing Officer: Dave McTeague
Stat. Auth.: ORS 684
Stats. Implemented: ORS 684
Proposed Amendments: 811-015-0030
Last Date for Comment: 1-22-09, 9 a.m. or following hearing
Summary: The proposed amendment adds a new option for continuing education for minor surgery certified chiropractic physicians adding a new option. Currently, certified doctors must obtain 12 hours CE in minor surgery/proctology every three years. The proposed amended rule adds an option of documenting 12 observed or performed procedures and four hours CE (or instruction) in the same three year period.
Rules Coordinator: Dave McTeague
Address: Board of Chiropractic Examiners, 3218 Pringle Rd. SE, Suite 150, Salem, OR 97302
Telephone: (503) 378-5816

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Board of Massage Therapists
Chapter 334

Rule Caption: OBMT comprehensive changes to increase readability, update practices, update terminology and streamline processes.

Date:	Time:	Location:
1-16-09	11 a.m.	OBMT Board Room 748 Hawthorne Ave NE Salem OR 97301

Hearing Officer: R. Craig McMillin
Stat. Auth.: ORS 182, 183, 687, 687.011, 687.081, 687.121, 687.122 & SB 1127
Stats. Implemented: ORS 183, 687, 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121
Proposed Adoptions: 334-040-0001
Proposed Amendments: 334-010, 334-020, 334-030, 334-001-0000, 334-001-0035, 334-001-0045, 334-001-0060, 334-010-0005, 334-010-0010, 334-010-0012, 334-010-0015, 334-010-0017, 334-010-0025, 334-010-0033, 334-010-0046, 334-010-0047, 334-010-0050, 334-020-0005, 334-020-0015, 334-020-0050, 334-020-0055, 334-030-0001, 334-030-0005
Proposed Repeals: 334-010-0016, 334-010-0031, 334-020-0020, 334-020-0025, 334-020-0030, 334-020-0035, 334-020-0040, 334-020-0045, 334-020-0060, 334-020-0065, 334-020-0070, 334-020-0075, 334-020-0080, 334-020-0085, 334-020-0090, 334-030-0002, 334-030-0010
Proposed Ren. & Amends: 334-010-0041 to 334-010-0008, 334-030-0025 to 334-040-0010
Last Date for Comment: 1-16-09, close of hearing
Summary: Over the past several years the OBMT rules committee has conducted a comprehensive review of rule. This review was done to increase readability, update practices, update terminology and streamline processes. Almost every rule has been effected by this process in some manner. In addition, Division 30 has been split into two divisions. Division 30 will now cover Standards of Conduct. A new division 40 will address Complaints and Discipline. Over the past 6 months 2 hearings have already been held and suggestions considered and incorporated. This hearing will be on Version 4 of the proposed rules changes of which a complete markup is available on the home page of the Oregon Board of Massage Therapists web site at www.oregon.gov/obmt
Rules Coordinator: Patty Glenn
Address: 748 Hawthorne Avenue NE, Salem OR 97301
Telephone: (503) 365-8657

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Board of Tax Practitioners
Chapter 800

Rule Caption: 2008 overhaul of OAR's based on recommendations made by the Rules Advisory Committee and approved by the Board.

Date:	Time:	Location:
1-21-09	9 a.m.	3218 Pringle Rd. SE, #120 Salem, OR 97302

Hearing Officer: Jane Billings
Stat. Auth.: ORS 673.605, 673.740 & 673.990
Stats. Implemented: ORS 673.605, 673.740 & 673.990
Proposed Amendments: 800-010-0020, 800-010-0025, 800-010-0040, 800-010-0041, 800-010-0042, 800-015-0005, 800-015-0010, 800-015-0015, 800-015-0030, 800-020-0015, 800-020-0020, 800-020-0025, 800-020-0030, 800-025-0020, 800-025-0023, 800-025-0027, 800-025-0030, 800-025-0040, 800-025-0060, 800-030-0025
Last Date for Comment: 1-21-09
Summary: 2008 overhaul of OAR's based on recommendations made by the Rules Advisory Committee and approved by the Board.
Rules Coordinator: Monica J. Walker
Address: Board of Tax Practitioners, 3218 Pringle Rd. SE, # 120, Salem, OR 97302
Telephone: (503) 378-4034

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Construction Contractors Board
Chapter 812

Rule Caption: Adds a definition, amends fee and commercial continuing education language, and adjusts civil penalties relating to written contracts.

Date:	Time:	Location:
1-27-09	11 a.m.	West Salem Roth's IGA Santiam Rm. 1130 Wallace Rd. NW Salem, OR

Hearing Officer: Tom Skaar

Stat. Auth.: ORS 183.310 - 183.500, 670.310, 701.124, 701.235, 701.238 & 701.992
Stats. Implemented: ORS 87.093, 279C.590, 701.005, 701.026, 701.042, 701.046, 701.056, 701.063, 701.091, 701.098, 701.106, 701.124, 701.227, 701.238, 701.305, 701.315, 701.330, 701.345 & 701.992
Proposed Adoptions: 812-002-0262, 812-003-0141
Proposed Amendments: 812-003-0140, 812-005-0800, 812-020-0070
Last Date for Comment: 1-27-09, 11 a.m.
Summary: 812-002-0262 is adopted to provide an exemption for tree removal contractors who are "engaged in the commercial harvest of forest products". This definition derives from the common and ordinary term used in the phrase.

812-003-0140 is amended because in the 2007 legislative session CCB's law changed the fees from licensing and renewal fees to application fees. Part of the reason for the change was due to the fact that the agency spends its time and resources to process a new license or renewal application whether the license is ever issued or not.

812-003-0141 is adopted to allow the agency to refund a portion of the unused two-year fee of a four-year license, if licensee within the first two-years following renewal voluntarily terminates their license. This was formed as part of 812-003-0140.

812-005-0800 is amended — currently CCB may impose a civil penalty upon a contractor who fails to use a written contract in an amount of not less than $200 or more than $2,000. Yet, if a contractor uses a written contract, but the contract does not contain all of the required items, the penalties are more severe. The amendment to subsection (11) makes a failing to use a written contract the more severe offense. As of 2009, is a contractor uses a written contract, but fails to include all of the required provisions, the civil penalty is not less than $500 or more than $5,000. This is more than the sanction for not using a written contract at all — arguably the more serious violation. The amendment to subsection (34) reduces the sanctions to reflect that this is the less serious violation.

812-020-0070 is amended to clarify that, at the time of certification, the number of key employees is determined as of the previous date when the license was issued, reissued, or renewed.
Rules Coordinator: Catherine Dixon
Address: Construction Contractors Board, 700 Summer St. NE, Suite 300, Salem, OR 97310
Telephone: (503) 378-4621, ext. 4077

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Department of Agriculture
Chapter 603

Rule Caption: Civil Penalty Determination Procedure.
Stat. Auth.: ORS 561 & 468B
Other Auth.: OAR 603-074
Stats. Implemented: ORS 561 & 468B
Proposed Amendments: 603-074-0080
Last Date for Comment: 1-23-09
Summary: Correcting dollar amount in Administrative Rule 603-074-0080 due to typographical error.
Rules Coordinator: Sue Gooch
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301
Telephone: (503) 986-4583

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Department of Agriculture,
Oregon Fryer Commission
Chapter 620

Rule Caption: Permanently eliminates the assessment charged to growers for the Oregon Fryer Commission.

Date:	Time:	Location:
1-15-09	9 a.m.	Yamhill Grill 2818 Portland Rd. Newberg, OR 97132

Hearing Officer: Kris Anderson
Stat. Auth.: ORS 576.325, 576.327 & 183.335
Other Auth.: ORS 576.304(14)
Stats. Implemented: ORS 576.325
Proposed Amendments: 620-010-0020
Last Date for Comment: 1-15-09, 10:30 a.m.
Summary: This rule replaces the Temporary Rules that expires Feb. 28, 2009. The Oregon Fryer Commission will permanently eliminate the assessment charged to Oregon growers due to a number of increases in costs to growers that have made continued operation of their businesses difficult. The Oregon Fryer Commission has voted to proceed with legislation to dissolve the commission. The assessment was suspended retroactive to Sept. 1, 2008 with a Temporary Rule that expires Feb. 28, 2009. The permanent rule change will eliminate the assessment during the time the commission is awaiting legislative action.
Rules Coordinator: Julie Schiele
Address: Department of Agriculture, Oregon Fryer Commission, 3100 Haworth Ave., Suite 230, Newberg, OR 97132
Telephone: (503) 537-6200

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Department of Consumer and Business Services,
Division of Finance and Corporate Securities
Chapter 441

Rule Caption: Sets fees for banking and consumer finance programs.

Date:	Time:	Location:
1-23-09	9 a.m.	Labor & Industries Bldg. Rm. 260 350 Winter St. NE Salem, OR

Hearing Officer: Richard Y. Blackwell
Stat. Auth.: ORS 705.20 & 725.185
Stats. Implemented: ORS 705.620 & 725.185
Proposed Amendments: 441-500-0020, 441-730-0030
Last Date for Comment: 1-23-09, 5 p.m.
Summary: These rules revise the annual licensing fees or assessments paid by state-chartered banks and consumer finance lenders.
Rules Coordinator: Shelley Greiner
Address: Department of Consumer and Business Services, Finance and Corporate Securities, 350 Winter St. NE, Rm. 410, Salem, OR 97301
Telephone: (503) 947-7484

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Department of Consumer and Business Services,
Insurance Division
Chapter 836

Rule Caption: Adoption of Annual and Supplemental Statement Blanks and Instructions for Reporting Year 2008.
Stat. Auth.: ORS 731.244, 731.574 & 733.210
Stats. Implemented: ORS 731.574 & 733.210
Proposed Amendments: 836-011-0000
Last Date for Comment: 1-23-09
Summary: This rulemaking proposes to prescribe, for reporting year 2008, the required forms for the annual and supplemental financial statements required of insurers and health care service contractors under ORS 731.574, as well as the necessary instructions for completing the forms.
Rules Coordinator: Sue Munson
Address: Department of Consumer and Business Services, Insurance Division, 350 Winter St. NE, Rm. 440, Salem, OR 97301
Telephone: (503) 947-7272

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Department of Corrections
Chapter 291

Rule Caption: Use of Electronic Immobilizing Devices for Parole and Probation Officers.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Proposed Adoptions: 291-022-0161, 291-022-0162
Proposed Amendments: 291-022-0115, 291-022-0160
Last Date for Comment: 2-25-09
Summary: These rule modifications are necessary to establish policies and procedures for deployment and use of electronic immobilizing devices in use of force situations for parole and probation officers.
Rules Coordinator: Janet R. Worley
Address: Department of Corrections, 2575 Center St. NE, Salem, OR 97301-4667
Telephone: (503) 945-0933

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Department of Environmental Quality
Chapter 340

Rule Caption: 2009 Omnibus Hazardous Waste Rulemaking.

Date:	Time:	Location:
2-3-09	3 p.m.	811 SW Sixth Ave., Rm. 10 Portland, OR

Hearing Officer: David LeBrun, DEQ
Stat. Auth.: ORS 465.009, 466.020, 465.505, 466.165, 468.020, 183, 459 & 468
Stats. Implemented: ORS 465.003, 465.009, 466.005, 466.075, 466.105, 465.505, 466.020 & 466.150
Proposed Adoptions: 340-104-0021, 340-105-0140
Proposed Amendments: 340-100-0002, 340-102-0065
Proposed Repeals: 340-102-0060
Last Date for Comment: 2-10-09, 5 p.m.
Summary: The Department of Environmental Quality operates the Federal hazardous waste program in Oregon under delegation from the Environmental Protection Agency. A requirement for continuing delegation is that the State must periodically review and adopt new or changed Federal rules. DEQ last updated its rules in October 2003, incorporating by reference most Federal rules promulgated through June 30, 2002. We now propose to adopt 13 Federal rules published between July 1, 2002 and July 28, 2006. None of the rules to be adopted are more stringent than DEQ's current rules, so we do not expect any negative fiscal or economic impacts to regulated entities in Oregon.

In addition, we are deleting one State rule that has been preempted by Federal rules, adding two State rules that delete references to an EPA program DEQ has not adopted, and amending one State rule to reflect changes made to statute during the 2007 legislative session. None of the State rule changes increase either regulation or costs to regulated entities.

To submit comments or request additional information, please contact Scott Latham at the Department of Environmental Quality (DEQ), 811 SW Sixth Ave, Portland, OR 97204-1390, toll free in Oregon at 800-452-4011 or 503-229-5953, or at latham.scott@deq.state.or.us, or by fax 503-229-6977, or visit DEQ's website http://www.deq.state.or.us/news/publicnotices/PN.asp
Rules Coordinator: Larry McAllister
Address: Department of Environmental Quality, 811 SW Sixth Ave., Portland, OR 97204
Telephone: (503) 229-6412

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Lengthen the Seasonal Closure of the Clatsop Beach Commercial and Recreational Razor Clam Fisheries.

Date:	Time:	Location:
2-20-09	8 a.m.	Loft at the Red Bldg. No. 20 Basin St., Suite F Astoria, OR 97103

Hearing Officer: Fish & Wildlife Commission
Stat. Auth.: ORS 496.012, 469.138, 496.162, 506.036, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 496.012, 469.138, 496.162, 506.036, 506.109, 506.119 & 506.129
Proposed Adoptions: Rules in 635-005, 635-039
Proposed Amendments: Rules in 635-005, 635-039
Proposed Repeals: Rules in 635-005, 635-039
Last Date for Comment: 2-20-09
Summary: Amended rules to lengthen the seasonal closure for commercial and recreational razor clam harvest on Clatsop Beach to reduce wastage of the razor clam resource. Rule modifications would close razor clam harvest from June 15 through September 30.
Rules Coordinator: Therese Kucera
Address: Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
Telephone: (503) 947-6033

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Rule Caption: 2009 Columbia River Commercial and Recreational Fishing Seasons and Miscellaneous Regulations.

Date:	Time:	Location:
2-20-09	8 a.m.	Loft at the Red Bldg. No. 20 Basin St., Suite F Astoria, OR 97103

Hearing Officer: Fish & Wildlife Commission
Stat. Auth.: ORS 183.325, 496.138, 496.146, 497.121, 506.109, 506.119 & 506.129
Stats. Implemented: ORS 496.004, 496.009, 496.162, 506.129 & 507.030
Proposed Adoptions: Rules in 635-017, 635-023, 635-041, 635-042
Proposed Amendments: Rules in 635-017, 635-023, 635-041, 635-042
Proposed Repeals: Rules in 635-017, 635-023, 635-041, 635-042
Last Date for Comment: 2-20-09
Summary: Consider amendment of rules related to: (1) Commercial fishing in the Columbia River below Bonneville Dam and Select Areas; (2) Treaty Indian commercial, subsistence and ceremonial fishing in the Columbia River above Bonneville Dam; and (3) Recreational fishing in the main-stem Columbia and Willamette rivers.

Housekeeping and technical corrections may occur to ensure rule consistency.
Rules Coordinator: Therese Kucera
Address: Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
Telephone: (503) 947-6033

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Department of Forestry
Chapter 629

Rule Caption: Delegates authorization of statutory modifications and waivers within a stewardship agreement to the State Forester.

Date:	Time:	Location:
1-28-09	9 a.m.	ODF, Bldg. D, Santiam Rm. 2600 State St. Salem, OR 97310

Hearing Officer: Lanny Quackenbush
Stat. Auth.: ORS 526.016(4)
Other Auth.: ORS 526.041(1) & 541.423(4)
Stats. Implemented: ORS 541.423
Proposed Amendments: 629-021-0700
Last Date for Comment: 3-5-09
Summary: The proposed rule amendment delegates the authority to allow limited statutory modification and waivers as a term of a stewardship agreement from the Board of Forestry to the State Forester. Under ORS 527.736(4), modifications or waivers may only be considered for the following statutes: ORS 527.676, 527.740, 527.750 and 527.755.
Rules Coordinator: Gayle Birch
Address: Department of Forestry, 2600 State St., Salem, OR 97310
Telephone: (503) 945-7210

Department of Human Services,
Addictions and Mental Health Division:
Mental Health Services
Chapter 309

Rule Caption: A Committed Person's Right to Fresh Air and the Outdoors.

Date:	Time:	Location:
1-22-09	10:15–11:15 a.m.	500 Summer St. NE, E86 Rm. 137A Salem, OR 97301

Hearing Officer: Richard Luthe
Stat. Auth.: ORS 409.010, 409.050, 426.060, 426.385, 430.205 - 430.210 & 443.450
Other Auth.: HB 2312 Enrolled (2007 Session)
Stats. Implemented: ORS 426.005 - 426.309, 443.400 - 443.455 & 443.991
Proposed Amendments: Rules in 309-033, 309-035
Last Date for Comment: 1-30-09, 5 p.m.
Summary: HB 2312 Enrolled (2007 Session) established that, under most circumstances, a committed person has the right to fresh air and the outdoors. The Addictions & Mental Health Division is amending rules in OAR 309-033 & OAR 309-035 to define terms, and to establish that these rights may be limited under certain circumstances.
Rules Coordinator: Richard Luthe
Address: 500 Summer Street NE E86, Salem, OR 97301
Telephone: (503) 947-1186

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Department of Human Services,
Public Health Division
Chapter 333

Rule Caption: Family Planning Expansion Project.

Date:	Time:	Location:
1-22-09	1 p.m.	800 NE Oregon St., Rm. 1C Portland, OR 97232

Hearing Officer: Jana Fussell
Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.010
Proposed Amendments: 333-004-0010, 333-004-0020, 333-004-0030, 333-004-0040, 333-004-0050, 333-004-0060, 333-004-0070, 333-004-0080, 333-004-0100, 333-004-0110, 333-004-0120, 333-004-0140, 333-004-0150, 333-004-0160
Proposed Repeals: 333-004-0090
Last Date for Comment: 1-26-09, 5 p.m.
Summary: The Department of Human Services, Public Health Division is proposing to amend and repeal Oregon Administrative Rules related to the Family Planning Expansion Program (FPEP). FPEP is a Medicaid waiver demonstration project approved by the Centers for Medicare and Medicaid Services (CMS). At this time, the program proposes to amend rules to incorporate federal Medicaid regulations on citizenship documentation and other eligibility requirements, and to reflect current program practice.
Rules Coordinator: Brittany Sande
Address: Department of Human Services, Public Health Division, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (971) 673-1291

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Rule Caption: WISEWOMAN Program.

Date:	Time:	Location:
1-22-09	3 p.m.	800 NE Oregon St., Rm. 1C Portland, OR 97232

Hearing Officer: Jana Fussell
Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 409.010 & 431.250
Proposed Adoptions: 333-010-0200, 333-010-0205, 333-010-0210, 333-010-0215, 333-010-0220, 333-010-0225, 333-010-0230, 333-010-0235, 333-010-0240, 333-010-0245, 333-010-0250, 333-010-0255, 333-010-0260, 333-010-0265, 333-010-0270, 333-010-0275, 333-010-0280, 333-010-0285, 333-010-0290
Last Date for Comment: 1-26-09, 5 p.m.
Summary: The Department of Human Services, Public Health Division is proposing to adopt rules to facilitate administration of the WISEWOMAN Program.
Rules Coordinator: Brittany Sande
Address: Department of Human Services, Public Health Division, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (971) 673-1291

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Department of Public Safety Standards and Training
Chapter 259

Rule Caption: Amend Minimum Standards for Polygraph Trainees and Polygraph Examiners and amend fingerprint submittal requirements.
Stat. Auth.: ORS 702.230
Stats. Implemented: ORS 703.230
Proposed Amendments: 259-020-0010, 259-020-0015, 259-020-0020, 259-020-0025
Last Date for Comment: 1-23-09, 5 p.m.
Summary: Requires the submittal of one fingerprint card, rather than two fingerprint cards, when processing through the Oregon State Police;

Requires an individual who has conducted polygraphs in another state to meet the minimum standards in effect in Oregon prior to obtaining a polygraph license;

Provides for reapplication process when a license has lapsed and outlines renewal requirements;

Allows provision for additional time, beyond the current two year time limitation, for a polygraph trainee to obtain a total of 200 examinations; and

Additional housekeeping changes were made for clarity and readability.
Rules Coordinator: Bonnie Salle-Narveaz
Address: 4190 Aumsville Hwy SE, Salem, OR 97317
Telephone: (503) 378-2431

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Department of Transportation,
Driver and Motor Vehicle Services Division
Chapter 735

Rule Caption: Clarifying when DMV Will Waive a Knowledge or Drive Test for a Motorcycle Endorsement.
Stat. Auth.: ORS 184.616, 184.619, 802.010, 802.200, 802.540, 807.070, 807.072, 807.080, 807.170 & 807.175
Stats. Implemented: ORS 807.070, 807.072, 807.080, 807.170, 807.175, 807.530 & 809.310
Proposed Adoptions: 735-062-0078
Proposed Amendments: 735-062-0040, 735-062-0080, 735-062-0140
Last Date for Comment: 1-21-09
Summary: ORS 807.072(1) allows DMV to waive a knowledge test required under ORS 807.070(2), by rule, if the department receives proof that the examination is given in conjunction with a motorcycle rider education course established under ORS 802.320. DMV proposes to adopt OAR 735-062-0078 to specify when DMV may waive the knowledge test required for a motorcycle endorsement if the applicant presents a course completion card from a motorcycle rider education course established under ORS 802.320.

DMV proposes to amend OAR 735-062-0040 to clarify that a knowledge test may also be required for an endorsement, such as a motorcycle endorsement. DMV proposes to amend OAR 735-062-0080 to specify that DMV may waive the motorcycle skills test only for an applicant 21 years of age or older if the applicant has a motorcycle endorsement issued by another jurisdiction. This clarification is needed as ORS 807.175 requires a person under 21 years of age to successfully complete a motorcycle rider education course

established by the department under ORS 802.320. Other changes are made for clarity.

These rules were recently out for public comment, noticed in the September 1, 2008 Oregon Bulletin with the public comment period ending on September 22, 2008. DMV received one public comment. Upon further review, DMV determined that the proposed rules should be revised to delete specific references to TEAM OREGON training courses. Because this constitutes a change to the proposed rules, DMV is noticing these rules again for a new public comment period.

Text of proposed and recently adopted ODOT rules can be found at the website: http://www.oregon.gov/ODOT/CS/RULES/

Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, Rm. 29, Salem, OR 97301
Telephone: (503) 986-3171

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Rule Caption: Medical Standards for Drivers of Commercial Motor Vehicles.
Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.040, 807.100, 807.340 & 809.419
Other Auth.: Title 49, CFR § 391.41 - 391.49
Stats. Implemented: ORS 807.040, 807.100, 807.340 & 809.419
Proposed Adoptions: 735-063-0000
Proposed Amendments: 735-063-0055, 735-063-0060, 735-063-0065, 735-063-0070, 735-063-0075
Proposed Repeals: 735-063-0050
Last Date for Comment: 1-21-09
Summary: There are federal standards for issuing a commercial driver license (CDL), including medical standards, that a person must meet to qualify for a CDL. The Oregon Department of Transportation (ODOT) may issue a waiver of physical disqualification to a driver who does not meet all federal physical qualification standards required for a driver of a commercial motor vehicle. The waiver allows the driver to operate a commercial motor vehicle in Oregon for intrastate commerce. These rules establish the medical standards for a driver of a commercial motor vehicle, the medical certificate that is acceptable in Oregon, and the procedures for acceptance of a medical certificate. The rules also establish when DMV will issue, deny, or revoke a waiver of physical disqualification to a person who does not meet all the physical requirements to drive a CMV.

DMV proposes to adopt a new rule, OAR 735-063-000, provides definitions to make these rules easier to read and understand,

The proposed amendments to OAR 735-063-0055 and OAR 735-063-0065 incorporate new definitions. Other changes are made to clarify language.

DMV proposes to amend OAR 735-063-0070 and 735-063-0075 regarding the Oregon Waiver of Physical Disqualification. Prior to October 1, 2007, these waivers were issued by the Motor Carrier Transportation Division of ODOT (MCTD). At that time, the responsibility for issuance of these waivers was transferred to DMV and the rules were amended to reflect DMV's role. DMV is further amending the rules to more clearly outline the application and issuance process, the conditions and restrictions of holding a waiver, and when a waiver may be denied or revoked. DMV is also deleting language concerning financial sanctions that are no longer applicable.

DMV proposes to repeal OAR 735-063-0050 because it simply repeats the statutory requirements of ORS 807.100. Text of proposed and recently adopted ODOT rules can be found at the website: http://www.oregon.gov/ODOT/CS/RULES/

Rules Coordinator: Lauri Kunze
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 355 Capitol St. NE, Rm. 29, Salem, OR 97301
Telephone: (503) 986-3171

Oregon Department of Education
Chapter 581

Rule Caption: Adopts by reference instructional materials for science and mathematics.
Stat. Auth.: ORS 326.051
Stats. Implemented: ORS 337.035
Proposed Adoptions: 581-011-0136, 581-011-0142
Last Date for Comment: 1-21-09, 5 p.m.
Summary: Adopts by reference criteria for instructional materials in mathematics, grades 9–12 and science for kindergarten through grade 12. Applies to contract years 2010–2016.
Rules Coordinator: Paula Merritt
Address: 255 Capitol St. N.E., Salem, OR 97310
Telephone: (503) 947-5746

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Rule Caption: Modifies rules relating to instructional materials used in kindergarten through grade 12 schools.
Stat. Auth.: ORS 327.051 & 337.035
Stats. Implemented: ORS 337
Proposed Adoptions: 581-011-0087, 581-011-0114
Proposed Amendments: 581-011-0050, 581-011-0052, 581-011-0055, 581-011-0060, 581-011-0065, 581-011-0066, 581-011-0067, 581-011-0070, 581-011-0071, 581-011-0075, 581-011-0080, 581-011-0086, 581-011-0090, 581-011-0095, 581-011-0117, 581-022-1622, 581-022-1640, 581-022-1650
Proposed Repeals: 581-011-0072, 581-011-0073, 581-011-0074, 581-011-0076, 581-011-0077, 581-011-0078, 581-011-0079, 581-011-0118, 581-011-0119, 581-011-0120, 581-011-0125, 581-011-0130, 581-011-0131, 581-011-0135, 581-011-0140, 581-011-0145, 581-011-0210
Last Date for Comment: 1-21-09, 5 p.m.
Summary: Modifies and clarifies rules relating to criteria for selection on instructional materials for kindergarten through grade 12 public schools. Repeals obsolete rules relating to instructional materials. Provides requirements for digital content in instructional materials.
Rules Coordinator: Paula Merritt
Address: 255 Capitol St. N.E., Salem, OR 97310
Telephone: (503) 947-5746

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Oregon Liquor Control Commission
Chapter 845

Rule Caption: Amendments to stipulate control of minor patronage and standardize language with temporary sales license rule.

Date:	Time:	Location:
1-27-09	10 a.m.–12 p.m.	9079 SE McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Jennifer Huntsman
Stat. Auth.: ORS 471, 471.030, 471.040 & 471.730(1) & (5)
Stats. Implemented: ORS 471.184, 471.223 & 471.227
Proposed Amendments: 845-005-0405, 845-0005-0410, 845-005-0415
Last Date for Comment: 2-10-09
Summary: These three rules describe the qualifications a Full or Limited On-Premises Sales Licensee must meet for the Commission to approve them for small-scale private catering, large-scale private catering, or applying for the temporary use of their license at another location. Also described is the process a Winery or Grower Sales Privilege licensee must follow to apply for using the privilege of their license on another premises. The proposed amendments match the changes recently made to Minor Posting and Temporary Sales License rules. Those amendments are: deleting "ongoing business operation" language and replacing it with the limitation that the same applicant at a single location can be issued a temporary license for no more than 31 license days per calendar year; definition of key terms; removing references to the Minor Posting rule and instead clarifying requirements in each temporary event rule regarding plans

to control minor patronage; and standardizing rule language with Temporary Sales License and Minor Posting rules.
Rules Coordinator: Jennifer Huntsman
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Rule Caption: Amendment to clarify the use of statute versus rule for sanctioning violations of age verification.

Date:	Time:	Location:
1-28-09	10 a.m.–12 p.m.	9079 SE McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Jennifer Huntsman
Stat. Auth.: ORS 471, 471.030, 471.040, 471.482 & 471.730
Stats. Implemented: ORS 471.130, 471.410, 471.430, 471.480 & 471.482
Proposed Amendments: 845-006-0335
Last Date for Comment: 2-11-09
Summary: This rule describes the requirements and responsibilities of licensees and permittees to prevent minors from purchasing and consuming alcohol on their premises or from being in an area that is prohibited to minors. The purpose of the amendment is to clarify that the Commission may sanction verification of age violations under either the applicable statute (ORS 471.130 and 471.410(2)) or this rule (OAR 845-006-0335), but not under both for the same violation. The amendment also clarifies that the Commission may impose a sanction under more than one section of the rule where there are multiple violations (such as selling to a minor and allowing a minor in a prohibited area.).
Rules Coordinator: Jennifer Huntsman
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Rule Caption: Amendments to clarify and strengthen prohibitions against certain drink promotions such as drinking contests.

Date:	Time:	Location:
2-3-09	10 a.m.–12 p.m.	9079 SE McLoughlin Blvd. Portland, OR

Hearing Officer: Jennifer Huntsman
Stat. Auth.: ORS 471, 471.030, 471.040 & 471.730(1) & (5)
Stats. Implemented: ORS 471.030, 471.040, 471.175, 471.178, 471.200, 471.315(3)(a)(G), 471.405(1), 471.408, 471.412, 471.675 & 471.730
Proposed Amendments: 845-006-0345
Last Date for Comment: 2-17-09
Summary: This rule describes a variety of acts which both licensees (including their employees or agents) and service permittees are prohibited from engaging in. Due to recent case history, staff is recommending the amendment of section (11) covering promotions, to specifically tighten the rule language prohibiting drinking contests (a)(E) and free-pouring alcohol (a)(F). Also, staff is recommending additional rule language in section (11) Promotions which would prevent the current practice of a cover charge and then penny drinks (a)(D) and clarify that no drink discounts are allowed after midnight (a)(C), as well as prohibiting on-premises sales of distilled spirits by the bottle (a)(B) and alcohol vaporization devices (a)(G). Staff also recommends making further clarifying amendments. These additional amendments include: an introductory paragraph clarifying that licensees are held accountable for the acts of their agents and employees; the addition to each section of the sanction level for violation of that section; and clarifying amendments to section (6) Liquor on Premises, section (7) Drive-up window, and section (10) related to kegs and minor patronage.
Rules Coordinator: Jennifer Huntsman
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

Rule Caption: Amendment increasing sanction for financial assistance violations and modifying list of possible mitigation/aggravation reasons.

Date:	Time:	Location:
2-4-09	10 a.m.–12 p.m.	9079 McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Jennifer Huntsman
Stat. Auth.: ORS 471, 471.030, 471.040, 471.730(1) & (5)
Stats. Implemented: ORS 471.315, 471.322 & 471.327
Proposed Amendments: 845-006-0500
Last Date for Comment: 2-18-09
Summary: This rules describes the various sanctions the Commission imposes on licensees, including cancellation or suspension of a license, and civil penalties. The rule also references Exhibit 1, which lists the proposed sanctions for the first and subsequent violations within each violation category and also provides the categories for the most common violations. This exhibit is not part of the Oregon Administrative Rule (OAR) Compilation. Staff proposes amendments to achieve three goals. The first is to raise Financial Assistance violations from a Category IV to a Category III violation. The second is to remove "previous lengthy history of compliance" as a possible reason for mitigating a sanction. And the third is to add "failure to use age verification equipment which was purchased as an offset to a previous penalty" as a possible reason for aggravating a sanction, While not part of the formal rulemaking process with the Secretary of State (SOS), staff also proposes revising Exhibit 1, both to make the corresponding change in the Category level for Financial Assistance violations and also to update language and rule citations to reflect rule amendments the Commission has adopted in the past year.
Rules Coordinator: Jennifer Huntsman
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222
Telephone: (503) 872-5004

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Oregon Medical Board
Chapter 847

Rule Caption: Expands definition of Unprofessional Misconduct; expands list of behaviors that constitute Sexual Misconduct.

Date:	Time:	Location:
1-16-09	9 a.m.	1500 SW 1st Ave., Suite 620 Portland, OR

Hearing Officer: Kathleen Haley
Stat. Auth.: ORS 677.190 & 677.265
Stats. Implemented: ORS 677.188, 677.190, 677.265 & 677.415
Proposed Amendments: 847-010-0073
Last Date for Comment: 1-16-09
Summary: The proposed rule change expands the definition of Unprofessional Conduct, and also expands the list of behaviors that constitute Sexual Misconduct.
Rules Coordinator: Diana M. Dolstra
Address: Board of Medical Examiners, 1500 SW 1st Ave., Suite #620, Portland, OR 97201
Telephone: (971) 673-2713

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Oregon Public Employees Retirement System
Chapter 459

Rule Caption: Extends health insurance coverage under PERS Plan to registered domestic partners.

Date:	Time:	Location:
1-20-09	2 p.m.	PERS Boardroom 11410 SW 68th Pkwy. Tigard, OR

Hearing Officer: Daniel Rivas
Stat. Auth.: ORS 238.410 & 238.650
Stats. Implemented: ORS 238.410, 238.415 & 238.420
Proposed Amendments: 459-035-0000 – 459-035-0220
Last Date for Comment: 1-21-09

Summary: Modifications to Division 35 rules extend health insurance coverage under the PERS Plan to registered domestic partners, in accordance with state law.
Rules Coordinator: Daniel Rivas
Address: Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281
Telephone: (503) 603-7713

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Rule Caption: Specifies the actuarial methods and assumptions to be included in ETOB studies.
Stat. Auth.: ORS 238.650
Stats. Implemented: ORS 237.620
Proposed Amendments: 459-030-0025
Last Date for Comment: 1-14-09
Summary: Sets forth the methods and assumptions needed to conduct an "equal to or better than" (ETOB) study that complies with acturial standards and allows a reasonable comparison based on the statutory standard.
Rules Coordinator: Daniel Rivas
Address: Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281
Telephone: (503) 603-7713

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Oregon State Marine Board
Chapter 250

Rule Caption: Establish moorage buffer in the Marion and Polk Counties area of the Willamette River.
Stat. Auth.: ORS 830
Stats. Implemented: ORS 830.110 & 830.175
Proposed Amendments: 250-020-0261
Proposed Repeals: 250-020-0290
Last Date for Comment: 1-31-09, 5 p.m.
Summary: This rule will set a 5 mph slow-no-wake zone within 100 feet of the Salem waterfront park transient moorage/dock facility. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
Rules Coordinator: June LeTarte
Address: 435 Commercial Street NE, #400, PO Box 14145, Salem OR 97309
Telephone: (503) 378-2617

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Oregon University System,
Eastern Oregon University
Chapter 579

Rule Caption: Amend revolving charge account plan.
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Amendments: 579-015-0000, 579-015-0005
Last Date for Comment: 1-21-09
Summary: Amend terms and conditions regarding revolving charge accounts at Eastern Oregon University.
Rules Coordinator: Lara Moore
Address: Oregon University System, Eastern Oregon University, One University Blvd., La Grande, OR 97850
Telephone: (541) 962-3368

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Oregon University System,
Western Oregon University
Chapter 574

Rule Caption: Revisions to special course fees and general services fees.
Stat. Auth.: ORS 351.070 & 351.072
Stats. Implemented: ORS 351.070 & 351.072
Proposed Amendments: 547-050-0005
Last Date for Comment: 1-21-09
Summary: Amendments will allow for increases, additions, and revisions of special course fees and general services fees.
Rules Coordinator: Debra L. Charlton
Address: Oregon University System, Western Oregon University, 345 N Monmouth Ave., Monmouth, OR 97361
Telephone: (503) 838-8175

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Oregon Youth Authority
Chapter 416

Rule Caption: Standards for the Foster Home.
Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420.888–420.892
Proposed Amendments: 416-530-0070
Last Date for Comment: 1-21-09, Close of Business
Summary: The rule modifications allow for the assignment of two juvenile sex offenders to one foster home bedroom with proper authorization.
Rules Coordinator: Winifred Skinner
Address: 530 Center Street NE, Suite 200; Salem, OR 97301-3765
Telephone: (503) 373-7570

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Travel Information Council
Chapter 733

Rule Caption: Clarify definitions and correct cross-references for Logo signs and related highway sign rules.
Stat. Auth.: ORS 377.700–377.840
Stats. Implemented: ORS 183.310–183.550
Proposed Amendments: Rules in 733-030
Proposed Repeals: Rules in 733-030
Last Date for Comment: 1-23-09
Summary: The Travel Information Council help a quarterly meeting on December 12, 2008. The Council proposed rules changes to amend highway sign rules to more clearly state definitions and language for Logo signs, TOD signs, Historical Markers, and Museum and historic signs; and to create consistent language and correct cross-references between rule sections.
Rules Coordinator: Diane Cheyne
Address: Travel Information Council, 229 Madrona Ave. SE, Salem, OR 97302
Telephone: (503) 378-4508

Board of Examiners for Engineering and Land Surveying
Chapter 820

Rule Caption: Clarify rules related to registration and applying for registration.
Adm. Order No.: BEELS 4-2008
Filed with Sec. of State: 12-12-2008
Certified to be Effective: 12-12-08
Notice Publication Date: 10-1-2008
Rules Amended: 820-010-0215
Subject: OAR 820-010-0215 — *Correct filing error on November 14, 2008* — Proposed amendments clarify the application process and required documentation.
Rules Coordinator: Mari Lopez—(503) 362-2666, ext. 26

820-010-0215
Form of Applications

(1) Applications for registration as professional engineers, professional land surveyors, professional photogrammetrists and for enrollment as an EI, an LSI, or an application for certification as a water right examiner shall be made on printed forms issued by the Board.

(2) All applications must be accompanied by the appropriate fee.

(3) The following must be submitted to the Board in a single package by the application deadline in OAR 820-010-0442:

(a) Application;

(b) Experience Details form;

(c) Reference Details forms;

(d) Request for Reasonable Accommodations to Oregon Specific Examinations; and

(e) Explanation of any work performed in conjunction with any educational program as defined in OAR 820-010-0010.

(4) The following documents may be submitted by the issuer to the Board office and received no later than March 1 for the Spring examination administration or no later than September 1 for the Fall examination administration:

(a) Official verification of examinations and/or substantially equivalent examinations successfully passed;

(b) Official verification of current registration by another jurisdiction;

(c) Official transcripts or course-by-course evaluations; or

(d) NCEES Records.

(5) Applicants who do not comply with this rule will be considered failing to complete the application process and subject to OAR 820-010-0300.

Stat. Auth.: ORS 670.310, 672.095, 672.157, & 672.255
Stats. Implemented: ORS 672.002 - 672.325
Hist.: EE 13, f. 3-29-72, ef. 4-15-72; EE 20, f. & ef. 12-15-77; EE 1-1983, f. 2-28-83, ef. 3-1-83; EE 2-1986, f. 3-26-86, ef. 3-31-86; EE 4-1987, f. & ef. 12-1-87; EE 1-1992, f. & cert. ef. 2-3-92; EE 1-1995, f. 8-15-95, cert. ef. 9-1-95; EE 1-1995, f. 8-15-95, cert. ef. 9-1-95; Renumbered from 820-010-0220; BEELS 6-2005, f. & cert. ef. 12-13-05; BEELS 5-2007, f. & cert. ef. 9-20-07; BEELS 3-2008, f. & cert. ef. 11-14-08; BEELS 4-2008, f. & cert. ef. 12-12-08

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Board of Naturopathic Examiners
Chapter 850

Rule Caption: Updates the formulary compendium.
Adm. Order No.: BNE 7-2008
Filed with Sec. of State: 12-8-2008
Certified to be Effective: 12-8-08
Notice Publication Date: 11-1-2008
Rules Amended: 850-060-0225, 850-060-0226
Subject: Updates the Formulary for Naturopathic physicians and Pharmacists:

Add to 850-060-0225 the following that can be prescribed: Amantadine, Exenatide, Memantine, Rimantidine, Selegiline.

Add to 850-060-0226 Classifications: Adamantanes**, Anti-Alzhiemer, Incretin Analogues**.
Rules Coordinator: Anne Walsh—(971) 673-0193

850-060-0225
Naturopathic Formulary Compendium

The following substances have been recommended for addition to the Formulary Compendium after review by the Board of Naturopathic Examiners Formulary Council established by the 65th Oregon Legislature. Substances listed on the formulary compendium can be prescribed in any dosage or any dosage form. Products marked with an asterisk (*) may be used by Naturopathic Physicians, but may not be prescribed. Combination products containing only active ingredients listed in the Formulary may be prescribed. Combination products containing any active ingredient(s), not listed in the Formulary, except non-legend drugs, may not be prescribed.

(1) Abacavir;
(2) Acarbose;
(3) Acetic Acid;
(4) Acetylcysteine;
(5) Acitretin;
(6) Acyclovir;
(7) Adapalene;
(8) Adenosine Monophosphate;
(9) Albuterol Sulfate;
(10) Alendronate;
(11) Allopurinol;
(12) Alprostadil;
(13) Amantadine;
(14) Amino Acids;
(15) Amino Aspirins;
(16) Aminoglycosides;
(17) Aminolevulinic Acid;
(18) Aminophylline;
(19) Aminosalicylic Acid;
(20) Ammonium Chloride;
(21) Ammonium lactate lotion 12%;
(22) Amoxicillin;
(23) Amoxicillin & Clavulanate;
(24) Amphotericin B;
(25) Ampicillin;
(26) Ampicillin & Sulbactam;
(27) Anastrozole;
(28) Anthralin;
(29) Atorvastatin;
(30) Atropine;
(31) Atropine Sulfate;
(32) Auranofin;
(33) Azelaic Acid;
(34) Azithromycin;
(35) Bacampicillin;
(36) Bacitracin;
(37) Baclofen;
(38) Becaplermin;
(39) Belladonna;
(40) Benazepril;
(41) Benzodiazepines;
(42) Benzoic Acid;
(43) Benzonatate;
(44) Betaine;
(45) Betamethasone;
(46) Bethanechol Chloride;
(47) Bichloracetic Acid*;
(48) Bimatoprost Solution 0.03%;
(49) Biologicals;
(50) Bisphosphonates;
(51) Bromocriptine;
(52) Budesonide;
(53) Buprenorphine;
(54) Butorphanol;
(55) Cabergoline;
(56) Calcipotriene;
(57) Calcitonin;
(58) Calcitriol;
(59) Carbamide Peroxide;
(60) Carbidopa;
(61) Carbol-Fuchsin;
(62) Captopril;
(63) Cefaclor;
(64) Cefdinir;
(65) Cefibuten;
(66) Cefadroxil;
(67) Cefditoren;
(68) Cefixime;
(69) Cefonicid Sodium;
(70) Cefpodoxime Proxetil;

(71) Cefprozil;
(72) Ceftibuten;
(73) Cefuroxime;
(74) Celecoxib;
(75) Cellulose Sodium Phosphate;
(76) Cenestin;
(77) Cephalexin;
(78) Cephradine;
(79) Chirocaine*;
(80) Chloramphenicol;
(81) Chloroquine;
(82) Citrate Salts;
(83) Clarithromycin;
(84) Clindamycin;
(85) Clioquinol;
(86) Clostridium botulinum toxin (ab);
(87) Cloxacillin;
(88) Codeine;
(89) Colchicine;
(90) Colistimethate;
(91) Collagenase;
(92) Condylox;
(93) Cortisone;
(94) Coumadin;
(95) Cromolyn Sodium;
(96) Cyanocobalamin;
(97) Cycloserine;
(98) Cytisine
(99) Danazol;
(100) Deferoxamine/Desferroxamine (Board approved certification required before therapeutic IV chelation is allowed);
(101) Demeclocycline Hydrochloride;
(102) Desmopressin;
(103) Desoxyribonuclease;
(104) Dexamethasone;
(105) Dextran;
(106) Dextromethorphan;
(107) Dextrose;
(108) Dextrothyroxine;
(109) Dicloxacillin;
(110) Dihydroergotamine Migranal;
(111) Didanosine;
(112) Dimethyl Sulfone (DMSO);
(113) Digitalis;
(114) Digitoxin;
(115) Digoxin;
(116) Dinoprostone;
(117) Diphenhydramine
(118) Diphylline;
(119) Dirithromycin;
(120) DMPS (Board approved certification required before therapeutic IV chelation is allowed);
(121) DMSA;
(122) Doxercalciferol;
(123) Doxycycline;
(124) Dronabinol;
(125) Dyclonine;
(126) EDTA (Board approved certification required before therapeutic IV chelation is allowed);
(127) Electrolyte Solutions;
(128) Emtricitabine;
(129) Enalapril;
(130) Ephedrine;
(131) Epinephrine*;
(132) Epinephrine (auto-inject);
(133) Ergoloid Mesylates;
(134) Ergonovine Maleate;
(135) Ergotamine;
(136) Erythromycins;
(137) Erythropoietin;
(138) Estradiol;
(139) Estriol;
(140) Estrogen-Progestin Combinations;
(141) Estrogens, Conjugated;
(142) Estrogen, Esterified;
(143) Estrone;
(144) Estropipate;
(145) Eszopiclone;
(146) Ethyl Chloride;
(147) Etidronate;
(148) Exenatide;
(149) Ezetimibe;
(150) Famciclovir;
(151) Fentanyl;
(152) Fibrinolysin;
(153) Flavoxate;
(154) Fluconazole;
(155) Fludrocortisone Acetate;
(156) Flunisolide;
(157) Fluorides;
(158) Fluoroquinolones;
(159) Fluoroquinolines;
(160) Fluorouracil;
(161) Fluticasone propionate;
(162) Fluvastatin;
(163) Fosinopril;
(164) Gaba Analogs;
(165) Gabapentin;
(166) Galantamine H. Br.;
(167) Gamma-Hydroxy Butyrate;
(168) Ganciclovir;
(169) Gentamicin;
(170) Gentian Violet;
(171) Glycerin/Glycerol;
(172) Griseofulvin;
(173) Guaifenesin;
(174) Heparin - subcutaneous, sublingual and heparin locks;
(175) Hexachlorophene;
(176) Homatropine Hydrobromide*;
(177) Human Growth Hormone;
(178) Hyaluronic Acid;
(179) Hyaluronidase;
(180) Hydrocodone;
(181) Hydrocortisone;
(182) Hydrogen Peroxide;
(183) Hydromorphone;
(184) Hydroquinone;
(185) Hydroxychloroquine;
(186) Hydroxypolyethoxydodecane*;
(187) Hyoscyamine;
(188) Iloprost Inhalation Solution;
(189) Imiquimod Cream (5%);
(190) Immune Globulins*;
(191) Insulin;
(192) Interferon Alpha b w/Ribaviron;
(193) Iodine;
(194) Iodoquinol;
(195) Iron Preparations;
(196) Isosorbide Dinitrate;
(197) Isotretinoin;
(198) Itraconazole;
(199) Kanamycin Sulfate;
(200) Ketoconazole;
(201) Lactulose;
(202) Lamivudine;
(203) Letrozole;
(204) Leucovorin Calcium;
(205) Levalbuteral;
(206) Levocarnitine;
(207) Levodopa;
(208) Levonorgestrel;
(209) Levorphanol;
(210) Levothyroxine;
(211) Lincomycin;
(212) Lindane;
(213) Liothyronine;
(214) Liotrix;
(215) Lisinopril;
(216) Lisuride;
(217) Lithium;

(218) Lovastatin;
(219) Mebendazole;
(220) Meclizine;
(221) Medroxyprogesterone;
(222) Medrysone;
(223) Mefloquine;
(224) Megestrol Acetate;
(225) Mercury, Ammoniated;
(226) Memantine;
(227) Mesalamine;
(228) Metformin;
(229) Methadone;
(230) Methimazole;
(231) Methoxsalen;
(232) Methscopolamine;
(233) Methylergonovine;
(234) Methylprednisolone;
(235) Methylsulfonylmethane (MSM);
(236) Methyltestosterone;
(237) Methysergide;
(238) Metronidazole;
(239) Miglitol;
(240) Minerals (Oral & Injectable);
(241) Minocycline;
(242) Misoprostol;
(243) Moexipril;
(244) Monobenzone;
(245) Morphine;
(246) Mupirocin;
(247) Nafarelin acetate;
(248) Naloxone;
(249) Naltrexone;
(250) Natamycin;
(251) Nateglinide;
(252) Nicotine;
(253) Nitroglycerin;
(254) Novobiocin;
(255) Nystatin;
(256) Olsalazine;
(257) Omeprazole;
(258) Opium;
(259) Over the Counter (OTC)
(260) Oxacillin;
(261) Oxamniquine;
(262) Oxaprozin;
(263) Oxtriphylline;
(264) Oxycodone;
(265) Oxygen;
(266) Oxymorphone;
(267) Oxytetracycline;
(268) Oxytocin*;
(269) Pancrelipase;
(270) Papain;
(271) Papavarine;
(272) Paramethasone;
(273) Paregoric;
(274) Penciclovir;
(275) Penicillamine (Board approved certification required before therapeutic IV chelation is allowed);
(276) Penicillin;
(277) Pentosan;
(278) Pentoxifylline;
(279) Pergolide;
(280) Perindopril;
(281) Permethrin;
(282) Phenazopyridine;
(283) Phenylalkylamine;
(284) Phenylephrine*;
(285) Physostigmine;
(286) Pilocarpine;
(287) Pimecrolimus Cream 1%;
(288) Piperazine Citrate;
(289) Podophyllum Resin;
(290) Polymyxin B Sulfate;
(291) Polysaccharide-Iron Complex;
(292) Potassium Iodide;
(293) Potassium Supplements;
(294) Pramoxine;
(295) Pravastatin;
(296) Praziquantel;
(297) Prednisolone;
(298) Prednisone;
(299) Pregabalin;
(300) Progesterone;
(301) Progestins;
(302) Propionic Acids;
(303) Propylthiouracil;
(304) Prostaglandins;
(305) Proton Pump inhibitor;
(306) Pseudoephedrine;
(307) Pyrazinamide;
(308) Pyrethrins;
(309) Quinapril;
(310) Quinidine;
(311) Quinilones;
(312) Quinine Sulfate;
(313) Quinines;
(314) Quinolines;
(315) Ramopril;
(316) Rauwolfia Alkaloids;
(317) Rho(D) Immune globulins*;
(318) Rifabutin;
(319) Rifampin;
(320) Rimantidine;
(321) Risendronate;
(322) Ranolazine;
(323) Salicylamide;
(324) Salicylate Salts;
(325) Salicylic Acid;
(326) Salsalate;
(327) Scopolamine;
(328) Selegiline;
(329) Selenium Sulfide;
(330) Sildenafil Citrate;
(331) Silver Nitrate;
(332) Simvastatin;
(333) Sitagliptin;
(334) Sodium Polystyrene Sulfonate;
(335) Sodium Tetradecyl Sulfate
(336) Sodium Thiosulfate;
(337) Spironolactone;
(338) Stavudine;
(339) Spectinomycin;
(340) Sucralfate;
(341) Sulfasalazine;
(342) Sulfonamide/Trimethoprim/Sulfones;
(343) Tacrolimus;
(344) Tazarotene topical gel;
(345) Telithromycin;
(346) Tenofovir;
(347) Testosterone;
(348) Tetracycline;
(349) Theophylline;
(350) Thiabendazole;
(351) Thyroid;
(352) Thyroxine;
(353) Tiagabine;
(354) Tibolone;
(355) Tiludronate;
(356) Tinidazole;
(357) Tobramycin;
(358) Topical steroids;
(359) Tramadol;
(360) Trandolapril;
(361) Trazodone;
(362) Tretinoin;
(363) Triamcinolone;
(364) Triamterene;
(365) Trichloracetic Acid*;
(366) Trimetazidine;

(367) Trioxsalen;
(368) Triptans;
(369) Troleandomycin;
(370) Undecylenic Acid;
(371) Urea;
(372) Urised;
(373) Ursodiol;
(374) Valacyclovir;
(375) Valproic Acid;
(376) Vancomycin;
(377) Varenicline;
(378) Verapamil;
(379) Verdenafil HCL;
(380) Vidarabine;
(381) Vitamins (Oral & Injectable);
(382) Yohimbine;
(383) Zalcitabine;
(384) Zidovudine;
(385) Zolpidem;
(386) Local Anesthetics:
(a) Benzocaine*;
(b) Bupivacaine*;
(c) Chloroprocaine*;
(d) Dyclonine*;
(e) Etidocaine*;
(f) Lidocaine*;
(g) Lidocaine (non-injectable dosage form);
(h) Mepivocaine*;
(i) Prilocaine*;
(j) Procaine*;
(k) Tetracaine*.
(387) Vaccines:
(a) BCG*;
(b) Cholera*;
(c) Diptheria*;
(d) DPT*;
(e) Haemophilus b Conjugate*;
(f) Hepatitis A Virus*;
(g) Hepatitis B*;
(h) Influenza Virus*;
(i) Japanese Encephalitis Virus*;
(j) Measles Virus*;
(k) Mumps Virus*;
(l) Pertussis*;
(m) Plague*;
(n) Pneumococcal*;
(o) Poliovirus Inactivated*;
(p) Poliovirus-Live Oral*;
(q) Rabies*;
(r) Rubella*;
(s) Smallpox*;
(t) Tetanus IG*;
(u) Tetanus Toxoid*;
(v) Typhoid*;
(w) Varicella*;
(x) Yellow Fever*;
(388) SkinTests:
(a) Diptheria*;
(b) Mumps*;
(c) Tuberculin*.

Stat. Auth.: ORS 685.125
Stats. Implemented: ORS 681.145
Hist.: NE 2-1990, f. & cert. ef. 11-8-90; NE 1-1997, f. 10-13-97, cert. ef. 10-20-97; BNE 1-1999, f. 6-24-99, cert. ef. 6-25-99; BNE 1-2000, f. & cert. ef. 1-10-00; BNE 3-2000, f. & cert. ef. 8-16-00; BNE 2-2001, f. & cert. ef. 2-7-01; BNE 4-2001, f. & cert. ef. 5-25-01; BNE 8-2001, f. & cert. ef. 12-7-01; BNE 4-2002, f. & cert. ef. 8-8-02; BNE 3-2003, f. & cert. ef. 6-9-03; BNE 5-2003, f. & cert. ef. 12-5-03; BNE 5-2004, f. & cert. ef. 6-10-04; BNE 3-2005, f. & cert. ef. 2-4-05; BNE 5-2005, f. & cert. ef. 6-10-05; Renumbered from 850-010-0225, BNE 8-2005, f. & cert. ef. 10-27-05; BNE 9-2005, f. & cert. ef 12-12-05; BNE 4-2006, f. & cert. ef. 12-11-06; BNE 3-2007, f. & cert. ef. 6-12-07; BNE 1-2008, f. & cert. ef. 2-19-08; BNE 2-2008, f. & cert. ef. 3-21-08; BNE 6-2008, f. & cert. ef. 6-11-08; BNE 7-2008, f. & cert. ef. 12-8-08

850-060-0226
Naturopathic Formulary by Classification

The following classifications for substances listed in 850-060-0225 have been recommended by the Board of Naturopathic Examiners Formulary Council established by the 65th Oregon Legislature. Substances listed on the formulary compendium can be prescribed in any dosage or any dosage form. Products marked with an asterisk (*) may be used by Naturopathic Physicians, but may not be prescribed. Combination products containing only active ingredients listed in the Formulary may be prescribed. Combination products containing any active ingredient(s), not listed in the Formulary, except non-legend drugs, may not be prescribed. A double asterisk (**) indicates examples include but are not limited to the substances listed.

(1) Adamantanes**;
(a) Amantadine;
(b) Memantine;
(c) Rimantidine;
(2) Amino Acids;
(a) Levocarnitine**;
(3) Antiestrogens;
(a) Nafarelin Acetate;
(b) Tibolone;
(4) Antigout;
(a) Colchicine;
(b) allopurinol;
(5) Antihistamine
(a) Diphenhydramine
(6) Anti-Alzheimer;
(a) Memantine;
(7) Anti-infective Agents;
(a) Antihelmintics;
(A) Thiabendazole.
(B) Oxamniquine.
(C) Mebendazole.
(b) Antibacterials;
(A) Aminoglycosides**;
(i) Gentamicin;
(ii) Kanamycin Sulfate;
(iii) Tobramycin;
(B) Cephalosporins**;
(i) Cefaclor;
(ii) Cefadroxil;
(iii) Cefdinir;
(iv) Cefditoren;
(v) Cefibuten;
(vi) Cefixime;
(vii) Cefonicid Sodium;
(viii) Cefpodoxime Proxetil;
(ix) Cefprozil;
(x) Ceftibuten;
(xi) Cefuroxime;
(xii) Cephalexin;
(xiii) Cephradine;
(C) Chloramphenicol;.
(D) Macrolides and Ketolides**;
(i) Azithromycin;
(ii) Clarithromycin;
(iii) Dirithromycin;
(iv) Erythromycins;
(v) Telithromycin;
(vi) Troleandomycin;
(E) Penicillins**;
(i) Amoxicillin and Clavulanate;
(ii) Amoxicillin;
(iii) Ampicillin and Sulbactam;
(iv) Ampicillin;
(v) Bacampicillin;
(vi) Cloxacillin;
(vii) Dicloxacillin;
(viii) Oxacillin;
(ix) Penicillin;
(F) Quinolones**;
(i) Fluoroquinolines;
(G) Sulfonamides;
(i) Sulfonamide/Trimethoprim/ Sulfones;
(H) Tetracyclines**;
(i) Demeclocycline Hydrochloride;
(ii) Doxycycline;
(iii) Minocycline;
(iv) Oxytetracycline;

(v) Tetracycline;
(I) Misc. antibacterials;
(i) Bacitracin;
(ii) Clindamycin;
(iii) Colistimethate;
(iv) Lincomycin;
(v) Novobiocin;
(vi) Polymyxin B Sulfate;
(vii) Spectinomycin;
(viii) Vancomycin;
(c) Antifungals;
(A) Azoles**;
(i) Fluconazole;
(ii) Itraconazole;
(iii) Ketoconazole;
(iv) Tinidazole;
(B) Amphotericin B;
(C) Gentian Violet;
(D) Griseofulvin;
(E) Nystatin;
(d) Antimycobacterials;
(A) Aminosalicylic Acid;
(B) Cycloserine;
(C) Pyrazinamide;
(D) Rifabutin;
(E) Rifampin;
(e) Antivirals;
(A) Amantadine;
(B) Rimantidine;
(C) Interferon**;
(D) Nucleoside/nucleotide analogs**;
(i) Abacavir;
(ii) Acyclovir;
(iii) Didanosine;
(iv) Emtricitabine;
(v) Famciclovir;
(vi) Ganciclovir;
(vii) Lamivudine;
(viii) Penciclovir;
(ix) Stavudine;
(x) Tenofovir;
(xi) Valacyclovir;
(xii) Viarabine;
(xiii) Zalcitabine;
(xiv) Zidovudine;
(f) Antiprotozoal;
(A) Iodoquinol;
(B) Metronidazole;
(C) Quinines;
(i) Chloroquine;
(ii) Hydroxychloroquine;
(iii) Mefloquine;
(iv) Quinine Sulfate;
(g) Misc;
(A) Immune Globulins* **;
(B) Lindane;
(C) Permethrin;
(D) Pyrethrins;
(8) Antineoplastic Agents;
(a) Anastrozole;
(b) Letrozole;
(9) Anti-thyroid;
(a) Thionamides;
(A) Methimazole;
(B) Propylthiouracil;
(10) Autonomic Drugs;
(a) Parasympathomimetic;
(A) Bethanechol;
(B) Galantamine H. Br;
(b) Anticholinergic;
(A) Atropine Sulfate;
(B) Atropine;
(C) Belladonna;
(D) Flavoxate;
(E) Homatropine Hydrobromide*;
(F) Hyoscyamine;
(G) Meclizine;
(H) Methscopolamine;
(I) Physostigmine;
(J) Pilocarpine;
(K) Scopolamine;
(c) Sympathomimetic;
(A) Ephedrine;
(B) Epinephrine*;
(C) Epinephrine (auto-inject);
(D) Psuedoephedrine;
(d) Sympatholytic;
(A) Yohimbine;
(e) Skeletal Muscle Relaxants;
(A) Clostridium botulinum toxin (ab);
(B) Baclofen;
(f) Misc;
(A) Nicotine;
(11) Beta Adrenergic Blocking Agents**;
(12) Biologicals;
(a) Cytokine;
(A) Monoclonal antibodies;
(b) Enzymes**;
(A) Collagenase;
(B) Desoxyribonuclease;
(C) Fibrinolysin;
(D) Hyaluronidase;
(E) Pancrelipase;
(F) Papain;
(c) Hormones — see hormone;
(d) Immune gobulins — see anti-infective, misc;
(e) Interferons — see antivirals;
(f) Prostaglandins**;
(A) Alprostadil;
(B) Bimatoprost;
(C) Iloprost;
(D) Dinoprostone;
(E) Misoprostal;
(g) Blood derivatives;
(13) Blood Formation and Coagulation;
(a) Coumadin;
(b) Erythropoietin;
(c) Heparin; subcutaneous, sublingual and heparin locks;
(14) Cardiovascular Drugs;
(a) Cardiac;
(A) Adenosine Monophosphate;
(B) Digitalis;
(C) Digitoxin;
(D) Digoxin;
(E) Quinidine;
(b) Antilipemic;
(A) HMG CoA Reductase Inhibitors**;
(i) Atorvastatin;
(ii) Fluvastatin;
(iii) Lovastatin;
(iv) Pravastatin;
(v) Simvastatin;
(B) Ezetimibe;
(c) Diuretics;
(A) Spironolactone;
(B) Triamterene;
(d) Hypotensive;
(A) Lisuride;
(B) Rauwolfia Alkaloids;
(e) Vasodilating;
(A) Nitrates**;
(i) Isosorbide Dinitrate;
(ii) Mononitrate;
(iii) Nitroglycerin;
(B) Papavarine;
(f) Calcium Channel blockers;
(A) Phenylalkyamine**;
(i) Verapamil;
(g) ACE inhibitors**;
(A) Benazepril;

(B) Captopril;
(C) Enalapril;
(D) Fosinopril;
(E) Lisinopril;
(F) Moexipril;
(G) Perindopril;
(H) Quinapril;
(I) Ramopril;
(J) Trandolapril;
(15) Central Nervous System Agents;
(a) Analgesics and Antipyretics;
(A) NSAIDS;
(i) Amino Aspirins;
(ii) Celecoxib;
(iii) Mesalamine;
(iv) Olsalazine;
(v) Oxaprozin;
(vi) Proprionic Acid Derivatives**;
(aa) Fenoprofen;
(bb) Flurbiprofen;
(cc) Ibuprofen;
(dd) Ketoprofen;
(ee) Oxaprozin;
(ff) Naproxen;
(vii) Salicyclic Acid;
(viii) Salicylamide;
(ix) Salicylate Salts;
(x) Salsalate;
(xi) Sulfasalazine;
(B) Opioids**;
(i) Buprenorphine;
(ii) Butorphanol;
(iii) Codeine;
(iv) Dextromethorphan;
(v) Fentanyl;
(vi) Hydrocodone;
(vii) Hydromorphone;
(viii) Levorphanol;
(ix) Methadone;
(x) Morphine;
(xi) Opium;
(xii) Oxycodone;
(xiii) Oxymorphone;
(xiv) Paregoric;
(xv) Tramadol;
(b) Opioid Antagonists;
(A) Naloxone;
(B) Naltrexone;
(c) Anticonvulsants;
(A) Gaba Analogues**;
(i) Gabapenten;
(ii) Pregabalin;
(iii) Tigabine;
(B) Valproic Acid;
(d) Anti-Parkinson's;
(A) Bromocriptine;
(B) Carbidopa;
(C) Cabergoline;
(D) Levodopa;
(E) Pergolide;
(F) Selegiline;
(e) Psychotherapeutic;
(A) Anxiolytics, sedatives and hypnotics;
(i) Benzodiazepines**;
(ii) Piperazine;
(aa) Eszopiclone;
(bb) Ranolazine;
(cc) Sildenafil Citrate;
(dd) Trimetazidine;
(ee) Verdenafil HCL;
(iii) Zolpidem;
(B) Anti-Manic;
(i) Lithium;
(f) Misc;
(A) Gamma-Hydroxy Butyrate;
(B) Triptans**;
(16) Diabetic;
(a) Acarbose;
(b) Insulin;
(c) Metformin;
(d) Miglitol;
(e) Nateglinide;
(17) Electrolytic;
(a) Ammonium Chloride;
(b) Bisphosphonates**;
(A) Alendronate;
(B) Etidronate;
(C) Risendronate;
(D) Tiludronate;
(c) Cellulose Sodium Phosphate (calcium removing);
(d) Dextran;
(e) Dextrose;
(f) Electrolyte Solutions;
(g) Fluorides;
(h) Iodine;
(i) Iron Preparations;
(j) Minerals (Oral & Injectable);
(k) Polysaccharide-Iron Complex;
(l) Potassium Iodide;
(m) Potassium Supplements;
(n) Sodium Polystyrene Sulfonate;
(18) Ergot Derivatives**;
(a) Dihydroergotamine;
(b) Ergoloid Mesylates;
(c) Ergonovine Maleate;
(d) Ergotamine;
(19) EENT preparations;
(a) Acetic Acid;
(b) Ophthalmic Solution (0.03%);
(c) Carbamide Peroxide;
(d) Natamycin;
(e) Phenylephrine;
(f) Prostaglandins — see Biologicals;
(20) GI drugs;
(a) Antidiarrhea — see opioids;
(b) Cathartics and laxatives;
(A) Lactulose;
(c) Antiemetics;
(A) Dronabinol;
(d) Antiulcer and acid suppressants;
(A) Misoprostol;
(B) Proton Pump Inhibitors**;
(i) Omeprazole;
(C) Sucralfate;
(e) Misc;
(A) Citrate Salts;
(B) Ursodiol;
(21) Gold Compounds;
(a) Auranofin;
(22) Heavy Metal antagonists (see 850-060-225 for specific education requirements);
(a) Deferoxamine/Desferroxamine;
(b) DMPS;
(c) DMSA;
(d) EDTA;
(e) Penicillamine;
(f) Sodium Thiosulfate;
(23) Histamine-1 Antagonists, excluding all 3rd generation antagonists;
(24) Histamine-2 Antagonists**;
(25) Hormones and synthetic substitutes**;
(a) Adrenals;
(A) Betamethasone;
(B) Budesonide;
(C) Cortisone;
(D) Dexamethasone;
(E) Fludrocortisone Acetate;
(F) Flunisolide;
(G) Fluticasone Propionate;
(H) Hydrocortisone;

(I) Paramethasone;
(J) Prednisolone;
(K) Prednisone;
(L) Tibolone;
(M) Triamcinolone;
(b) Androgens;
(A) Danazol;
(B) Methyltestosterone;
(C) Testosterone;
(c) Contraceptives;
(A) Estrogen-Progestin Combinations;
(B) Progestins;
(d) Estrogens and antiestrogens;
(A) Cenestin;
(B) Estradiol;
(C) Estriol;
(D) Estrogen, Esterified;
(E) Estrogens, Conjugated;
(F) Estrone;
(G) Estropipate;
(e) Pituitary;
(A) Desmopressin;
(B) Human Growth Hormone;
(C) Oxytocin;
(f) Progestins;
(A) Medroxyprogesterone;
(B) Medrysone;
(C) Megestrol Acetate;
(D) Methylprednisolone;
(E) Progesterone;
(F) Progestins;
(g) Thyroid;
(A) Dextrothyroxine;
(B) Levonorgestrel;
(C) Levothyroxine;
(D) Liothyronine;
(E) Liotrix;
(F) Thyroxine;
(26) Immunological;
(a) Tacrolimus;
(b) Rho(D) Immune globulins*;
(27) Incretin Analogues**;
(a) Exenatide;
(28) Local anesthetics**;
(a) Benzocaine*;
(b) Betaine;
(c) Bupivacaine*;
(d) Chirocaine*;
(e) Chloroprocaine*;
(f) Dyclonine*;
(g) Ethyl Chloride;
(h) Etidocaine*;
(i) Hydroxypolyetho-xydodecane*;
(j) Lidocaine (non-injectable dosage form);
(k) Lidocaine*;
(l) Mepivocaine*;
(m) Pramoxine;
(n) Prilocaine*;
(o) Procaine*;
(p) Tetracaine*;
(29) Prostaglandins — see Biologicals;
(30) Quinoline;
(a) Praziquantel;
(31) Sclerosing Agents;
(a) Sodium Tetradecyl Sulfate;
(32) Skin and mucous membrane agents;
(a) Anti-infectives;
(A) Benzoic Acid;.
(B) Carbol-Fuchsin;
(C) Clioquinol;
(D) Hexachlorophene;
(E) Iodoquinol;
(F) Mercury, Ammoniated;
(G) Mupirocin;
(H) Selenium Sulfide;
(I) Silver Nitrate;
(J) Undecylenic Acid;
(b) Anti-inflammatory;
(A) Topical steroids;
(c) Antipruritics and local anesthetics;
(A) Pentosan;
(B) Phenazopyridine;
(d) Cell stimulants and proliferants;
(A) Anthralin;
(B) Tretinoin;
(e) Keratolytic;
(A) Adapalene;
(B) Aminolevulinic Acid;
(C) Bichloracetic Acid;
(D) Imiquimod Cream (5%);
(E) Isotretinoin;
(F) Podophyllum Resin;
(G) Trichloracetic Acid*;
(H) Urea;
(f) Misc;
(A) Acitretin;
(B) Ammonium lactate lotion 12%;
(C) Azelaic Acid;
(D) Becaplermin;
(E) Calcipotriene;
(F) Condylox;
(G) Fluorouracil;
(H) Hydroquinone;
(I) Methoxsalen;
(J) Monobenzone;
(K) Pimecrolimus Cream 1%;
(L) Tazarotene topical gel;
(M) Trioxsalen;
(33) Skin Tests**;
(a) Diphtheria*;
(b) Mumps*;.
(c) Tuberculin*;
(34) Smoking Cessation;
(a) Cytisine
(b) Varenicline
(35) Upper Respiratory;
(a) Acetylcysteine;
(b) Albuterol Sulfate;
(c) Benzonatate;
(d) Cromolyn Sodium;
(e) Guaifenesin;
(f) Levalbuteral;
(g) Nedocromil;.
(h) Xanthines**;
(A) Aminophylline;
(B) Diphylline;
(C) Oxtriphylline;
(D) Pentoxifylline;
(E) Theophylline;
(36) Vaccines**;
(a) BCG*;
(b) Cholera*;
(c) Diphtheria*;
(d) DPT*;.
(e) Haemophilus b Conjugate*;
(f) Hepatitus A Virus*;
(g) Hepatitus B*;
(h) Influenza Virus*;
(i) Japanese Encephalitis Virus*;
(j) Measles Virus*;
(k) Mumps Virus*;
(l) Pertussis*;
(m) Plague*;
(n) Pneumococcal*;
(o) Poliovirus — Inactivated*;
(p) Poliovirus — Live Oral*;
(q) Rabies*;
(r) Rubella*;
(s) Smallpox*;
(t) Tetanus IG*;.

(u) Tetanus Toxoid*;
(v) Typhoid*;
(w) Varicella*;
(x) Yellow Fever*;
(37) Vitamins**;
(a) Calcitonin;
(b) Calcitriol;
(c) Cyanocobalamin;
(d) Doxercalciferol;
(e) Leucovorin Calcium;
(f) Vitamins (Oral & Injectable);
(38) Misc;
(a) Colchicine (gout);
(b) Dimethyl Sulfone (DMSO);
(c) Glycerin/Glycerol;
(d) Hyaluronic Acid;
(e) Hydrogen Peroxide;
(f) MSM;
(g) OTC Substances;
(h) Oxygen;
(i) Sitagliptin;
(j) Trazodone;
(k) Urised;

Stat. Auth.: ORS 685.125
Stats. Implemented: ORS 685.145
Hist.: BNE 1-2002, f. & cert. ef. 2-19-02; BNE 4-2002, f. & cert. ef. 8-8-02; BNE 3-2003, f. & cert. ef. 6-9-03; BNE 5-2003, f. & cert. ef. 12-5-03; BNE 5-2004, f. & cert. ef. 6-10-04; Renumbered from 850-010-0226, BNE 8-2005, f. & cert. ef. 10-27-05; BNE 9-2005, f. & cert. ef 12-12-05; BNE 4-2006, f. & cert. ef. 12-11-06; BNE 3-2007, f. & cert. ef. 6-12-07; BNE 1-2008, f. & cert. ef. 2-19-08; BNE 2-2008, f. & cert. ef. 3-21-08; BNE 6-2008, f. & cert. ef. 6-11-08; BNE 7-2008, f. & cert. ef. 12-8-08

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Board of Nursing
Chapter 851

Rule Caption: Renewal of Nurse Practitioner Prescriptive Authority Clarified.
Adm. Order No.: BN 7-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 11-26-08
Notice Publication Date: 10-1-2008
Rules Amended: 851-050-0138, 851-056-0006, 851-056-0022
Subject: These rules cover the authority of the nurse practitioner to prescribe and dispense drugs, and clarify that nurse practitioners with current prescriptive authority are required to maintain it for renewal of their nurse practitioner certificate.
Rules Coordinator: KC Cotton—(503) 947-5746

851-050-0138
Renewal of Nurse Practitioner Certification

(1) Renewal of certification shall be on the same schedule as the renewal system of the registered nurse license. The requirements for recertification are:

(a) Current unencumbered license as a registered nurse in the state of Oregon.

(b) Submission of all required application fees. Fees are not refundable. An application that has not been completed during the current biennial renewal cycle shall be considered void.

(c) Completion of 100 clock hours of continuing education related to advanced practice nursing and to the area(s) of specialty certification. As of January 2, 2007, no less than 50% shall be comprised of CME or CE accredited courses at the advanced practice specialty level.

(A) Continuing education must be obtained in the following ways:

(i) Independent learning activities e.g., reading professional journals;

(ii) Unstructured learning activities, e.g. professional meetings and clinical rounds;

(iii) Structured learning activities, e.g. seminars and workshops.

(B) Continuing education hours shall be documented on the renewal form.

(C) An applicant for renewal who has graduated from the nurse practitioner program less than two years prior to his/her first renewal will not be required to document the full 100 clock hours of continuing education. The applicant's continuing education will be prorated on a monthly basis based on the length of time between graduation and the date of the first renewal.

(D) Nurse practitioners shall maintain accurate documentation and records of any claimed continuing education and practice hours for no less than five years from the date of submission to the Board.

(d) Verification of practice hours which meet the practice requirement in OAR 851-050-0004.

(e) Verification of utilization of prescriptive authority which meets the requirements specified in 851-056-0014 unless already certified as an Oregon Nurse Practitioner without prescriptive authority.

(2) Renewal may be denied if the applicant does not meet the practice prescribing, or continuing education requirement for renewal.

(3) Applications for renewal up to 60 days past the expiration date shall meet all requirements for renewal and pay a delinquent fee.

(4) Any individual whose nurse practitioner certification is expired may not practice or represent themselves as a nurse practitioner in Oregon until certification is complete, subject to civil penalty.

Stat. Auth.: ORS 678.375 & 678.380
Stats. Implemented: ORS 678.380
Hist.: NER 34, f. & ef. 10-1-76; NER 5-1981, f. & ef. 11-24-81; NER 8-1985, f. & ef. 12-9-85; NB 3-1990, f. & cert. ef. 4-2-90; Renumbered from 851-020-0310; NB 2-1992, f. & cert. ef. 2-13-92; NB 8-1993, f. & cert. ef. 8-23-93; NB 7-1996, f. & cert. ef. 10-29-96; BN 10-2003, f. & cert. ef. 10-2-03; BN 8-2004, f. 5-4-04, cert. ef. 5-12-04; BN 13-2006, f. & cert. ef. 10-5-06; BN 7-2008, f. & cert. ef. 11-26-08

851-056-0006
Application Requirements for Prescriptive Authority in Oregon

(1) Current, unencumbered registered nurse license in the State of Oregon.

(2) Currently has or is eligible for an unencumbered nurse practitioner or clinical nurse specialist certificate in the State of Oregon.

(3) Submission of application and fees required by the Board. Fees are nonrefundable. An application not completed after one calendar year will be considered void.

(4) Evidence of successful completion of 45 contact hours of pharmacology as defined in OAR 851-056-0008 including content related to the specialty scope of practice which shall be met through:

(a) Completion within two years prior to the application date; or

(b) Evidence of completion of a 30 hour discrete pharmacology course congruent with the specialty role sought with:

(A) An additional 15 CE hours in pharmacological management congruent with the area of clinical specialty completed in the two years prior to the application date; and

(B) Current prescriptive authority in another state or U.S. jurisdiction, including a U.S. federal institution or facility; or

(c) Evidence of completion of a clinical nurse specialist or nurse practitioner program within two years prior to application date, which included a 45 hour pharmacology course and subsequent clinical practicum in pharmacologic management of individual patients prior to graduation.

(5) Evidence of successful completion of required clinical education in patient management. An applicant may be considered to meet this requirement through:

(a) Completion of a directly supervised clinical practicum of no less than 150 hours which includes differential diagnosis and applied pharmacological management of patients congruent with the specialty role sought for academic or continuing education credit; or

(b) Evidence of unencumbered prescriptive authority in another state or U.S. jurisdiction, including a U.S. federal institution or facility with a minimum of 400 hours utilizing prescriptive authority and patient management within the past two years.

(6) Evidence of successful completion of accredited graduate level nursing courses documented by CE or academic credit. Such courses must include physical assessment, pathophysiology, and clinical management sufficient to prepare the applicant for safe prescribing with individual patients. Integrated courses taken before January 1, 1996 may be considered if content otherwise meets all requirements for equivalency.

(7) Applicants for initial certification as a nurse practitioner shall meet all requirements for prescriptive authority. Clinical nurse specialists may obtain and renew certification with the Board without prescriptive authority.

(8) Initial applicants seeking prescriptive authority who do not meet Oregon's pharmacology requirements shall complete a pharmacology course from a list approved by the Board, equal to a minimum of 45 contact hours.

(9) Nurse practitioners who were certified in Oregon prior to July 1, 1997, and who did not have prescriptive authority as of that date, are not required to obtain or renew with prescriptive authority.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.370, 678.372, 678.375, 678.380, 678.385 & 678.390

Hist.: BN 10-2006, f. & cert. ef. 10-5-06; BN 5-2008, f. & cert. ef. 6-24-08; BN 7-2008, f. & cert. ef. 11-26-08

851-056-0022
Renewal of Dispensing Authority

Dispensing authority may be renewed with each renewal of prescriptive authority upon submission of application, and documentation that the nurse practitioner or clinical nurse specialist and their patients continue to meet criteria in OAR 851-056-0020(5). Failure to complete application material as requested or failure to meet criteria in this rule shall be grounds for denial, suspension, inactivation or revocation of dispensing authority.

Stat. Auth.: ORS 678.390
Stats. Implemented: ORS 678.670, 678.675, 678.385 & 678.390
Hist.: BN 10-2006, f. & cert. ef. 10-5-06; BN 7-2008, f. & cert. ef. 11-26-08

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Rule Caption: Elimination of Barrier to Meet CNA Staffing Requirements in Licensed Nursing Facilities.
Adm. Order No.: BN 8-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 11-26-08
Notice Publication Date: 10-1-2008
Rules Amended: 851-062-0020
Subject: These rules establish the standards for certification of nursing assistants and medication aides. This change in rule language will allow individuals who are employed to perform CNA authorized duties in licensed nursing facilities up to four-months from their date of hire to become certified in Oregon.
Rules Coordinator: KC Cotton—(971) 673-0638

851-062-0020
Certification of Nursing Assistants Required

(1) A CNA must have a current, valid Oregon CNA 1 certificate and be listed on the Oregon CNA Registry prior to performing CNA 1 authorized duties. Nursing assistants who perform CNA 1 authorized duties as an employee of a licensed nursing facility in the State of Oregon must obtain Oregon CNA 1 certification, according to these rules, no later than four months after the date of hire.

(2) A nursing assistant who is enrolled in an approved nursing assistant level 1 training program that meets the standards set forth in OAR 851-061-0010 through 851-061-0130 may perform nursing assistant duties with appropriate supervision.

(3) Unlicensed persons who are performing tasks that have been delegated to them by a Registered Nurse according to OAR 851-047-0000 through 851-047-0040 may be certified or may be exempted from the requirement for certification.

(4) Successful completion of a Board-approved training program, alone, does not result in the granting of a CNA certificate. The training program is one element of certification requirements. All requirements must be met before the Board grants certification.

(5) A RN, LPN, student nurse or unlicensed graduate of a school of nursing is required to have current CNA 1 certification before assuming a CNA position and identifying himself or herself as a CNA.

Stat. Auth.: ORS 678.440 & 678.442
Stats. Implemented: ORS 678.440 & 678.442
Hist.: BN 6-1999, f. & cert. ef. 7-8-99; BN 2-2004, f. 1-29-04, cert. ef. 2-12-04; BN 8-2008, f. & cert. ef. 11-26-08

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Bureau of Labor and Industries
Chapter 839

Rule Caption: Amends the prevailing rates of wage for the period beginning July 1, 2008.
Adm. Order No.: BLI 42-2008
Filed with Sec. of State: 12-1-2008
Certified to be Effective: 12-1-08
Notice Publication Date:
Rules Amended: 839-025-0700
Subject: The amended rules amends the prevailing rates of wage as determined by the Commissioner of the Bureau of Labor and Industries for the period beginning July 1, 2008.
Rules Coordinator: Marcia Ohlemiller—(971) 673-0784

839-025-0700
Prevailing Wage Rate Determination/Amendments to Determination

(1) Pursuant to ORS 279C.815, the Commissioner of the Bureau of Labor and Industries has determined that the wage rates stated in publications of the Bureau of Labor and Industries entitled *Prevailing Wage Rates on Public Works Contracts in Oregon* and *Prevailing Wage Rates for Public Works Contracts in Oregon subject to BOTH the state PWR and federal Davis-Bacon Act* dated July 1, 2008, are the prevailing rates of wage for workers upon public works in each trade or occupation in the locality where work is performed for the period beginning July 1, 2008, and the effective dates of the applicable special wage determination and rates amendments:

(a) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective June 6, 2008).

(b) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective June 13, 2008).

(c) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective June 20, 2008).

(d) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective July 4, 2008).

(e) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective July 25, 2008).

(f) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective August 29, 2008).

(g) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective September 19, 2008).

(h) Amendment to Oregon Determination 2008-02 (effective October 1, 2008).

(i) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective October 1, 2008).

(j) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective October 3, 2008).

(k) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective October 24, 2008).

(l) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective November 7, 2008).

(m) Amendments/Corrections to July 1, 2008 PWR Rates for Public Works Contracts in Oregon subject to BOTH State PWR Law and federal Davis-Bacon Act (reflecting changes to Davis-Bacon rates effective November 21, 2008).

(2) Copies of *Prevailing Wage Rates on Public Works Contracts in Oregon* and *Prevailing Wage Rates for Public Works Contracts in Oregon subject to BOTH the state PWR and federal Davis-Bacon Act* dated July 1, 2008, are available from any office of the Wage and Hour Division of the Bureau of Labor and Industries. The offices are located in Eugene, Medford, Portland and Salem and are listed in the blue pages of the phone book. Copies are also available on the bureau's webpage at www.oregon.gov/boli or may be obtained from the Prevailing Wage Rate Coordinator, Prevailing Wage Rate Unit, Wage and Hour Division, Bureau of Labor and Industries, 800 NE Oregon Street #1045, Portland, Oregon 97232; (971) 673-0839.

Stat. Auth.: ORS 279C.815, 651.060
Stats. Implemented: ORS.279C.815
Hist.: BLI 7-1998(Temp), f. & cert. ef. 10-29-98 thru 4-27-99; BLI 1-1999, f. 1-8-99, cert. ef. 1-15-99; BLI 4-1999, f. 6-16-99, cert. ef. 7-1-99; BLI 6-1999, f. & cert. ef. 7-23-99; BLI 9-1999, f. 9-14-99, cert. ef. 10-1-99: BLI 16-1999, f. 12-8-99, cert. ef. 1-1-00; BLI 4-2000, f. & cert. ef. 2-1-00; BLI 9-2000, f. & cert. ef. 3-1-00; BLI 10-2000, f. 3-17-00, cert. ef. 4-1-00; BLI 22-2000, f. 9-25-00, cert. ef. 10-1-00; BLI 26-2000, f. 12-14-00 cert. ef. 1-1-01; BLI 1-2001, f. & cert. ef. 1-5-01; BLI 3-2001, f. & cert. ef. 3-15-01; BLI 4-2001, f. 3-27-01, cert. ef. 4-1-01; BLI 5-2001, f. 6-21-01, cert. ef. 7-1-01; BLI 8-2001, f. & cert. ef. 7-20-01; BLI

14-2001, f. 9-26-01, cert. ef. 10-1-01; BLI 16-2001, f. 12-28-01, cert. ef. 1-1-02; BLI 2-2002, f. 1-16-02, cert. ef. 1-18-02; BLI 8-2002, f. 3-25-02, cert. ef. 4-1-02; BLI 12-2002 f. 6-19-02 cert. ef. 7-1-02; BLI 16-2002, f. 12-24-02 cert. ef. 1-1-03; BLI 1-2003, f. 1-29-03, cert. ef. 2-14-03; BLI 3-2003, f. & cert. ef. 4-1-03; BLI 4-2003, f. 6-26-03, cert. ef. 7-1-03; BLI 5-2003, f. 9-17-03, cert. ef. 10-1-03; BLI 9-2003, f. 12-31-03, cert. ef. 1-5-04; BLI 1-2004, f. 4-9-04, cert. ef. 4-15-04; BLI 6-2004, f. 6-25-04, cert. ef. 7-1-04; BLI 11-2004, f. & cert. ef. 10-1-04; BLI 17-2004, f. 12-10-04 cert. ef. 12-13-04; BLI 18-2004, f. 12-20-04, cert. ef. 1-1-05; Renumbered from 839-016-0700, BLI 7-2005, f. 2-25-05, cert. ef. 3-1-05; BLI 8-2005, f. 3-29-05, cert. ef. 4-1-05; BLI 18-2005, f. 9-19-05, cert. ef. 9-20-05; BLI 19-2005, f. 9-23-05, cert. ef. 10-1-05; BLI 26-2005, f. 12-23-05, cert. ef. 1-1-06; BLI 1-2006, f. 1-24-06, cert. ef. 1-25-06; BLI 2-2006, f. & cert. ef. 2-9-06; BLI 4-2006, f. 2-23-06, cert. ef. 2-24-06; BLI 14-2006, f. 3-30-06, cert. ef. 4-1-06; BLI 20-2006, .f & cert. ef. 6-16-06; BLI 21-2006, f. 6-16-06 cert. ef. 7-1-06; BLI 23-2006, f. 6-27-06 cert. ef. 6-29-06; BLI 25-2006, f. & cert. ef. 7-11-06; BLI 26-2006, f. & cert. ef. 7-13-06; BLI 28-2006, f. 7-21-06, cert. ef. 7-24-06; BLI 29-2006, f. 8-8-06, cert. ef. 8-9-06; BLI 32-2006, f. & cert. ef. 9-13-06; BLI 33-2006, f. 9-28-06, cert. ef. 10-1-06; BLI 36-2006, f. & cert. ef. 10-4-06; BLI 37-2006, f. & cert. ef. 10-19-06; BLI 40-2006, f. 11-17-06, cert. ef. 11-20-06; BLI 43-2006, f. 12-7-06, cert. ef. 12-8-06; BLI 45-2006, f. 12-26-06, cert. ef. 1-1-07; BLI 5-2007, f. 1-30-07, cert. ef. 1-31-07; BLI 6-2007, f. & cert. ef. 3-5-07; BLI 7-2007, f. 3-28-07, cert. ef. 3-30-07; BLI 8-2007, f. 3-29-07, cert. ef. 4-1-07; BLI 9-2007, f. & cert. ef. 4-2-07; BLI 10-2007, f. & cert. ef. 4-30-07; BLI 12-2007, f. & cert. ef. 5-31-07; BLI 13-2007, f. 6-8-07, cert. ef. 6-11-07; BLI 14-2007, f. 6-27-07, cert. ef. 6-28-07; BLI 15-2007, f. & cert. ef. 6-28-07; BLI 16-2007, f. 6-29-07, cert. ef. 7-1-07; BLI 18-2007, f. 7-10-07, cert. ef. 7-12-07; BLI 21-2007, f. 8-3-07, cert. ef. 8-8-07; BLI 22-2007, cert. & ef. 8-30-07; BLI 23-2007, f. 8-31-07, cert. ef. 9-4-07; BLI 24-2007, f. 9-11-07, cert. ef. 9-12-07; BLI 25-2007, f. 9-19-07, cert. ef. 9-20-07; BLI 26-2007, f. 9-25-07 cert. ef. 9-26-07; BLI 27-2007, f. 9-25-07 cert. ef. 10-1-07; BLI 28-2007, f. 9-26-07 cert. ef. 10-1-07; BLI 31-2007, f. 11-20-07, cert. ef. 11-23-07; BLI 34-2007, f. 12-27-07, cert. ef. 1-1-08; BLI 1-2008, f. & cert. ef. 1-4-08; BLI 2-2008, f. & cert. ef. 1-11-08; BLI 3-2008, f. & cert. ef. 2-21-08; BLI 6-2008, f. & cert. ef. 3-13-08; BLI 8-2008, f. 3-31-08, cert. ef. 4-1-08; BLI 9-2008, f. & cert. ef. 4-14-08; BLI 11-2008, f. & cert. ef. 4-24-08; BLI 12-2008, f. & cert. ef. 4-30-08; BLI 16-2008, f.& cert. ef. 6-11-08; BLI 17-2008, f. & cert. ef. 6-18-08; BLI 19-2008, f. & cert. ef. 6-26-08; BLI 20-2008, f. & cert. ef. 7-1-08; BLI 23-2008, f. & cert. ef. 7-10-08; BLI 26-2008, f. & cert. ef. 7-30-08; BLI 28-2008, f. & cert. ef. 9-3-08; BLI 30-2008, f. & cert. ef. 9-25-08; BLI 31-2008, f. 9-29-08, cert. ef. 10-1-08; BLI 32-2008, f. & cert. ef. 10-8-08; BLI 36-2008, f. & cert. ef. 10-29-08; BLI 41-2008, f. & cert. ef. 11-12-08; BLI 42-2008, f. & cert. ef. 12-1-08

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Rule Caption: Rule amendments that implement statutory changes to Oregon's housing discrimination law.
Adm. Order No.: BLI 43-2008
Filed with Sec. of State: 12-3-2008
Certified to be Effective: 12-5-08
Notice Publication Date: 7-1-2008
Rules Amended: 839-003-0005, 839-003-0010, 839-003-0020, 839-003-0025, 839-003-0040, 839-003-0045, 839-003-0050, 839-003-0055, 839-003-0060, 839-003-0065, 839-003-0070, 839-003-0080, 839-003-0085, 839-003-0090, 839-003-0095, 839-003-0100, 839-003-0200, 839-003-0205, 839-003-0210, 839-003-0215, 839-003-0220, 839-003-0225, 839-003-0230, 839-003-0235, 839-003-0240, 839-003-0245, 839-005-0000, 839-005-0003, 839-005-0010, 839-005-0016, 839-005-0026, 839-005-0195, 839-005-0200, 839-005-0205, 839-005-0220
Subject: Amend the administrative rules listed above in order to implement statutory changes to Oregon's housing discrimination law enacted by the 2008 special session of the Oregon Legislature, and to conform the rules to federal housing discrimination law.
Rules Coordinator: Marcia Ohlemiller—(971) 673-0784

839-003-0005
Definitions

Except where otherwise required by ORS 654.005 and except as provided below, definitions for terms used in these rules are found in ORS 659A.001 and 659A.100:

(1) "Administrator" means the Administrator of the Civil Rights Division of the Bureau of Labor and Industries or a designee of the administrator.

(2) "Bureau" means the Bureau of Labor and Industries.

(3) "Commissioner" means the Commissioner of the Bureau of Labor and Industries or a designee of the commissioner.

(4) "Complaint" means for the purpose of ORS chapter 659A, except housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law, a written, verified statement signed by the complainant or the complainant's attorney that:

(a) Gives the name and address of the complainant and the respondent;

(b) Identifies the protected class basis of the complaint;

(c) Describes the actions complained of, including:

(A) The date(s) of occurrence;

(B) What the action was and how it harmed the complainant; and

(C) The causal connection between the complainant's protected class and the alleged harm.

(5) "Complainant" means a person filing a complaint personally or through an attorney.

(6) "Days," unless otherwise stated in the text of a document, means calendar days. "Work days" means Monday through Friday, except holidays officially recognized by the State of Oregon or the federal government.

(7) "Division" means the Civil Rights Division of the Bureau of Labor and Industries.

(8) "EEOC" means the Equal Employment Opportunity Commission of the federal government.

(9) "Federal Housing Law" means The Fair Housing Act (42 U.S.C. 3601 et seq.) for which the U.S. Department of Housing And Urban Development ("HUD") has jurisdiction.

(10) "Notice" means written information delivered personally or sent by mail to the person's last known personal or business address or business address of the person's designated representative.

(11) "OSEA" means the Oregon Safe Employment Act, ORS 654.001 et seq.

(12) "Protected class" means a group of people protected by law from discrimination on the basis of a shared characteristic, or a perception of that characteristic, such as race, sex, age, disability or other.

(13) "Person" has the meaning given in ORS 659A.001(9).

(14) "Respondent" includes any person or other entity against whom a complaint or charge of unlawful practices is filed with the division or whose name has been added to such complaint or charge pursuant to ORS 659A.835(1).

(15) "Formal Charges" are formal charges drafted and issued by the bureau's Hearings Unit.

(16) "Substantial evidence" means proof that a reasonable person would accept as sufficient to support the allegations of the complaint.

(17) "Substantial Evidence Determination" means the division's written findings of substantial evidence.

(18) "Written verified complaint" means a complaint that is:

(a) In writing; and

(b) Under oath or affirmation.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.001, 659A.145 & 659A.421, Fed Housing Law
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 7-1982, f. & ef. 4-22-82; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 36-2007 f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0010
Who May File

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Complaints of housing discrimination must be filed in accordance with 839-003-0200.

(1) Any person claiming to be harmed by an act prohibited by statutes enforced by the Civil Rights Division may file a complaint with the division personally or through an attorney.

(2) Any employee, or a representative authorized to do so by ORS 654.062(2), may file a complaint with the division alleging discrimination by an employer against the employee for raising issues of employee safety or health in the workplace.

(3) The commissioner or Attorney General of Oregon may file a complaint whenever there is reason to believe that a person or entity has violated statutes enforced by the division.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.820 & 659A.825
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 7-1982, f. & ef. 4-22-82; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0020
Civil Suit

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law, except as provided below.

(1) A person alleging unlawful discrimination under state law may file a civil suit as provided in ORS 659A.870 to 659A.885, or 30.680.

(a) A person is not required to file a complaint of a violation of state law with the division before filing a civil suit.

(b) A person filing a civil suit in state or federal court waives the right to file a complaint with the division with respect to those matters alleged in the civil suit. This subsection does not apply to housing discrimination

complaints under ORS 659A.145 or 659A.421 or federal housing law.

(2) After filing a complaint with the division, a complainant may file a civil suit in state or federal court alleging the same matters as those alleged in the complaint filed with the division. The complainant should notify the division of the civil suit. When the division receives notice from the complainant or complainant's attorney, or court documents indicating that such a suit has been filed, the division will dismiss the complaint. The division will notify the complainant and respondent that the division has dismissed the complaint and will take no further action. This subsection does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law.

(3) The commissioner will notify the complainant in writing of the right to file suit in state court, as provided in ORS 659A.870 to 659A.885, when a complaint is dismissed by the division or on the one-year anniversary of the complaint filing, whichever occurs first. The complainant will have 90 days from the notice mailing date to file a civil suit. A complainant filing suit against a public body must also file a tort claim notice as required by ORS 30.275. This subsection does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421or federal housing law.

(4) A civil action under ORS 659A.885 against a public body, as defined in ORS 30.260, or any officer, employee or agent of a public body as defined in ORS 30.260, based on an unlawful employment practice must be commenced within one year after the occurrence of the unlawful employment practice unless a complaint has been timely filed under ORS 659A.820.

(5) An action alleging breach of a division settlement agreement, entered into under ORS 659A.001 to 659A.030, 659A.233, 659A.303, 659A.145, 659A.409, 659A.420, 659A.421, 659A.150 to 659A.224 and 659A.800 to 659A.890, may be filed under 659A.860 in accordance with the applicable statute of limitations.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 30.275, 30.680, 659A.001-659A.030, 659A.233, 659A.303, 659A.409, 659A.420, 659A.421, 659A.150-659A.224 & 659A.800- 659A.890
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 12-1982, f. & ef. 8-10-82; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 9-2006, f. 3-16-06, cert. ef. 3-20-06; BLI 24-2006(Temp), f. 7-5-06, cert. ef. 7-7-06 thru 1-3-07; BLI 38-2006, f. 10-25-06, cert. ef. 10-27-06; BLI 36-2007 f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0025
Filing a Complaint

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421or federal housing law. Complaints of housing discrimination must be filed in accordance with 839-003-0200.

(1) A person or the person's attorney may file a complaint, in person or by mail, with the division at any bureau office in the state of Oregon. The complaint must meet the standards provided in OAR 839-003-0005(4).

(2) The filing date is the date the division receives a complaint that meets the standards contained in OAR 839-003-0005(4).

(3) Except as provided in section (5) of this rule, a person must file a complaint with the division no later than one year after the alleged unlawful practice. If the alleged unlawful practice is of a continuing nature, the right to file a complaint exists so long as the person files the complaint within one year of the most recent date the unlawful practice occurred.

(4) A person alleging constructive discharge must file a discrimination complaint with the division within one year of the date the discharge occurred.

(5) A person alleging discrimination for reporting or opposing unsafe or unhealthy work conditions under ORS 654.062 must contact the division within 90 days of having reasonable cause to believe that such violation has occurred. An employee would have reasonable cause to believe a violation has occurred on the earliest date that the employee:

(a) Believed retaliation had occurred against the employee for opposing employee health and safety hazards; and

(b) Knew or should have known of the right to file a complaint with the division and of the requirement that the complaint be filed within 90 days of the alleged retaliation.

(A) If a notice required by OSEA, as provided in OAR 437-001-0275(2)(a), was properly posted in the employee's workplace, continuously on and following the date of the alleged retaliation, the division will find that the employee knew or should have known of the 90-day filing requirement.

(B) If the employer failed to post the required OSEA poster, the 90-day filing requirement will begin on the date the employee learned of the right to file a complaint and of the 90-day filing requirement. The employee may establish this date based on the employee's own statement or other evidence offered by the employee.

(C) If the employer disagrees with the employee's presented date as the date the employee learned of the right to file a complaint, the burden is on the employer to show that the employee knew or should have known on an earlier date.

(D) If extenuating circumstances exist, the division may extend the 90-day period as provided in 29 CFR Part 15(d)(3).

(6) The procedures for filing a complaint are as follows:

(a) A person or the person's attorney makes an inquiry to the division;

(b) The division may provide the person or the person's attorney with a letter of information and/or questionnaire to assist in determining if there is a basis for filing a complaint;

(c) If the division determines the person has a basis for filing a complaint, the division will draft a complaint based upon the information provided by the person and send or give the complaint to the person or the person's attorney for verification. The person or the person's attorney will request any necessary changes to the complaint.

(d) The person or the person's attorney will verify and sign the complaint. The complaint will then be submitted to the division.

(e) If the person is an unemancipated minor the complaint must be signed by the minor and the parent or legal guardian of the minor.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 654.062, 659A.820 & 29 CFR Part 15(d)(3)
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BL 2-1998, f. & cert. ef. 2-3-98; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 12-2004, f. 10-22-04 cert. ef. 10-25-04; BLI 19-2007(Temp), f. & cert. ef. 7-18-07 thru 1-1-08; BLI 29-2007, f. 9-27-07 cert. ef. 10-1-07; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0040
Amendment of Complaints

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Complaints of housing discrimination must be amended in accordance with 839-003-0205.

(1) The division may amend a complaint to correct technical defects and to add additional persons as respondents. The division may amend a complaint on its own initiative or at the complainant's request (with the division's agreement) at any time prior to the issuance of Formal Charges, except that respondents may only be added during the course of investigation. Examples of technical defects include: clerical errors, additions or deletions, name and address corrections, and statute citation errors.

(2) A complaint may be amended to add a protected class only if the addition is supported by facts already alleged. New facts may not be added. If new facts are alleged, the complainant must file a new complaint meeting the standards provided in OAR 839-003-0005(4).

(3) Amended complaints need not be verified or signed by the complainant or the complainant's attorney.

(4) The division will send a copy of the amended complaint to the complainant and all respondents.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.820
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 2-2005, f. 1-6-05, cert. ef. 1-7-05; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0045
Withdrawal of Complaint

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. The withdrawal of a housing discrimination complaint is addressed in 839-003-0210. A complainant may voluntarily withdraw a complaint at any time by giving the division written notice of the complainant's decision to withdraw. If the complainant wants a federal "right to sue letter," the complainant must provide a written request to EEOC or to the division. If the complainant makes the request to the division, the division will forward the request to EEOC.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0050
Administrative Dismissal

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Administrative dismissal of a housing discrimination complaint is addressed in 839-003-0215.

(1) The division will dismiss the complaint if it determines that the bureau has no jurisdiction over the allegations of the complaint.

(2) The division may dismiss the complaint if the complainant files a proceeding, based on the same set of facts, with another agency having the authority to provide remedy to the complainant for the alleged discrimination.

(3) If a complainant or the complainant's attorney fails to cooperate with the division, the division may dismiss the complaint.

(4) The complainant must notify the division in writing of address and telephone number changes. When a complainant cannot be located by reasonable efforts, the division may dismiss the complaint.

(5) The division will dismiss a complaint unless substantial evidence of unlawful discrimination is found. Such dismissal notice will include a statement that the complaint has been dismissed and a notice of complainant's right to file a civil suit, if such right exists.

(6) The division will dismiss complaints alleging violation of federal discrimination statutes administered by EEOC (OAR 839-003-0015) in accordance with federal requirements.

(7) The division may elect to administratively dismiss a complaint without investigation. In such instances, the division will notify the complainant and respondent of the dismissal and issue notice of the complainant's right to file a civil suit, if such right exists.

(8) The division will dismiss a complaint if it learns that the complainant has filed a civil suit alleging the same matters, as provided in OAR 839-003-0020.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 30.680, 659A.835, 659A.850 & 659A.870 - 659A.885
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0055
Conciliation Agreements Prior to Completion of the Investigation

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law.

(1) The division encourages complainants and respondents to resolve complaints by mutual agreement at any time. The division will facilitate settlement negotiations between the complainant and respondent, as provided in this rule, at any time during the investigation.

(2) If the complainant and respondent agree upon settlement, the division will draft a settlement agreement that states:

(a) That a "no fault" settlement has been reached;

(b) That the complainant, the respondent and the Civil Rights Division accept the terms of the agreement as a resolution of the complaint;

(c) The specific action(s) the complainant and respondent will take as a result of the complaint settlement and the time within which the action(s) will be taken; and

(d) That the division may investigate any alleged breach of the agreement.

(3) The settlement agreement will not include release language that applies to any forum other than the Civil Rights Division.

(4) The complainant, the respondent and a representative of the division will sign the division's settlement agreement. The complainant and respondent will receive copies of the signed agreement. Upon execution of this agreement, the division will notify the complainant and respondent that the complaint is dismissed.

(5) The division may allow the complainant and the respondent to enter into a private agreement with release language in addition to the division's agreement. The division will not be a party to nor enforce private agreements.

(6) Nothing in these rules is intended to preclude private settlement between the complainant and the respondent.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.835, 659A.840 & 659A.850
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 36-2007 f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0060
Fact-Finding Conference

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law.

(1) At its discretion, the division may hold a fact-finding conference. This conference may encompass part or all of the division's investigation of the complaint. The complainant and the respondent will attend the conference and a division representative will conduct the conference. The purposes of the conference will be to:

(a) Review evidence regarding the complaint;

(b) Identify the undisputed elements of the complaint;

(c) Define and, if possible, resolve the disputed elements of the complaint; and

(d) Attempt to settle the complaint.

(2) The division will schedule the conference, notifying the complainant and the respondent of the time and place. The division may require the complainant and the respondent to provide information and documents relevant to the complaint. The division may issue subpoenas ad testificandum to compel the respondent's representatives to attend the conference and issue subpoenas duces tecum to compel the production of documents at the conference.

(3) The conference may be rescheduled, subject to the division's approval, at the request of the complainant or the respondent, or at the division's discretion.

(4) The complainant's failure to attend the conference may cause the complaint to be administratively dismissed if the division determines that the complainant has failed to cooperate pursuant to OAR 839-003-0050(3).

(5) If the complainant attends the conference but the respondent's representatives fail to attend, the division representative may proceed based on the information in the division's possession.

(6) The respondent's representatives at a fact-finding conference should include persons with:

(a) Knowledge of the facts bearing on the complaint; and

(b) Authority to negotiate a settlement agreement.

(7) The complainant and the respondent may be accompanied by legal counsel, but counsel's role is strictly limited to providing legal advice to the counsel's client.

(8) The division's representative conducting the conference may:

(a) Question the participants about their knowledge of the situation;

(b) Ask for additional statements and documentation from the complainant and the respondent;

(c) Terminate discussion of a particular point when further discussion would be irrelevant or repetitive;

(d) Exclude witnesses with the exception of the complainant, the respondent and counsel;

(e) Order unruly participants to leave the conference;

(f) Tape-record the conference with the knowledge of the participants;

(g) Attempt to negotiate a settlement agreement between the parties; and

(h) Recess or terminate the conference at any time.

(9) If the conference does not result in settlement, the division will either continue the investigation or dismiss the complaint. This subsection does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.800, 659A.850 & 659A.860
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 1-1993, f. 3-25-93, cert. ef. 4-1-93; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 36-2007 f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0065
Investigations

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Investigation of housing discrimination complaints is addressed in 839-003-0220.

(1) The division may investigate the allegations contained in a complaint to determine objectively whether there is substantial evidence of unlawful discrimination. The division will determine the method by which complaints will be investigated or otherwise processed. The division will not investigate allegations occurring more than one year prior to the date the complaint was filed unless the allegations constitute a continuing violation or the circumstances occurring more than one year prior to the date the complaint was filed pertain to timely allegations.

(2) The investigation may include interviews with the complainant, the respondent representatives, and any other persons whom the division chooses to interview. The investigation may also involve the examination and analysis of written documents.

(3) The investigator may tape-record statements with the knowledge of the participants.

(4) The respondent has the right to have a representative present during interviews of current supervisory employees.

(5) The respondent's current, non-supervisory, or former employees, may request that a representative for the respondent be present during interviews by a division representative.

(6) A complainant, respondent or witness interviewed by the division may request a copy of the summary report of the individual's own interview. The division may request that the complainant, respondent or witness confirm by signature that the summary report is an accurate representation of the interview. The complainant, respondent or witness may submit to the division additional comments regarding the interview.

(7) The division representative may make written request to the respondent for documents, records, files or other sources of evidence. The respondent will provide such information within 21 days of the date of the division's written request. The division may grant the respondent additional time in which to respond.

(8) The division may issue subpoenas compelling division access to premises, records and witnesses. Failure to respond to a subpoena may result in the division making a determination based on available information.

(9) Upon conclusion of the investigation, the division will either issue a Substantial Evidence Determination or will dismiss the complaint. The division will mail a copy of the Substantial Evidence Determination or dismissal notice to the complainant and respondent.

(10) If the division does not find substantial evidence of unlawful discrimination, the division will dismiss the complaint, notify the complainant and respondent of the dismissal and notify the complainant of the right to file a civil suit, if such right exists.

(11) If the division finds substantial evidence of unlawful discrimination, the complaint may be assigned to a division representative for settlement. However, the commissioner may proceed directly to a contested case hearing if the interests of justice so require.

(12) A Substantial Evidence Determination or dismissal may not be appealed to the division.

(13) The division may reopen a case at its own discretion.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 659A.800, 659A.805, 659A.835, 659A.870 - 659A.885

Hist.: BL 7-1981, f. & ef. 6-25-81; BL 13-1981, f. & ef. 11-18-81; BL 12-1982, f. & ef. 8-10-82; BL 12-1992(Temp), f. & cert. ef. 11-3-92; BL 2-1993, f. 3-25-93, cert. ef. 4-1-93; BL 4-1996, f. & cert. ef. 3-12-96; BL 2-1998, f. & cert. ef. 2-3-98; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0070

Settlement Process After Substantial Evidence Determination

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. The settlement process after a substantial evidence determination in housing discrimination complaints is addressed in 839-003-0225.

(1) If the division finds substantial evidence of unlawful discrimination, the division may seek to eliminate the effects of the unlawful discriminatory act(s) by conference, settlement and persuasion. The division will facilitate settlement negotiations between the complainant and respondent as provided in OAR 839-003-0055.

(2) If no settlement agreement is reached in the period of time set aside for settlement after a Substantial Evidence Determination, the division retains the discretion to further negotiate settlement, administratively dismiss the complaint, or proceed to a contested case hearing.

(3) The complainant may withdraw the complainant's own complaint at any time.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 659A.835 & 659A.840

Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0080

Access to Records/Confidentiality

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law.

(1) During an investigation, the contents of the investigative file and related records, other than the complaint, are confidential. However, any individual may inspect and copy information or statements that the individual has given to the division. The division may charge a fee for inspection or to copy information.

(2) After the complaint is closed, a copy of the closed file will be available for a fee. To obtain a copy of a closed file a person must make a written request to the division. The request must include the person's name, address and telephone number, the complainant's and the respondent's names and payment of the fee, as determined by the division.

(3) The division will not at any time disclose any information that is required to be kept confidential by ORS 659A.840(6) or any other state or federal law or under any contractual agreement between the bureau and federal, state and local agencies.

(4) A complainant's or respondent's designation of information as confidential will not supercede the State of Oregon Public Records Law.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 192.440(3) & 192.501(8)

Hist.: BL 7-1981, f. & ef. 6-25-81; BL 10-1984(Temp), f. & ef. 9-6-84; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 36-2007 f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0085

Subpoenas

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law.

(1) The commissioner or the commissioner's designee may issue a subpoena to require:

(a) The presence and testimony of witnesses;

(b) The production of evidence, including but not limited to books, records, correspondence or documents in the possession or under the control of the person subpoenaed; and

(c) Access to evidence to be examined or copied.

(2) If any person fails to comply with a subpoena issued under this rule, the commissioner may initiate the legal procedures necessary to enforce compliance.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 659A.800(4)

Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0090

Remedy

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Remedies in complaints of housing discrimination are in addressed in 839-003-0230.

(1) In cases of employment discrimination remedy includes, but is not limited to:

(a) Employment or reemployment;

(b) Wages or other benefits lost due to the practice;

(c) Out-of-pocket expenses attributable to the practice;

(d) Compensation for emotional distress and impaired personal dignity; and

(e) Interest.

(2) Consideration of all acts alleged to comprise a hostile work environment in a complaint, including alleged acts occurring outside the one year statute of limitations for filing a complaint, is permissible for the purposes of assessing liability, so long as any act contributing to that hostile work environment takes place within the statutory period.

(3) In order to recover damages for lost wages, the complainant will generally be required to mitigate damages by seeking employment.

(a) Earned income from employment may be deducted from lost wage damages.

(b) In most cases, unearned income such as unemployment or public assistance benefits will not be deducted from lost wage damages.

(4) Settlements of complaints and the awards in commissioner's Final Orders do not necessarily include all possible remedies named in sections (1) and (2) of this rule. Nothing in this rule will be construed to limit or alter the statutory powers of the commissioner to protect the rights of persons similarly situated to the complainant or to order the performance of an act or a series of acts designed to eliminate the effect of any unlawful practice found.

(5) The commissioner may order the respondent to eliminate the effects of any unlawful practice found and may require respondent to:

(a) Perform a designated act or series of acts that are calculated to carry out the policy of these rules in order to eliminate the effects of an unlawful practice and to protect the rights of those affected;

(b) Take action and submit reports to the commissioner on the manner of compliance with the terms and conditions specified in the commissioner's order or agreement;

(c) Refrain from any action prohibited by the order or agreement that would jeopardize the rights of the individuals or groups named in the complaint or would frustrate the purpose and the policy of these rules and relevant statutes.

(6) When the respondent makes an offer of remedy, the division will inform the complainant of the offer. If the complainant does not accept an offer that the division has determined will eliminate the effects of the unlawful practice, the division may dismiss the complaint.

(7) Any agreement or order issued by the commissioner may be enforced by mandamus or injunction or by suit in equity to compel specific performance.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.800, 659A.850, 659A.860, 659A.865, 659A.885
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 20-2005, f. 10-20-05, cert. ef. 10-21-05; BLI 8-2006, f. 3-16-06 cert. ef. 3-20-06; BLI 36-2007 f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0095
Enforcement of Settlement Agreements and Orders

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Enforcement of settlement agreements and orders is addressed in 839-003-0240.

(1) Any agreement or order issued by the commissioner may be enforced by mandamus or injunction or by suit in equity to compel specific performance, as provided in ORS 659A.860.

(2) If the complainant believes the terms of a bureau settlement agreement have been breached, the complainant may file a complaint with the division alleging retaliation, or file a new complaint re-alleging the original violation if it is still occurring. The division may review the provisions of the settlement agreement and investigate.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.850, 659A.860 & 659A.865
Hist.: BL 7-1981, f. & ef. 6-25-81; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0100
Commissioner's Complaint

This section does not apply to housing discrimination complaints under ORS 659A.145 or 659A.421 or federal housing law. Commissioner's complaints of housing discrimination are addressed in 839-003-0245.

(1) The Commissioner of the Bureau of Labor and Industries may make, sign and file a complaint whenever the commissioner has reason to believe that any person or group of persons has been denied rights due to an unlawful practice or employment practice. The complaint will be processed in the same manner as any other complaint filed under OAR 839-003-0005.

(2) In the matter of concurrent complaints, nothing in these rules will be construed to:

(a) Require or prohibit the filing of a commissioner's complaint involving the same or similar issues or allegations stated in any other complaint filed with the division or circuit court by an individual under ORS 659A.820, 659A.825, or 659A.885;

(b) Require or prohibit the continued processing or initiation of a commissioner's complaint in the event that a complaint filed with the division or circuit court by an individual under ORS 659A.820, 659A.825, or 659A.885, is resolved or dismissed, with or without remedy to the individual; or

(c) Alter or limit an individual's private right of action provided under ORS 659A.870 to 659A.885.

Stat. Auth.: ORS 183 & 659A.805
Stats. Implemented: ORS 659A.820, 659A.825 & 659A.870 - 659A.885
Hist.: BL 7-1985(Temp), f. & ef. 10-17-85; BL 11-1986, f. & ef. 10-29-86; BL 4-1996, f. & cert. ef. 3-12-96; BLI 11-2000, f. & cert. ef. 3-24-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0200
Filing a Complaint Under State and Federal Housing Discrimination Laws

(1) A person claiming to be aggrieved by an alleged unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law includes a person who believes that the person has been injured by an unlawful practice or discriminatory housing practice or will be injured by an unlawful practice or discriminatory housing practice that is about to occur.

(2) A person claiming to be aggrieved by an alleged unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law or the person's attorney, or the commissioner may file a complaint, in person or by mail, with the division at any bureau office in the state of Oregon. Complaint means a written, verified statement signed by the complainant or the complainant's attorney that:

(a) Gives the name and address of the complainant and the respondent;

(b) Describes the acts or omissions alleged to be an unlawful practice, including those acts or omissions the person believes are about to occur and;

(c) Describes how the person was harmed or will be harmed by such actions.

(3) The filing date is the date the division receives a complaint that meets the standards contained in OAR 839-003-0200(2).

(4) A person must file a complaint with the division no later than one year after the alleged unlawful practice. If the alleged unlawful practice is of a continuing nature, the right to file a complaint exists so long as the person files the complaint within one year of the most recent date the unlawful practice occurred.

(5) The procedures for filing a complaint are as follows:

(a) A person or the person's attorney makes an inquiry to the division;

(b) The division may provide the person or the person's attorney with a letter of information and/or questionnaire;

(c) If the division determines the person has a basis for filing a complaint, the division will draft a complaint based upon the information provided by the person and send or give the complaint to the person or the person's attorney for verification. The person or the person's attorney will request any necessary changes to the complaint.

(d) The person or the person's attorney will verify and sign the complaint. The complaint will then be submitted to the division.

(e) If the person is an unemancipated minor the complaint must be signed by the minor and the parent or legal guardian of the minor.

(6) The Division will serve notice upon the complainant acknowledging the filing of the complaint and advising the complainant of the time limits and choice of forums provided under ORS chapter 659A and federal housing law.

(7) Within 10 days after the filing of a complaint, the division will serve the respondent with a copy of the original complaint that identifies the alleged discriminatory housing practice and a notice that advises the respondent of the procedural rights and obligations of the Respondent, including the respondent's right to file an answer to the complaint.

(8) Each respondent may file, not later than 10 days after receipt of notice from the division, an answer to such complaint.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 654.062, 659A.145, 659A.421, 659A.820 & 29 CFR Part 15(d)(3)
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0205
Amending a Housing Discrimination Complaint

(1) The division may amend a complaint to correct technical defects, to add additional persons as respondents and to add additional information found during the investigation of a complaint, including new factual allegations. The division may amend a complaint on its own initiative or at the complainant's request (with the division's agreement) at any time prior to the issuance of Formal Charges, except that respondents may only be added during the course of investigation. Examples of technical defects include: clerical errors, additions or deletions, name and address corrections, and statute citation errors.

(2) Within 10 days after identifying an additional person who will named as a respondent, the division will serve the person with a copy of the complaint that identifies the alleged discriminatory housing practice and a notice that advises the person of the procedural rights and obligations of the person, including the person's right to file an answer to the complaint.

(a) Such notice, in addition to meeting the requirements of subsection (1)(a), will explain the basis for the division's belief that the person to whom the notice is addressed is properly joined as a respondent.

(b) Each respondent may file, not later than 10 days after receipt of notice from the division, an answer to such complaint.

(3) The division will send a copy of the amended complaint to the complainant and all respondents.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.145, 659A.421, 659A.820
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0210
Withdrawal of a Housing Discrimination Complaint

A complainant may voluntarily withdraw a complaint at any time by

giving the division written notice of the complainant's decision to withdraw.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.145, 659A.421
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0215
Administrative Dismissal of a Housing Discrimination Complaint

(1) The division will dismiss the complaint if it determines that the bureau has no jurisdiction over the allegations of the complaint.

(2) If a complainant or the complainant's attorney fails to cooperate with the division, the division may dismiss the complaint.

(3) The complainant will notify the division in writing of address and telephone number changes. When a complainant cannot be located by reasonable efforts, the division may dismiss the complaint.

(4) The division will dismiss a complaint unless substantial evidence of unlawful discrimination is found. The division will provide written notice of such dismissal to complainant and respondent.

(5) The division cannot issue a finding of substantial evidence of discrimination once complainant has filed a civil suit alleging the same matters as provided in OAR 839-003-0235, and the trial for the civil suit has commenced.

(6) The division will dismiss complaints alleging discrimination under federal housing law statutes administered by HUD in accordance with federal requirements.

(7) The division will notify the complainant in writing of the right to file suit in state court, as provided in ORS 659A.870 to 659A.885, when a complaint is dismissed by the division. A complainant filing suit against a public body must also file a tort claim notice as required by ORS 30.275.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 30.680, 659A.145, 659A.421, 659A.835, 659A.850 & 659A.870 - 659A.885
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0220
Housing Discrimination Investigations

(1) The division will investigate the allegations contained in any complaint filed under ORS 659A.820 or 659A.825 alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law to determine objectively whether there is substantial evidence of unlawful discrimination. The division will determine the method by which complaints will be investigated or otherwise processed. The division will not investigate allegations occurring more than one year prior to the date the complaint was filed unless the allegations constitute a continuing violation or the circumstances occurring more than one year prior to the date the complaint was filed pertain to timely allegations.

(2) The division will commence an investigation of any complaint alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law within 30 days after the timely filing of the complaint.

(3)(a) At the end of each investigation of a complaint alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law the division will prepare a final investigative report containing:

(A) The names and dates of the contacts with witnesses;

(B) A summary and the dates of correspondence and other contacts with the complainant and the respondent;

(C) A summary description of other pertinent records;

(D) A summary of witness statements; and

(E) Answers to interrogatories.

(b) A final investigative report under this section may be amended if additional evidence is later discovered.

(c) The division will make the final investigative report available, upon request, to both the complainant and the respondent.

(4) The division will complete an investigation of any complaint alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law within 100 days after the filing of the complaint, unless it is impracticable to do so. If the division is unable to complete the investigation of the complaint within 100 days after the filing of the complaint the division will notify the complainant and respondent in writing of the reasons for not doing so.

(5) The division will make final disposition of any complaint alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law within one year after the filing of the complaint, unless it is impracticable to do so. If the division is unable to make final disposition of the complaint within one year the division will notify the complainant and respondent in writing of the reasons for not doing so.

(6) If the division determines that it is impracticable to complete an investigation and make final disposition of any complaint within one year the commissioner's authority to conduct investigations or other proceedings to resolve a complaint alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law does not cease within the one year period under ORS 659A.830(3).

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.145, 659A.421, 659A.800, 659A.805, 659A.835 & 659A.870 - 659A.885
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0225
Settlement Process After Substantial Evidence Determination in Housing Discrimination Complaints

(1) During the period beginning with the filing of a complaint and ending with the filing of a charge or a dismissal by the division, the division will, to the extent feasible, seek to eliminate the effects of the unlawful discriminatory act(s) by engaging in conciliation, settlement and persuasion. The division will facilitate any settlement negotiations between the complainant and respondent as provided in OAR 839-003-0055.

(2) Nothing said or done in the course of settlement discussions concerning a complaint alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law may be disclosed under ORS 192.410 to 192.505 or in any other manner, or used as evidence in a subsequent proceeding under this chapter or federal housing law, without the written consent of the persons concerned.

(3) If no settlement agreement is reached in the period of time set aside for settlement after a Substantial Evidence Determination, the division will proceed to a contested case hearing.

(4) The complainant may withdraw the complainant's own complaint at any time.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.145, 659A.421, 659A.835, 659A.840
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0230
Remedies in Housing Discrimination Complaints

(1) In cases of housing discrimination remedy includes, but is not limited to:

(a) Rental, lease or sale of real property;

(b) Service lost;

(c) Expenses or lost benefits attributable to the practice;

(d) Compensation for emotional distress and for impaired personal dignity; and

(e) Interest.

(2) Settlements of complaints and the awards in commissioner's Final Orders do not necessarily include all possible remedies named in sections (1) of this rule. Nothing in this rule will be construed to limit or alter the statutory powers of the commissioner to protect the rights of persons similarly situated to the complainant or to order the performance of an act or a series of acts designed to eliminate the effect of any unlawful practice found.

(3) The commissioner may order the respondent to eliminate the effects of any unlawful practice found and may require respondent to do one or more of the following:

(a) Perform a designated act or series of acts that are calculated to carry out the policy of these rules in order to eliminate the effects of an unlawful practice and to protect the rights of those affected;

(b) Take action and submit reports to the commissioner on the manner of compliance with the terms and conditions specified in the commissioner's order or agreement;

(c) Refrain from any action prohibited by the order or agreement that would jeopardize the rights of the individuals or groups named in the complaint or would frustrate the purpose and the policy of these rules and relevant statutes.

(4) Any agreement or order issued by the commissioner may be enforced by mandamus or injunction or by suit in equity to compel specific performance.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.145, 659A.421, 659A.800, 659A.850, 659A.860, 659A.865 & 659A.885

Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0235
Civil Suit

(1) A person alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law may file a civil suit as provided in ORS 659A.870 to 659A.885, or 30.680.

(a) A person is not required to file a complaint of a violation of state law with the division before filing a civil suit.

(2) A civil suit alleging an unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law, may be filed no later than two years after the occurrence or termination of an alleged discriminatory housing practice, or within two years after the breach of any settlement agreement entered into under ORS 659A.840, whichever occurs last. The two-year period may not include any time during which an administrative proceeding was pending with respect to the housing practice.

(3) After filing a complaint with the division, a complainant may file a civil suit in state or federal court alleging the same matters as those alleged in the complaint filed with the division. The complainant should notify the division of the civil suit. When the division receives notice from the complainant or complainant's attorney, or court documents indicating that such a suit has been filed the division will not dismiss the complaint until the civil trial commences. The division will notify the complainant and respondent that the division has dismissed the complaint and will take no further action.

(4) If Formal Charges have been issued with respect to a housing discrimination complaint, and an administrative law judge has commenced a hearing on the record under ORS chapter 659A, the complainant may not commence a civil action in court that alleges the same matters.

(5) When the commissioner or the Attorney General has reasonable cause to believe that a person or group of persons is engaged in a pattern or practice of resistance to the rights protected by ORS 659A.145 or 659A.421 or federal housing law, the commissioner or the Attorney General may file a civil action on behalf of the aggrieved individuals in the same manner as an individual or group of individuals may file a civil action under ORS 659A.885.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 30.275, 30.680, 659A.001 - 659A.030, 659A.145, 659A.150 - 659A.224, 659A.233, 659A.303, 659A.409, 659A.420, 659A.421, & 659A.800 - 659A.890
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0240
Enforcement of Settlement Agreements and Orders in Housing Discrimination Complaints

(1) Any agreement or order issued by the commissioner may be enforced by mandamus or injunction or by suit in equity to compel specific performance, as provided in ORS 659A.860.

(2) If the complainant believes the terms of a bureau settlement agreement have been breached, the complainant may file a complaint with the division alleging retaliation, or file a new complaint re-alleging the original violation if it is still occurring. The division will review the provisions of the settlement agreement and investigate.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.145, 659A.421, 659A.850, 659A.860, 659A.865
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-003-0245
Commissioner's Complaint

(1) The Commissioner of the Bureau of Labor and Industries may make, sign and file a complaint whenever the commissioner has reason to believe that any person or group of persons has been denied rights or is about to be denied rights due to an unlawful practice under ORS 659A.145 or 659A.421 or federal housing law. The complaint will be processed in the same manner as any other complaint filed under OAR 839-003-0200.

(2) In the matter of concurrent complaints, nothing in these rules will be construed to:

(a) Require or prohibit the filing of a commissioner's complaint involving the same or similar issues or allegations stated in any other complaint filed with the division or circuit court by an individual under ORS 659A.820, 659A.825, or 659A.885;

(b) Require or prohibit the continued processing or initiation of a commissioner's complaint in the event that a complaint filed with the division or circuit court by an individual under ORS 659A.820, 659A.825, or 659A.885, is resolved or dismissed, with or without remedy to the individual; or

(c) Alter or limit an individual's private right of action provided under ORS 659A.870 to 659A.885.

Stat. Auth.: ORS 183, 659A.805
Stats. Implemented: ORS 659A.145, 659A.421, 659A.820, 659A.825, 659A.870 - 659A.885
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0000
Purpose and Scope

(1) It is the policy of the State of Oregon that unlawful discrimination because of race, color, religion, sex, sexual orientation, national origin, marital status, age, disability and other classes protected under Oregon statutes is a matter of state concern and that such discrimination threatens individual rights and privileges and menaces the institutions and foundations of a free democratic state.

(2) Prohibited discrimination is a basis of unlawful practices and unlawful employment practices described in ORS chapter 659A and other chapters of the Oregon statutes.

(3) The Civil Rights Division of the Bureau of Labor and Industries is responsible for protecting individual rights through the enforcement of civil rights statutes prohibiting unlawful practices and unlawful employment practices over which the bureau has jurisdiction.

(4) The purpose of these rules is to implement, interpret and describe the division's approach to civil rights enforcement under the bureau's jurisdiction.

(5) These rules apply to all inquiries and complaints received by the division on or after the effective date of these rules.

(6) An individual claiming a violation of the civil rights statutes may file a complaint with the Civil Rights Division as provided in OAR 839-003-0025 or 839-003-0200 for complaints alleging housing discrimination filed under ORS 659A.145, 659A.421 or federal housing law.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A
Hist.: BL 9-1982, f. & ef. 6-11-8; BL 4-1996, f. & cert. ef. 3-12-96; BLI 19-2000, f. & cert. ef. 9-15-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0003
Definitions

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law.

(1) "Bureau" means the Bureau of Labor and Industries.

(2) "Complainant" means an individual who files a complaint with the division, personally or through the individual's attorney, pursuant to the guidelines provided in OAR 839-003-0025 or 839-003-0200 for complaints alleging housing discrimination filed under ORS 659A.145, 659A.421 or federal housing law.

(3) "Division" means the Civil Rights Division of the Bureau of Labor and Industries.

(4) "Employee" does not include any individual employed by that individual's parents, spouse or child or in the domestic service of any person.

(5) "Employer" means any person in this state who, directly or through an agent, engages or utilizes the personal service of one or more employees, reserving the right to control the means by which such service is or will be performed. Employer also includes any public body that, directly or through an agent, engages or utilizes the personal service of one or more employees, reserving the right to control the means by which such service is or will be performed, including all officers, agencies, departments, divisions, bureaus, boards and commissions of the legislative, judicial and administrative branches of the state, all county and city governing bodies, school districts, special districts, municipal corporations and all other political subdivisions of the state.

(6) "Person" includes one or more individuals, partnerships, associations, labor organizations, limited liability companies, joint-stock companies, corporations, legal representatives, trustees, and trustees in bankruptcy or receivers. "Person" also includes a public body as defined in ORS 30.260. For the purposes of ORS 659A.145 or 659A.421 or federal housing law, "person" also includes fiduciaries, mutual companies, trusts and unincorporated organizations.

(7) "Employment agency" includes any person undertaking to procure employees or opportunities to work.

(8) "Labor organization" includes any organization that is constituted

for the purpose, in whole or in part, of collective bargaining or in dealing with employers concerning grievances, terms or conditions of employment or of other mutual aid or protection in connection with employees.

(9) "Protected class" means a group of people protected by law from discrimination on the basis of a shared characteristic, such as race, sex, sexual orientation, disability, or other, or a perception of that characteristic.

(10) "Respondent" includes any person against whom a complaint or charge of unlawful practices is filed with the division or whose name has been added to such complaint or charge pursuant to ORS 659A.835(1).

(11) "Sexual orientation" means an individual's actual or perceived heterosexuality, homosexuality, bisexuality, or gender identity, regardless of whether the individual's gender identity, appearance, expression or behavior differs from that traditionally associated with the individual's assigned sex at birth.

(12) "Gender identity" means an individual's gender-related identity, whether or not that identity is different from that traditionally associated with the individual's assigned sex at birth, including, but not limited to, a gender identity that is transgender or androgynous.

(13) "Gender expression" means the manner in which an individual's gender identity is expressed, including, but not limited to, through dress, appearance, manner, or speech, whether or not that expression is different from that traditionally associated with the individual's assigned sex at birth.

(14) "Sex" means the anatomical, physiological and genetic characteristics associated with being male or female.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A, OL 2007 Ch 100
Hist.: BLI 19-2000, f. & cert. ef. 9-15-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0010
Discrimination Theories

As used in enforcing ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law.

(1) Substantial evidence of intentional unlawful discrimination exists if the division's investigation reveals evidence that a reasonable person would accept as sufficient to support the following elements:

(a) The respondent is a respondent as defined by ORS 659A.001(10) and OAR 839-005-0003(10) of these rules;

(b) The complainant is a member of a protected class;

(c) The complainant was harmed by an action of the respondent; and

(d) The complainant's protected class was a motivating factor for the respondent's action. In determining whether the complainant's protected class was the reason for the respondent's action, the division uses whichever of the following theories applies:

(A) Specific Intent Theory: The respondent knowingly and purposefully discriminates against an individual because of that individual's membership in a protected class, unless the respondent can show that a bona fide occupational qualification or a bona fide voluntary, court-ordered affirmative action plan (OAR 839-005-0045) allows the action.

(B) Different or Unequal Treatment Theory: The respondent treats members of a protected class differently than others who are not members of that protected class. When the respondent makes this differentiation because of the individual's protected class and not because of legitimate, non-discriminatory reasons, unlawful discrimination exists. In establishing a case of different or unequal treatment:

(i) There must be substantial evidence that the complainant was harmed by an action of the respondent under circumstances that make it appear that the respondent treated the complainant differently than comparably situated individuals who were not members of the complainant's protected class. Substantial evidence of discrimination exists if the division's investigation reveals evidence that a reasonable person would accept as sufficient to support that protected class membership was a motivating factor for the respondent's alleged unlawful action. If the respondent fails to rebut this evidence with evidence of a legitimate non-discriminatory reason, the division will conclude that substantial evidence of unlawful discrimination exists.

(I) Pretext: If the respondent rebuts the evidence with evidence of a legitimate non-discriminatory reason, but there is substantial evidence that the respondent's reason is a pretext for discrimination, the division will conclude there is substantial evidence of unlawful discrimination.

(II) Mixed Motive: If the respondent presents substantial evidence that a legitimate, non-discriminatory reason contributed to the respondent's action, but the division finds the individual's protected class membership was also a substantial factor in the respondent's action, the division will determine there is substantial evidence of discrimination.

(ii) The complainant at all times has the burden of proving that the complainant's protected class was the reason for the respondent's unlawful action.

(2) Adverse Impact Discrimination in Employment: Substantial evidence of adverse impact discrimination does not require establishment of intentional discrimination as provided in (1) of this rule. Adverse impact discrimination exists if the division's investigation reveals evidence that a reasonable person would accept as sufficient to support the following elements:

(a) The respondent is a respondent as defined by ORS 659A.001(10) and OAR 839-005-0003(10) of these rules;

(b) The respondent has a standard or policy that is applied equally.

(c) The standard or policy has the effect of screening out or otherwise affecting members of a protected class at a significantly higher rate than others who are not members of that protected class; and

(d) The complainant is a member of the protected class adversely affected by the respondent's standard or policy and has been harmed by the respondent's application of the standard or policy.

(3) Adverse Impact Discrimination in Housing:

(a) For the purposes of interpreting ORS 90.390, a court or the commissioner may find that a person has violated or is going to violate ORS 659A.145 or 659A.421 if:

(A) The person applies a facially neutral housing policy to a member of a protected class;

(B) Application of the policy adversely impacts members of the protected class to a greater extent than the policy impacts persons generally.

(b) In determining under subsection (a) of this section whether a violation has occurred or will occur and, if it is determined that a violation has occurred or will occur, what relief should be granted, a court or the commissioner will consider:

(A) The significance of the adverse impact on the protected class;

(B) The importance and necessity of any business purpose for the facially neutral housing policy; and

(C) The availability of less discriminatory alternatives for achieving the business purpose for the facially neutral housing policy.

(4) Discrimination based on disability may involve intentional discrimination, including harassment, or discrimination that need not be intentional, including adverse impact, or the failure to permit reasonable modifications, the refusal to make reasonable accommodations or the failure to design and construct covered buildings under applicable rules. To be protected from discrimination based on disability, an individual must have a disability, as defined in ORS 659A.100(1) and (2) and the relevant rules. Reasonable accommodation for purposes of employment is defined in ORS 659A.118 and OAR 839-006-0206. Reasonable accommodation in real property transactions is covered by ORS 659A.145 and OAR 839-005-0220. Reasonable modifications in services, programs or activities, provision of auxiliary aids, services by state government, removal of barriers to facilities, goods and services and provision of auxiliary aids by public accommodations are covered by ORS 659A.142 and OAR 839-006-0310 to 0330. Reasonable modifications in housing and the design and construction of covered buildings are covered by ORS 659A.145. Claims of disability discrimination brought under federal housing law are defined under that law.

(5) For the purposes of housing discrimination complaints under ORS 659A.145 or 659A.421 or discrimination under federal housing law, a complainant need not be a member of a protected class. Substantial evidence in complaints of housing discrimination exists when the division's investigation reveals, based on the totality of circumstances known at the time of the decision, that a reasonable person would accept as sufficient to believe that a discriminatory housing practice has occurred or is about to occur.

(6) An employer must reasonably accommodate an employee or applicant's religious belief, observance or practice unless the employer can demonstrate that such accommodation would cause undue hardship on the employer's business.

(7) Harassment in Employment: Harassment based on an individual's protected class is a type of intentional unlawful discrimination. In cases of alleged unlawful sexual harassment in employment see OAR 839-005-0030.

(a) Conduct of a verbal or physical nature relating to protected classes other than sex is unlawful when substantial evidence of the elements of intentional discrimination, as described in section (1) of this rule, is shown and:

(A) Such conduct is sufficiently severe or pervasive to have the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environ-

ment;

(B) Submission to such conduct is made either explicitly or implicitly a term or condition of employment; or

(C) Submission to or rejection of such conduct is used as the basis for employment decisions affecting that individual.

(b) The standard for determining whether harassment is sufficiently severe or pervasive to create a hostile, intimidating or offensive working environment is whether a reasonable person in the circumstances of the complaining individual would so perceive it.

(c) Employer Proxy: An employer is liable for harassment when the harasser's rank is sufficiently high that the harasser is the employer's proxy, for example, the employer's president, owner, partner or corporate officer.

(d) Harassment by Supervisor plus Tangible Employment Action: An employer is liable for harassment by a supervisor with immediate or successively higher authority over an individual when the harassment results in a tangible employment action that the supervisor takes or causes to be taken against the individual. A tangible employment action includes, but is not limited to, any of the following:

(A) Terminating employment, including constructive discharge;

(B) Failing to hire;

(C) Failing to promote; or

(D) Changing a term or condition of employment, such as work assignment, work schedule, compensation or benefits or making a decision that causes a significant change in an employment benefit.

(e) Harassment by Supervisor, No Tangible Employment Action: When harassment by a supervisor with immediate or successively higher authority over the individual is found to have occurred, but no tangible employment action was taken, the employer is liable if:

(A) The employer knew of the harassment, unless the employer took immediate and appropriate corrective action.

(B) The employer should have known of the harassment. The division will find that the employer should have known of the harassment unless the employer can demonstrate:

(i) That the employer exercised reasonable care to prevent and promptly correct any harassing behavior; and

(ii) That the complaining individual unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer or to otherwise avoid harm.

(f) Harassment by Coworkers or Agents: An employer is liable for harassment by the employer's employees or agents who do not have immediate or successively higher authority over the complaining individual when the employer knew or should have known of the conduct, unless the employer took immediate and appropriate corrective action.

(g) Harassment by Non-Employees: An employer is liable for harassment by non-employees in the workplace when the employer or the employer's agents knew or should have known of the conduct unless the employer took immediate and appropriate corrective action. In reviewing such cases, the division will consider the extent of the employer's control and any legal responsibility the employer may have with respect to the conduct of such non-employees.

(h) Withdrawn Consent: An employer may be liable for harassment by the employer's supervisory or non-supervisory employees, agents or non-employees even if the acts complained of were of a kind previously consented to by the complaining individual, if the employer knew or should have known that the complaining individual had withdrawn consent to the offensive conduct.

(i) When employment opportunities or benefits are granted because of an individual's submission to an employer's harassment, the employer is liable for unlawful discrimination against other individuals who were qualified for but denied that opportunity or benefit.

(8) Harassment in Housing and Public Accommodations: Harassment on the basis of a protected class, including sexual harassment, is an unlawful practice in housing and in places of public accommodation when:

(a) Substantial evidence of the elements of OAR 839-005-0010(1) is shown; and

(b) Such conduct has the purpose or effect of creating an intimidating, hostile or offensive environment. The standard for determining whether harassment in housing and in places of public accommodation creates an intimidating, hostile or offensive environment is whether a reasonable person in the circumstances of the complaining individual would so perceive it.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 659A & 42 U.S.C. 3601 et seq.

Hist.: BL 9-1982, f. & ef. 6-11-82; BL 4-1996, f. & cert. ef. 3-12-96; BLI 6-1998, f. & cert. ef. 10-22-98; BLI 19-2000, f. & cert. ef. 9-15-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 3-2007, f. 1-29-07, cert. ef. 2-2-07; BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0016

Exceptions to Discrimination Based on Sexual Orientation

(1) The following actions are not unlawful practices under ORS chapter 659A, including housing discrimination under ORS 659A.145 or 659A.421 or federal housing law:

(a) Housing and the use of facilities. It is not an unlawful practice for a bona fide church or other religious institution to take any action with respect to housing or the use of facilities when:

(A) The action taken is based on a bona fide religious belief about sexual orientation; and

(B) The housing or the use of facilities involved is closely connected with or related to the primary purpose of the church or institution; and

(C) The housing or the use of facilities involved is not connected with a commercial or business activity that has no necessary relationship to the church or institution.

(b) Employment Preference. It is not an unlawful employment practice for a bona fide church or other religious institution, including but not limited to a school, hospital or church camp, to prefer an employee, or an applicant for employment, of one religious sect or persuasion over another if:

(A) The employee or applicant belongs to the same religious sect or persuasion as the church or institution; and

(B) In the opinion of the church or institution, the preference will best serve the purposes of the church or institution; and

(C) The employment involved is closely connected with or related to the primary purposes of the church or institution; and

(D) The employment involved is not connected with a commercial or business activity that has no necessary relationship to the church or institution.

(c) Employment Actions. It is not an unlawful employment practice for a bona fide church or other religious institution to take any employment action based on a bona fide religious belief about sexual orientation when:

(A) The employment position involved is directly related to the operation of the church or other place of worship, such as clergy, religious instructors and support staff;

(B) The employment position involved is in a nonprofit religious school, nonprofit religious camp, nonprofit religious day care center, nonprofit religious thrift store, nonprofit religious bookstore, non profit religious radio station or nonprofit religious shelter; or

(C) The employment position involves religious activities, as long as the employment position:

(i) Is closely connected with or related to the primary purpose of the church or institution; and

(ii) Is not connected with a commercial or business activity that has no necessary relationship to the church or institution.

(d) Dress Code. An employer is not prohibited from enforcing an otherwise valid dress code or policy, as long as the employer provides, on a case-by-case basis, for reasonable accommodation of an individual based on the health and safety needs of the individual.

(2) The above exceptions do not excuse a failure to provide reasonable and appropriate accommodations permitting all persons access to restrooms consistent with their expressed gender.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 659A, OL 2007 Ch 100

Hist.: BLI 35-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0026

Protections and Rights Relating to Pregnancy

(1) Pregnant women are protected from sex discrimination in employment.

(2) In judging the physical ability of an individual to work, pregnant women must be treated the same as males, non-pregnant females and other employees with off-the-job illnesses or injuries.

(3) The statutes prohibit discrimination regarding employee and dependent spouse or domestic partner benefits for pregnancy when employee and dependent spouse or domestic partner benefits exist for other medical conditions.

(4) Women needing to be absent from work because of pregnancy or childbirth may have rights under the Oregon Family Leave Act, as provided in ORS 659A.150 to 659A.186 and OAR 839-009-0200 to 839-009-0320.

Stat. Auth.: ORS 659A.805

Stats. Implemented: ORS 659A.029, 659A.030, 659A.150- 659A.186, OL 2007 Ch 99

Hist.: BLI 19-2000, f. & cert. ef. 9-15-00; BLI 10-2002, f. & cert. ef. 5-17-02; BLI 35-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0195
Purpose and Scope

(1) The public policy of the State of Oregon guarantees all persons the fullest possible participation in the social and economic life of the state, including the right to purchase, lease, rent or occupy property without discrimination on the basis of race, color, religion, sex, sexual orientation, national origin, marital status, disability, familial status, source of income and other classes protected under Oregon statutes. The Bureau of Labor and Industries, through the Civil Rights Division, protects these rights by enforcement of ORS 659A.145, 659A.421 and the Fair Housing Act (42 U.S.C. 3601 et seq.) for which the U.S. Department of Housing and Urban Development has jurisdiction.

(2) A person claiming to be aggrieved by an alleged unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law may file a complaint with the Civil Rights Division as described in OAR 839-003-0200.

(a) A person claiming to be aggrieved by an alleged unlawful practice under ORS 659A.145 or 659A.421 or discrimination under federal housing law includes a person who believes that the person has been injured by an unlawful practice or discriminatory housing practice or will be injured by an unlawful practice or discriminatory housing practice that is about to occur.

(3) These rules apply to all complaints and inquiries relating to these sections received on or after the effective date of these rules.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.103, 659A.142 & 659A.145, 659A.421 & 42 U.S.C. 3601 et. seq.
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0200
Definitions

(1) "Disabled Person" means a person with a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment.

(2) "Dwelling" means any building, structure, or portion of a building or structure that is occupied as, or designed or intended for occupancy as, a residence by one or more families, and any vacant land that is offered for sale or lease for the construction or location of any such building, structure, or portion of such a building or structure. "Family" includes a single individual.

(3)(a) "Familial status" means the relationship between one or more individuals who have not attained 18 years of age and who are domiciled with:

(A) A parent or another person having legal custody of the individual; or

(B) The designee of the parent or other person having such custody, with the written permission of the parent or other person.

(b) "Familial status" includes any individual, regardless of age or domicile, who is pregnant or is in the process of securing legal custody of an individual who has not attained 18 years of age.

(4) "Federal Housing Law" means The Fair Housing Act (42 U.S.C. 3601 et seq.) for which the U.S. Department of Housing And Urban Development has jurisdiction.

(5) "Major life activity" includes, but is not limited to, self-care, ambulation, communication, transportation, education, socialization, employment and ability to acquire, rent or maintain property.

(a) Examples of specific major life activities include, but are not limited to, walking, sitting, standing, lifting, reaching, speaking, interacting with others, thinking, seeing, hearing, breathing, learning, reading, eating, sleeping, performing manual tasks, reproduction and working.

(b) To be substantially limited in the major life activity of working, a person must be significantly restricted in the ability to perform a class of jobs or a broad range of jobs in various classes as compared to the ability of an average person with comparable skill, experience, education or other job-related requirements needed to perform those same positions.

(6) "Misclassified," as used in ORS 659A.100(2)(b), means an erroneous or unsupported medical diagnosis, report, certificate or evaluation.

(7) "Person associated with a purchaser," as used in ORS 659A.145(1), includes one or more individuals, partnerships, associations, labor organizations, limited liability companies, joint stock companies, corporations, legal representatives, trustees, trustees in bankruptcy or receivers, fiduciaries, mutual companies, trusts and unincorporated organizations and public bodies as defined in ORS 30.260 that have the primary purpose of serving, representing or otherwise benefiting the protected class.

(8) "Physical or mental impairment" means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin and endocrine; or any mental or psychological disorder, such as mental retardation, organic brain syndrome, traumatic brain injury, emotional or mental illness, and specific learning disabilities.

(9) "Property" and "real property" means property used or intended for commercial, business or residential purposes including, but not limited to a dwelling.

(10) "Purchaser" includes an occupant, prospective occupant, renter, prospective renter, lessee, prospective lessee, buyer or prospective buyer.

(11) "Receipt or alleged receipt of treatment for a mental disorder," as used in ORS 659A.142(5), means actual treatment of a person for a mental condition or an assertion that the person received such treatment.

(12) "Regarded as having an impairment," as used in ORS 659A.100(2)(c), means:

(a) A person having a physical or mental impairment that does not substantially limit a major life activity but who has been treated as having an impairment by a seller, lessor, advertiser, real estate broker or salesperson, or the agent of any seller, lessor, advertiser, real estate broker or salesperson;

(b) A person having a physical or mental impairment that substantially limits a major life activity only as a result of the attitude of others toward such impairment; or

(c) A person having no physical or mental impairment but who is treated as having an impairment by a seller, lessor, advertiser, real estate broker or salesperson, or the agent of any seller, lessor, advertiser, real estate broker or salesperson.

(13) "Residential real estate related transaction" means any of the following:

(a) The making or purchasing of loans or providing other financial assistance:

(A) For purchasing, constructing, improving, repairing or maintaining a dwelling; or

(B) Secured by residential real estate; or

(b) The selling, brokering or appraising of residential real property.

(14) "Substantially limits" means:

(a) The impairment renders the person unable to perform a major life activity that the average person in the general population can perform; or

(b) The impairment significantly restricts the condition, manner or duration under which a person can perform a particular major life activity as compared to the condition, manner or duration under which the average person in the general population can perform the same major life activity.

(15) "To rent" includes to lease, to sublease, to let and otherwise to grant for a consideration the right to occupy premises not owned by the occupant.

(16) "Treatment" includes examination, evaluation, diagnosis and therapy by a health professional within the scope of the professional's applicable license.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.103, 659A.142 & 659A.145, 659A.421 & 42 U.S.C. 3601 et. seq, OL 2007 Ch. 100
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0205
Prohibited Discrimination

(1) A person may not, because of race, color, religion, sex, sexual orientation, national origin, marital status, disability, familial status, source of income and other classes protected under Oregon statutes of any person:

(a) Refuse to sell, lease or rent any real property to a purchaser;

(b) Expel a purchaser from any real property;

(c) Make any distinction, discrimination or restriction against a purchaser in price, terms, conditions or privileges relating to the sale, rental, lease or occupancy of real property or in the furnishing of any facilities or services in connection with real property;

(d) Attempt to discourage the sale, rental, lease or occupancy of any real property to a purchaser;

(e) Publish, circulate, issue or display or cause to be published, circulated, issued or displayed, any communication, notice, advertisement, or sign of any kind whether oral, written or electronic, relating to the sale,

rental or leasing of real property that indicates any preference, limitation, specification or unlawful discrimination based on race, color, religion, sex, sexual orientation, national origin, marital status, disability, familial status, source of income and other classes protected under Oregon statutes;

(f) Assist, induce, incite or coerce another person to commit an act or engage in a practice that violates ORS 659A.145, 659A.421, federal housing law or these rules;

(g) Coerce, intimidate, threaten or interfere with any person in the exercise or enjoyment of, or on account of having exercised or enjoyed, or on account of having aided or encouraged any other person in the exercise or enjoyment of, any right granted or protected by ORS 659A.145, 659A.421, federal housing law or these rules;

(h) Deny access to, or membership or participation in, any multiple listing service, real estate broker's organization or other service, organization or facility relating to the business of selling or renting dwellings, or discriminate against any person in the terms or conditions of the access, membership or participation;

(i) Represent to a person that a dwelling is not available for inspection, sale, rental or lease when the dwelling in fact is available for inspection, sale, rental or lease;

(j) Otherwise make unavailable or deny a dwelling to a person.

(2) A person whose business includes engaging in residential real estate related transactions may not discriminate against any person in making a transaction available, or in the terms or conditions of the transaction, because of race, color, religion, sex, sexual orientation, national origin, marital status, disability, familial status, source of income and other classes protected under Oregon statutes.

(3) A real estate licensee may not accept or retain a listing of real property for sale, lease or rental with an understanding that a purchaser may be discriminated against with respect to the sale, rental or lease thereof because of race, color, religion, sex, sexual orientation, national origin, marital status, disability, familial status, source of income and other classes protected under Oregon statutes.

(4) A person may not, for profit, induce or attempt to induce any other person to sell or rent any dwelling by representations regarding the entry or prospective entry into the neighborhood of a person or persons of a particular race, color, religion, sex, sexual orientation, national origin, marital status, disability, familial status, source of income and other classes protected under Oregon statutes.

(5) For purposes of OAR 839-005-0205 subsections (1) to (4), "source of income" does not include federal rent subsidy payments under 42 U.S.C. 1437f, income from specific occupations or income derived in an illegal manner.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.103, 659A.142 & 659A.145, 659A.421 & 42 U.S.C. 3601 et. seq.
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

839-005-0220
Disabled Persons

(1) Persons protected from discrimination on the basis of disability in real property transactions include any disabled person associated with a purchaser.

(2) In addition to the prohibitions in OAR 839-005-0205, discrimination in real property transactions based on a person's disability includes, but is not limited to:

(a) Refusing to permit, at the expense of the disabled person, reasonable modifications of existing premises occupied or to be occupied by such person if such modifications may be necessary to afford such person full enjoyment of the premises, except that, in the case of rental, the landlord may, where it is reasonable to do so, condition permission for modification on the renter agreeing to restore the interior of the premises to the condition that existed before the modification, reasonable wear and tear excepted;

(A) In the case of a rental, a disabled renter is only required to restore the interior premises to the condition that existed before the modification when the landlord required restoration as a condition to granting the disabled renter's reasonable modification request.

(b) Refusing to make reasonable accommodations in rules, policies, practices or services when such accommodations may be necessary to afford a disabled person equal opportunity to use and enjoy a dwelling and;

(c) Failure to design and construct a covered multifamily dwelling as required by the Fair Housing Act (42 U.S.C. 3601 et seq.).

(3) Direct Threat. A lessor or agent may engage in conduct otherwise prohibited by ORS 659A.145 when:

(a) A disabled person's leasing or rental of the subject property would constitute a direct threat to the health or safety of other individuals or would result in substantial physical damage to the property of others; and

(b) No reasonable accommodation is possible that would eliminate or acceptably minimize the risk to health and safety.

(4) A lessor or agent must allow alterations of existing premises if the premises are occupied by or to be occupied by a disabled person, and the disabled person pays for the alterations, as provided in OAR 839-005-0220(2).

(5) There is no just cause for discrimination on the basis of perceived disability.

(6) Receipt or alleged receipt of treatment for a mental disorder does not constitute evidence of an individual's inability to acquire, rent or maintain property.

(7) In the sale, lease or rental of real estate, a person may not disclose to any person that an occupant or owner of real property has or died from human immunodeficiency virus or acquired immune deficiency syndrome.

Stat. Auth.: ORS 659A.805
Stats. Implemented: ORS 659A.103, 659A.142 & 659A.145, 659A.421 & 42 U.S.C. 3601 et. seq.
Hist.: BLI 36-2007, f. 12-27-07 cert. ef. 1-1-08; BLI 7-2008(Temp), f. 3-20-08, cert. ef. 3-25-08 thru 9-21-08; Administrative correction 10-21-08; BLI 40-2008, f. 11-10-08, cert. ef. 11-12-08; BLI 43-2008, f. 12-3-08, cert. ef. 12-5-08

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Construction Contractors Board
Chapter 812

Rule Caption: Housekeeping amendments.
Adm. Order No.: CCB 18-2008
Filed with Sec. of State: 11-20-2008
Certified to be Effective: 11-20-08
Notice Publication Date: 10-1-2008
Rules Amended: 812-002-0060, 812-002-0420, 812-005-0280
Rules Repealed: 812-003-0450
Subject: OAR 812-002-0060 is amended to correct the ORS cite reference from 701.055(1) to 701.026(1) to match current statute.

OAR 812-002-0420 is amended to add reference to the new rule in chapter 812, division 20 that uses the term "lapse in license."

OAR 812-003-0450 is repealed; the language was amended and moved into 812-005-0280(1).

OAR 005-0280 is amended to amend and incorporate the language contained in 812-003-0450, to renumber, and cite references, The two rules regarding fitness, unfit or not fir were incorporated into one rule to make it easier to locate the rules and to cause less confusion.
Rules Coordinator: Catherine Dixon—(503) 378-4621, ext. 4077

812-002-0060
Bid

"Bid" as used in ORS 701.026(1) does not include a prospectus for an art project.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 279.073 & 701
Hist.: CCB 4-1998, f. & cert. ef. 4-30-98; CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 18-2008, f. & cert. ef. 11-20-08

812-002-0420
Lapse in License

"Lapse in license" as used in ORS 701.131(2)(b), 701.063(4), OAR 812-006-0020(1)(b), 812-006-0020(2)(b), and 812-020-0085 commences at the time that a license expires, is suspended or is terminated for any reason and ends when the license is renewed, reissued or reinstated by the agency.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.063, 701.131 & 701.225
Hist.: CCB 4-1998, f. & cert. ef. 4-30-98; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 6-2003(Temp), f. & cert. ef. 7-9-03 thru 1-3-04; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 7-2007, f. 12-13-07, cert. ef. 1-1-08; CCB 9-2008, f. 6-11-08, cert. ef. 7-1-08; CCB 18-2008, f. & cert. ef. 11-20-08

812-005-0280
Fitness Standards

(1) In considering whether to revoke, suspend, or refuse to issue a license pursuant to ORS 701.098(1)(h)(A)-(I), the agency shall consider whether the applicant's or licensee's criminal conduct is substantially related to the fitness and ability of the applicant or licensee to engage in construction contracting.

(a) Fitness to engage in construction contracting includes, but is not limited to the ability to:

(A) Refrain from violent, threatening, intimidating or sexually predatory behavior;

(B) Refrain from dishonest or fraudulent conduct; or

(C) Be financially responsible.

(b) Factors to be considered in denying or refusing to issue or renew a license include, but are not limited to, the date of the offense and the circumstances of the crime. In addition, factors relating to rehabilitation, or lack thereof, as evidenced by intervening events include, but are not limited to: failure to complete the criminal sentence, including probation or parole; failure to complete court ordered treatment; or failure to pay court ordered restitution.

(c) Upon notice and request from the Board, it will be the duty of an applicant or licensee to provide the requested information in order for the Board to conduct a criminal background check as authorized by 701.098(1)(h)(A)-(I). Requested information includes but is not limited to police reports, record of conviction, parole or probation reports, restitution records, counseling reports, and letters of recommendation.

(d) Failure to provide requested information in (1)(c) of this section may result in the denial of a license.

(2) The agency may revoke, suspend, or refuse to issue a license if the applicant, licensee, or an owner, officer or responsible managing individual of the applicant or licensee demonstrates a lack of financial responsibility pursuant to ORS 701.098(2) and 701.102(2)(d). Lack of financial responsibility is evidenced by failure to pay a final order of the board, issued under ORS 701.145 or 701.146, where the final order exceeds the amount of the applicable bond and the final order was issued against:

(a) The applicant or licensee; or

(b) A business in which the owner, officer or responsible managing individual of the applicant or licensee is, or was, an owner, officer or responsible managing individual during the work period in which the business' obligation giving rise to the final order arose or was incurred.

(c) As used in section (2) of this rule, "officer" includes any person listed in ORS 701.005(11) or OAR 812-002-0533.

(3) Pursuant to ORS 701.098(2), the agency may revoke, suspend, or refuse to reissue a license if a contractor engages in conduct that harms a consumer by:

(4) Arranging for or undertaking work as a contractor that:

(a) Is performed in a manner not in accordance with state building codes or accepted building standards demonstrating negligent or improper work;

(b) The work causes damage to the consumer or to the consumer's property; and

(c) The work is significantly substandard or is part of a pattern of substandard work performed by the contractor.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.098 & 701.102
Hist.: CCB 13-2008, f. 6-30-08, cert. ef. 7-1-08; CCB 18-2008, f. & cert. ef. 11-20-08

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Rule Caption: Amend Civil Penalty Regarding Unlicensed Contractor Causing Homeowner Damages.
Adm. Order No.: CCB 19-2008
Filed with Sec. of State: 11-20-2008
Certified to be Effective: 11-20-08
Notice Publication Date: 10-1-2008
Rules Amended: 812-005-0800
Subject: OAR 812-005-0800 is amended to clarify the triggers that authorize a $5,000 civil penalty from a Dispute Resolution Services (DRS) complaint to include a letter mailed to CCB from an owner indicating the consumer has been damaged by the contractor.
Rules Coordinator: Catherine Dixon—(503) 378-4621, ext. 4077

812-005-0800
Schedule of Penalties

The agency may assess penalties, not to exceed the amounts shown in the following guidelines:

(1) $600 for advertising or submitting a bid to do work as a contractor in violation of ORS 701.026 and OAR 812-003-0120, which may be reduced to $200 if the respondent becomes licensed or to $50 if the advertisement or bid is withdrawn immediately upon notification from the agency that a violation has occurred and no work was accepted as a result of the advertisement or bid; and

(2) $700 per offense without possibility of reduction for advertising or submitting a bid to do work as a contractor in violation of ORS 701.026 and OAR 812-003-0120, when one or more previous violations have occurred, or when an inactive, lapsed, invalid, or misleading license number has been used; and

(3) $1,000 per offense for performing work as a contractor in violation of ORS 701.026 when the Board has no evidence that the person has worked previously without having a license and no consumer has suffered damages from the work, which may be reduced to $700 if the respondent becomes licensed within a specified time; and

(4) $5,000 per offense for performing work as a contractor in violation of ORS 701.026, when an owner has filed a complaint for damages caused by performance of that work, which may be reduced to $700 if the contractor becomes licensed within a specified time and settles or makes reasonable attempts to settle with the owner.

(a) A "complaint for damages" as used in section (4) of this rule includes, but is not limited to:

(A) A Construction Contractors Board Dispute Resolution Services (DRS) complaint; or

(B) A letter to Construction Contractors Board indicating that a citizen has been damaged by the contractor; and

(5) $5,000 per offense for performing work as a contractor in violation of ORS 701.026, when one or more violations have occurred, or when an inactive, lapsed, invalid, or misleading license number has been used; and

(6) $500 per offense for failure to respond to the agency's request for the list of subcontractors required in ORS 701.345; and

(7) $1,000 per offense for hiring a unlicensed subcontractor; and

(8) For failing to provide an "Information Notice to Owners about Construction Liens" as provided in ORS 87.093, when no lien has been filed, $200 for the first offense, $400 for the second offense, $600 for the third offense, $1,000 for each subsequent offense. Any time a lien has been filed upon the improvement, $1,000.

(9) Failure to include license number in advertising or on contracts, in violation of OAR 812-003-0120: First offense $100, second offense $200, subsequent offenses $400.

(10) Failure to list with the Construction Contractors Board a business name under which business as a contractor is conducted in violation of OAR 812-003-0260: First offense $50, second offense $100, subsequent offenses $200.

(11) Failure to use a written contract as required by ORS 701.305, $200; when a claim has been filed, $400; second and subsequent offenses, $1,000.

(12) Violation of ORS 701.330, failure to provide a Consumer Notification form; $100 first offense; $500 second offense; $1,000 third offense; and $5,000 for subsequent offenses. Civil penalties shall not be reduced unless the agency determines from clear and convincing evidence that compelling circumstances require a suspension of a portion of the penalty in the interest of justice. In no event shall a civil penalty for this offense be reduced below $100.

(13) Failure to conform to information provided on the application in violation of ORS 701.046(4), issuance of a $5,000 civil penalty, and suspension of the license until the contractor provides the agency with proof of conformance with the application and the terms of the application.

(a) If the violator is a limited contractor or residential limited contractor working in violation of the conditions established pursuant to OAR 812-003-0130 or 812-003-0131, the licensee shall be permanently barred from licensure in the limited contractor category or residential limited contractor endorsement.

(b) If the violator is a licensed developer, residential developer or commercial developer working in violation of the conditions established pursuant to ORS 701.005(3), (6) or (13) or 701.042, the licensee shall be permanently barred from licensure in the licensed developer category or residential developer or commercial developer endorsement.

(14) Knowingly assisting an unlicensed contractor to act in violation of ORS chapter 701, $1,000.

(15) Failure to comply with any part of ORS chapters 316, 656, or 657, 701.035, 701.046 or 701.091, as authorized by ORS 701.106, $1,000 and suspension of the license until the contractor provides the agency with proof of compliance with the statute.

(16) Violating an order to stop work as authorized by ORS 701.225(3), $1,000 per day.

(17) Working without a construction permit in violation of ORS 701.098, $1,000 for the first offense; $2,000 and suspension of CCB license for three (3) months for the second offense; $5,000 and permanent revocation of CCB license for the third and subsequent offenses.

(18) Failure to comply with an investigatory order issued by the Board, $500 and suspension of the license until the contractor complies with the order.

(19) Violation of ORS 701.098(1)(k) by engaging in conduct as a contractor that is dishonest or fraudulent and injurious to the welfare of the public: first offense, $1,000, suspension of the license or both; second and subsequent offenses, $5,000, per violation, revocation or suspension of the license until the fraudulent conduct is mitigated in a manner satisfactory to the agency or both.

(20) Engaging in conduct as a contractor that is dishonest or fraudulent and injurious to the welfare of the public by:

(a) Not paying prevailing wage on a public works job; or

(b) Violating the federal Davis-Bacon Act; or

(c) Failing to pay minimum wages or overtime wages as required under state and federal law; or

(d) Failing to comply with the payroll certification requirements of ORS 279C.845; or

(e) Failing to comply with the posting requirements of ORS 279C.840: $1,000 and suspension of the license until the money required as wages for employees is paid in full and the contractor is in compliance with the appropriate state and federal laws.

(21) Violation of ORS 701.098(1)(k) by engaging in conduct as a contractor that is dishonest or fraudulent and injurious to the welfare of the public, as described in subparagraphs (19) or (20), where more than two violations have occurred: $5,000 and revocation of the license.

(22) When, as set forth in ORS 701.098(1)(g), the number of licensed contractors working together on the same task on the same job site, where one of the contractors is licensed exempt under ORS 701.035(2)(b), exceeded two sole proprietors, one partnership, or one limited liability company, penalties shall be imposed on each of the persons to whom the contract is awarded and each of the persons who award the contract, as follows: $1,000 for the first offense, $2,000 for the second offense, six month suspension of the license for the third offense, and three-year revocation of license for a fourth offense.

(23) Performing home inspections without being an Oregon certified home inspector in violation of OAR 812-008-0030(1): $5,000.

(24) Using the title Oregon certified home inspector in advertising, bidding or otherwise holding out as a home inspector in violation of OAR 812-008-0030(3): $5,000.

(25) Failure to conform to the Standards of Practice in violation of OAR 812-008-0202 through 812-008-0214: $750 per offense.

(26) Failure to conform to the Standards of Behavior in OAR 812-008-0201(2)-(8): $750 per offense.

(27) Offering to undertake, bidding to undertake or undertaking repairs on a structure inspected by an owner or employee of the business entity within 12 months following the inspection in violation of ORS 701.355: $5,000 per offense.

(28) Failure to include certification number in all written reports, bids, contracts, and an individual's business cards in violation of OAR 812-008-0201(4): $400 per offense.

(29) Violation of work practice standards for lead-based paint activity pursuant to OAR 812-007-0070; $5,000 per violation and suspension of the lead-based paint business endorsement for up to one year.

(30) Violation of ORS 279C.590:

(a) Imposition of a civil penalty on the contractor of up to ten percent of the amount of the subcontract bid submitted by the complaining subcontractor to the contractor or $15,000, whichever is less; and

(b) Imposition of a civil penalty on the contractor of up to $1,000; and

(c) Placement of the contractor on a list of contractors not eligible to bid on public contracts established to ORS 701.227(4), for a period of up to six months for a second offense if the offense occurs within three years of the first offense.

(d) Placement of the contractor on a list of contractors not eligible to bid on public contracts established to ORS 701.227(4), for a period of up to one year for a third or subsequent offense if the offense occurs within three years of the first offense.

(31) Violation of ORS 701.315, inclusion of provisions in a contract that preclude a homeowner from filing a breach of contract complaint with the Board: $1,000 for the first offense, $2,000 for the second offense, and $5,000 for the third and subsequent offenses.

(32) Violation of ORS 701.345, failure to maintain the list of subcontractors: $1,000 for the first offense; $2,000 for the second offense, and $5,000 for the third and subsequent offenses.

(33) Violation of 701.098(1)(e), knowingly providing false information to the Board: $1,000 and suspension of the license for up to three months for the first offense; $2,000 and suspension of the license for up to one year for the second offense; and $5,000 and permanent revocation of license for the third offense.

(34) Failing to provide a written contract with the contractual terms provided by ORS 701.305 or OAR 812-012-0110:

(a) On or before December 31, 2008: first offense, a warning letter; second offense, $500 civil penalty; and third offense, up to $5,000 civil penalty.

(b) After December 31, 2008: first offense, $500 civil penalty; second offense, $2,000 civil penalty; and third offense, up to $5,000 civil penalty.

(35) Working while the license is suspended if the licensee was required to provide an increased bond under ORS 701.068(5), 701.068(6) or OAR 12-003-0175: revocation.

(36) Working while the license is suspended for any violation of ORS 701.098(4)(a)(A) or 701.098(4)(a)(B): $5,000 for first offense, and revocation for second or subsequent offense.

(37) Working while the license is suspended for any reason except as otherwise provided for by this rule: revocation.

(38) Failure to comply with ORS 701.106(1)(a): $1,000 for first offense; $5,000 for the second offense; $5,000 and permanent revocation of CCB license for the third offense.

Stat. Auth.: ORS 183.310 - 183.500, 670.310, 701.235 & 701.992

Stats. Implemented: ORS 87.093, 279C.590, 701.005, 701.026, 701.042, 701.046 & 701.091

Hist.: 1BB 4-1982, f. & ef. 10-7-82; 1BB 1-1983, f. & ef. 3-1-83; Renumbered from 812-011-0080(13); 1BB 3-1983, f. 10-5-83, ef. 10-15-83; 1BB 3-1984, f. & ef. 5-11-84; 1BB 3-1985, f.& ef. 4-25-85; BB 1-1987, f. & ef. 3-5-87, BB 1-1988(Temp), f. & cert. ef. 1-26-88; BB 2-1988, f. & cert. ef. 6-6-88; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 2-1990, f. 5-17-90, cert. ef. 6-1-90; CCB 3-1990(Temp), f. & cert. ef. 7-27-90; CCB 4-1990, f. 10-30-90, cert. ef. 11-1-90; CCB 3-1991, f. 9-26-91, cert. ef. 9-29-91; CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 2-1992, f. & cert. ef. 4-15-92; CCB 4-1992, f. & cert. ef. 6-1-92; CCB 5-1993, f. 12-7-93, cert. ef. 12-8-93; CCB 2-1994, f. 12-29-94, cert. ef. 1-1-95; CCB 3-1995, f. 9-7-95, cert. ef. 9-9-95; CCB 4-1995, f. & cert. ef. 10-5-95; CCB 3-1996, f. & cert. ef. 8-13-96; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98 ; CCB 7-1999(Temp), f. & cert. ef. 11-1-99 thru 4-29-00; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 13-2000(Temp), f. & cert. ef 11-13-00 thru 5-11-01; CCB 2-2001 f. & cert. ef. 4-6-01; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 1-2002(Temp), f. & cert. ef. 3-1-02 thru 8-26-02; CCB 2-2002, f. & cert. ef. 3-1-02; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; CCB 8-2002, f. & cert. ef. 9-3-02; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 6-2004, f. 6-25-04, cert. ef. 9-1-04; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06; ; Renumbered from 812-005-0005, CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 2-2006, f. & cert. ef. 1-26-06; CCB 7-2006, f. & cert. ef. 6-23-06; CCB 15-2006, f. 12-12-06, cert. ef. 1-1-07; CCB 4-2007, f. 6-28-07, cert. ef. 7-1-07; CCB 2-2008(Temp), f. & cert. ef. 1-2-08 thru 6-29-08; CCB 5-2008, f. 2-29-08, cert. ef. 7-1-08; CCB 13-2008, f. 6-30-08, cert. ef. 7-1-08; CCB 17-2008, f. 9-26-08, cert. ef. 10-1-08; CCB 19-2008, f. & cert. ef. 11-20-08

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Rule Caption: Conflict of Interest — Training Providers/ Instructors Who Are Responsible Managing Individuals (RMIs).
Adm. Order No.: CCB 20-2008
Filed with Sec. of State: 11-20-2008
Certified to be Effective: 11-20-08
Notice Publication Date: 10-1-2008
Rules Amended: 812-006-0100, 812-006-0200
Subject: 812-006-0100 is amended to state that an active responsible individual (RMI) may not be (1) an approved training provider, (2) the principal of an approved training provider, or (3) a trainer.

812-006-0200 is amended to provide that no training provider may offer or provide training if the training provider is an active RMI; and provides that no trainer may offer training if the trainer is an active RMI.
Rules Coordinator: Catherine Dixon—(503) 378-4621, ext. 4077

812-006-0100
Responsible Managing Individual

(1) As used in these rules, a responsible managing individual (RMI) has that meaning as provided in ORS 701.005(15).

(2) Upon initial application, an applicant for a contractor's license shall designate at least one individual as the applicant's RMI and;

(a) Provide evidence that the applicant's RMI has completed the training and passed the test, as provided for in ORS 701.122, OAR 812-006-0150 and 812-006-0300; or

(b) Document that the applicant's RMI has experience as required by OAR 812-006-0450.

(3) An individual who is not an owner may not be designated as the RMI of more than one licensee.

(4) An RMI may not be an approved training provider or the principal of an approved provider or an approved trainer, as provided in OAR 812-006-0200, while serving as an RMI for a licensee. For purposes of this rule, the principal of an approved provider includes any owner, partner, officer, member, manager or trustee of the provider.

(5) When an RMI leaves a business, the business shall:

(a) Immediately appoint another RMI; and

(b) Immediately notify the agency in writing of the name of the individual and the date the individual joined the business.

(6) An RMI appointed under section (4) of this rule must:

(a) Document completion of the training and testing requirements under ORS 701.122, OAR 812-006-0150 and 812-006-0300; or

(b) Document that the RMI has experience as required by OAR 812-006-0450.

Stat. Auth.: ORS 670.310, 701.122 & 701.235
Stats. Implemented: ORS 701.005, 701.091 & 701.122
Hist.: CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 3-2005, f. & cert. ef. 8-24-05; CCB 6-2006, f. 5-25-06, cert. ef. 6-1-06; Renumbered from 812-006-0011, CCB 10-2006, f. 9-5-06, cert. ef. 10-1-06; CCB 9-2008, f. 6-11-08, cert. ef. 7-1-08; CCB 20-2008, f. & cert. ef. 11-20-08

812-006-0200
Training Provider Approval

(1) No training shall meet the requirements of ORS 701.122 unless it is offered by a provider approved by the agency.

(2) To receive agency approval, individuals and organizations shall make application and sign an agreement with the agency prior to offering the training.

(3) The provider application shall include, but will not be limited to, provisions for:

(a) Recording the name, address, contact information, and name of responsible administrator of the provider.

(b) Submitting trainer resumes or work summaries that demonstrate that all its trainers have at least two years experience either teaching adults or working in subject areas outlined in the Oregon Contractors Reference Manual.

(4) No provider may offer or provide any training until there is a fully executed agreement between the provider and the agency.

(5) No provider may offer or provide any training if, at the time of offering or providing the training, the provider is an RMI of a licensee.

(6) A provider must comply at all times with the following requirements:

(a) The provider will provide 16-hours of training under OAR 812-006-0150.

(b) The provider will verify that each student taking the training has a current agency-approved manual.

(c) The provider will use agency-approved curriculum and the agency-approved training manual.

(d) The provider will send electronic records of completion to the agency in a format approved by the agency and keep records of completion for a minimum of five years.

(e) The provider will communicate law changes and program procedural changes received from the agency to the provider's trainers and will implement these changes within 30 business days.

(f) The provider will use only approved trainers who have at least two years' total experience either teaching adults or working in the trainer's subject area or a combination of the two. CCB will not approve as a trainer any individual who, at the time of offering or providing the training, is an RMI of a licensee.

(g) The provider will request and receive, in writing, agency approval of all trainers at least 10 business days before trainers are scheduled to teach.

(h) The provider will provide a mechanism for students to contact their trainer(s) outside of class for a minimum of one hour per week for 90 days from date of enrollment.

(i) The provider will give all students information about how to contact trainers and hours of availability before the end of the training.

(j) The provider will comply with all applicable federal and state laws.

(7) The agency may publicize a provider's test passage rate for its students.

(8) The agency may revoke a provider's right to offer training and terminate the agreement of a provider at any time the provider fails to:

(a) Meet any requirement of the agreement; or

(b) Comply with these rules.

(9) The agency may revoke a provider's right to offer training and terminate the agreement of a provider:

(a) Whose students do not pass the agency test on their first attempt at least 70 percent of the time after the provider has provided training for at least three months, or whose students fail to maintain the 70 percent first attempt test passing rate during the remaining period of the agreement; or

(b) Who acquires or attempts to acquire agency test questions by unauthorized means, including but not limited to, photographing, photocopying or videotaping any part of the agency's test or paying or offering incentives to individuals or business entities to write down, photograph or videotape any part of the agency's test.

Stat. Auth.: ORS 670.310, 701.122 & 701.235
Stats. Implemented: ORS 701.122
Hist.: CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 5-2002, f. 5-28-02, cert. ef. 6-1-02; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 1-2005(Temp), f. & cert. ef. 1-5-05 thru 7-1-05; CCB 2-2005, f. 6-29-05, cert. ef. 7-1-05; CCB 3-2005, f. & cert. ef. 8-24-05; CCB 7-2005, f. 12-7-05, cert. ef. 1-1-06; CCB 7-2006, f. & cert. ef. 6-23-06; Renumbered from 812-006-0030, CCB 10-2006, f. 9-5-06, cert. ef. 10-1-06; CCB 9-2008, f. 6-11-08, cert. ef. 7-1-08; CCB 20-2008, f. & cert. ef. 11-20-08

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Rule Caption: Adoption of Continuing Education Rules for Construction Contractors with Commercial Endorsements.
Adm. Order No.: CCB 21-2008
Filed with Sec. of State: 11-20-2008
Certified to be Effective: 11-20-08
Notice Publication Date: 10-1-2008
Rules Adopted: 812-020-0050, 812-020-0055, 812-020-0060, 812-020-0062, 812-020-0065, 812-020-0070, 812-020-0072, 812-020-0080, 812-020-0082, 812-020-0085, 812-020-0087, 812-020-0090
Subject: Adopt administrative rules in chapter 812, division 20. The proposed rules establish and administer the continuing education program under ORS 701.124, which only apply to commercial contractors to complete continuing education by certifying completion on their first renewal application on or after July 1, 2010. (Note when the Notice of Proposed Rulemaking Hearing was filed, the division was noted as 13, however, the division was renumbered to division 20.)

812-020-0050 is adopted to set forth the authority for adopting rules to administer the continuing education (CE) program under ORS 701.124 and outlines purpose and scope of the rules in division 20.

812-020-0055 is adopted to define the terms in the division 20.

812-020-0060 is adopted to establish the rules taken effect upon passage and the date on which the rules will be first applied to renewing commercial contractors.

812-020-0062 is adopted to recognize and clarify statutory exemptions.

812-020-0065 is adopted to outline the requirements for commercial contractors to comply with ORS 701.124(1) to (4), defines the measurement of hours, and that no credit for the same key employee repeating the same course, but allows for multiple employees to take the same course.

812-020-0070 is adopted to detail hour and reporting requirements for different levels of commercial contractors and for commercial contractors with limited numbers of key employees. Explains at what point in time the number of key employees is determined.

812-020-0072 is adopted outline requirements for commercial contractors to maintain records no less than 24 months, allows agency to obtain records of CE participation, and authorizes suspension of license if CE proof is not provided.

812-020-0080 is adopted to implement ORS 701.063(5) (operative July 1, 2010) and will allow commercial contractors to prorate the CE requirement comparing the number of months inactive with the number of months active during the 24 months in a license period.

812-020-0082 is adopted to approximately prorate the amount of education for a commercial contractor that held the endorsement for less than half of the license period. This would generally occur because a contractor would convert its endorsement from a residential to a commercial during the 2-year license period.

812-020-0085 is adopted to allow commercial contractors who renew their expired licenses (within one year) to use both CE earned during the original two-year license period and the lapse in license period.

812-020-0087 is adopted to provide that a commercial contractor can only use the hours earned by its key employees if those key

employees worked for the contractor when they completed their courses.

812-020-0090 is adopted to clarify that in a few cases, such as LLCs owned by the same person; there will be the same key employee(s). The rule allows those related companies to each take credit for the CE hours.

Rules Coordinator: Catherine Dixon—(503) 378-4621, ext. 4077

812-020-0050
Authority, Purpose, and Scope of Rules — Continuing Education for Commercial Contractors

(1) Authority. These rules are promulgated in accordance with ORS 670.310(1) and 701.124, which authorize CCB to adopt rules to administer a continuing education system for commercial contractors.

(2) Purpose. The purpose of these rules is to further explain and detail the requirements for continuing education under ORS 701.124.

(3) Scope. These rules establish:

(a) Procedures for commercial contractors to report continuing education hours;

(b) Sanctions for commercial contractors failing to comply; and

(c) Processes for prorating requirements.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0055
Definitions — Continuing Education for Commercial Contractors

The following definitions apply to OAR 812-020-0050 to 812-020-0073:

(1) "Building code" means a specialty code as defined in ORS 455.010(7).

(2) "Commercial contractor" means a licensed contractor as defined under ORS 701.005(2).

(3) "Inactive commercial contractor" means a commercial contractor that has voluntarily placed its license in inactive status in accordance with OAR 812-003-0330 to 812-003-0370 and has not converted the license back to active status in accordance with ORS 812-003-0380.

(4) "Key employee" means an employee or owner of a contractor who is a corporate officer, manager, superintendent, foreperson, lead person or any other person who exercises management or supervisory authority over the construction activities of the business.

(5) "Lapse in license" has the meaning given that term by OAR 812-002-0420.

(6) "License period" means the two-year period from the date a contractor's license is first issued or last renewed until the date the license is next scheduled to expire.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0060
Effective Date — Continuing Education for Commercial Contractors

OAR 812-020-0050 to 812-020-0073 and the amendment to OAR 812-003-0280(2) take effect upon passage, and apply to commercial contractors that renew their licenses on and after July 1, 2010.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0062
Exemptions — Continuing Education for Commercial Contractors

(1) Commercial contractors subject to regulation under ORS 479.510 to 479.945 or 480.510 to 480.670 or chapter 693 do not need to satisfy the continuing education requirements. These contractors include, but are not limited to:

(a) Electrical contractors subject to regulation under ORS 479.510 to 479.945.

(b) Plumbing contractors subject to regulation under ORS chapter 693; or

(c) Boiler contractor subject to regulation under ORS 480.510 to 480.670.

(d) Elevator contractors subject to regulation under ORS 479.510 to 479.945.

(e) Renewable energy contractors subject to regulation under ORS 479.510 to 479.945.

(f) Pump installation contractors subject to regulation under ORS 479.510 to 479.945.

(g) Limited sign contractors subject to regulation under ORS 479.510 to 479.945.

(2) Commercial contractors endorsed only as commercial developers do not need to satisfy the continuing education requirements.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0065
Minimum Requirements — Continuing Education for Commercial Contractors

(1) Commercial contractors shall have a key employee, or combination of key employees, who complete continuing education.

(2) Education hours may be earned by attending offerings provided by any of the following:

(a) Post-secondary institutions such as colleges or universities;

(b) Trade schools;

(c) Trade associations;

(d) Professional societies;

(e) Private companies;

(f) Public agencies;

(g) Business associations; or

(h) Contractor-provided in-house training programs.

(3) Courses shall be a minimum of one clock hour to qualify for one hour of continuing education credit.

(4) Credit shall not be applied for the same key employee repeating the same continuing education course during a two-year period.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0070
Certification of Hours — Continuing Education for Commercial Contractors

(1) Upon renewal, a commercial contractor must certify that one or more key employees obtained the continuing education required by OAR 812-020-0050 to 812-020-0073.

(2) For a commercial general or specialty contractor — level 1 with five or more key employees, the commercial contractor must certify that one or more key employees completed at least 80 hours during the preceding license period.

(3) For a commercial general or specialty contractor — level 1 with four or fewer key employees, the commercial contractor must certify as follows:

(a) With four key employees, that one or more key employees completed at least 64 hours during the preceding license period.

(b) With three key employees, that one or more key employees completed at least 48 hours during the preceding license period.

(c) With two key employees, that one or more key employees completed at least 32 hours during the preceding license period.

(d) With one key employee, that the key employee completed at least 16 hours during the preceding license period.

(4) For a commercial general or specialty contractor — level 2, the commercial contractor must certify that one or more key employees completed at least 32 hours during the preceding license period.

(5) For purposes of sections (2) to (4) of this rule, the number of key employees is the number of such persons employed by the commercial contractor on the most recent date of license issue or reissue.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0072
Recordkeeping and Review — Continuing Education for Commercial Contractors

(1) Every commercial contractor shall maintain records of its key employees' participation in continuing education activities for a period no less than 24 months after the renewal date.

(2) The agency may request any commercial contractor's continuing education records for review.

(3) If a commercial contractor cannot prove that the commercial contractor's key employees completed the continuing education, the agency may suspend the license until the commercial contractor proves compliance or the commercial contractor's key employees complete the missing courses.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0080
Inactive Commercial Contractor — Continuing Education for Commercial Contractors

If a commercial contractor's license is placed in an inactive status during any part of the license period, the commercial contractor needs only complete the continuing education hours for the period the license was active. The continuing education hours required under OAR 812-020-0070 will be prorated for the period that the license was active. For example, if a commercial contractor is inactive 6 months during the license period (inactive 25% of the time), the contractor needs to certify completion of 75% of the hours otherwise required.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0082
Endorsed as Commercial Contractor Less Than License Period — Continuing Education for Commercial Contractors

(1) If a commercial contractor was endorsed as a commercial contractor for less than one year of the license period, the commercial contractor satisfies the continuing education requirements by completing one-half of the number of continuing education hours outlined in OAR 812-020-0070(2) to (4).

(2) If a commercial contractor was endorsed as a commercial contractor for one year or more of the license period, the commercial contractor satisfies the continuing education requirements by completing the total number of continuing education hours outlined in OAR 812-020-0070(2) to (4).

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0085
Lapse in License — Continuing Education for Commercial Contractors

If a license expires and is not renewed for a period not exceeding one year, the commercial contractor may seek renewal and backdating of the license. To renew the license, the commercial contractor must certify that it has satisfied the continuing education requirements either during the license period or during the lapse in license period, or both.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0087
Courses Completed by Key Employees — Continuing Education for Commercial Contractors

A commercial contractor may certify continuing education hours based upon courses completed by its key employees; provided that a key employee was employed by the commercial contractor when he or she completed a course. If a commercial contractor employs a key employee who completed continuing education course(s) before being hired by the commercial contractor, the commercial contractor may not include those hours to certify that it satisfied the continuing education requirement.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

812-020-0090
Key Employee of More than One Commercial Contractor — Continuing Education for Commercial Contractors

If a key employee who completes a continuing education course is employed when the course is completed by more than one commercial contractor, each commercial contractor may include those hours to certify that it satisfied the continuing education requirement.

Stat. Auth.: ORS 670.310, 701.124 & 701.235
Stats. Implemented: 701.124
Hist.: CCB 21-2008, f. & cert. ef. 11-20-08

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Department of Administrative Services, Budget and Management Division
Chapter 122

Rule Caption: This rule allows allotments to be reduced for the remainder of the 2007–09 biennium.
Adm. Order No.: BMD 1-2008(Temp)
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 12-11-08 thru 6-8-09
Notice Publication Date:
Rules Adopted: 122-060-0020
Subject: The Department of Administrative Services (Department) has determined the probable receipts from taxes and other revenue sources for the 2007–09 General Fund appropriations will be less than anticipated by the Legislative Assembly when it enacted the state's budget for the 2007–09 biennium and made adjustments to that budget in the special session held during the 2008 calendar year. Consequently, the amount of General Fund revenue available for the appropriations for the remainder of the 207_09 biennium will be less than the amounts estimated or allotted thereafter. Pursuant to ORS 291.261, acting on this determination and wit the Governor's approval, and following notice to the agencies affected, the Department is reducing allotment amounts for the remainder of the 2007–09 biennium to balance the state's budget and prevent state government from incurring a deficit in violation of Article XI, Section 7, of the Oregon Constitution.
Rules Coordinator: Yvonne Hanna—(503) 378-2349, ext. 325

122-060-0020
Allotment Reductions to Balance Budget and Prevent Deficit

(1)(a) The Department of Administrative Services (Department) has determined that probable receipts from taxes and other revenue sources for the 2007–09 General Fund appropriations will be less than anticipated by the Legislative Assembly when it enacted the state's budget for the 2007–09 biennium and made adjustments to that budget in the special session held during the 2008 calendar year. Consequently, the amount of General Fund revenue available for appropriations for the remainder of the 2007–09 biennium will be less than the amounts estimated or allotted therefore. Pursuant to ORS 291.261, acting on this determination and with the Governor's approval, and following notice to the agencies affected, the Department is reducing allotment amounts for the remainder of the 2007–09 biennium to balance the state's budget and prevent state government from incurring a deficit in violation of Article XI, Section 7, of the Oregon Constitution.

(b) The reductions in moneys allotted specified in Section (2) of this rule take effect on the date on which the Department files the rule with the Archives Division, Secretary of State.

(c) If one or more individual allotment reductions made under Section (2) of this rule is for any reason held to be invalid or unlawful, the remaining reductions shall not be affected but shall remain in full force and effect in accordance with the terms of this rule, and to this end the reductions made by this rule are severable.

(2) Moneys allotted for the final two quarters of the 2007–09 biennium from General Fund appropriations to agencies subject to the allotment system established in ORS Chapter 291 are reduced by the amounts necessary to effectively reduce the General Fund appropriations allotted during the entire 2007–09 biennium by 1.095156 percent.

(3) On a schedule to be established by the Department, each agency for which allotments are reduced under this rule must submit to the Department estimates for the remaining allotment periods of the 2007–09 biennium that are consistent with the reductions.

(4) Notwithstanding section (2) above, the Department shall make no reductions in moneys allotted for payment on debt obligations incurred by the state prior to the effective date of this rule.

Stat. Auth.: ORS 183.335(5), 184.340, 291.232 - 291.261
Stats Implemented: ORS 291.261
Hist.: BMD 1-2008(Temp), f. & cert. ef. 12-11-08 thru 6-8-09

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Department of Consumer and Business Services, Building Codes Division
Chapter 918

Rule Caption: Requires consistent forms and fee methodologies for use in all municipal building inspection programs.
Adm. Order No.: BCD 27-2008
Filed with Sec. of State: 12-12-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 1-1-2008
Rules Amended: 918-050-0000, 918-050-0010, 918-050-0020, 918-050-0030, 918-050-0100, 918-050-0110, 918-050-0120, 918-050-0130, 918-050-0140, 918-050-0150, 918-050-0160, 918-050-0170
Subject: This rule requires all municipal building inspection programs to calculate permit fees using the same calculation method-

ologies and use permit forms consistent with the division's minimum requirements.

Rules Coordinator: Shauna Parker—(503) 373-7438

918-050-0000
Purpose and Scope

Division 50 provides administrative procedures for use in all regions of the state and, where applicable, to specified regions of the state. These rules address a uniform methodology for arriving at building permit and inspection fees to provide consistency in fee calculation. Where a permitted item is not covered by the methodology in these rules, a municipality may either, develop a reasonable permit fee, or calculate a fee using a similar program area's methodology. These rules do not supersede or repeal the existing provisions of the state building code and related rules. These rules become effective on January 1, 2009.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 8-2000, f. 6-15-00, cert. ef. 7-1-00; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0010
Definitions

Terms not specifically defined will have the meanings given in the state building code.

(1) "Administrative fees" refers to fees assessed by a municipality to cover costs of administering and enforcing the building code apart from inspection and plan review services. Surcharges, assessed as part of the cost of doing business within a municipality and that are assessed without regard to whether the municipal action relates to the administration of the building code, are not administrative fees for the purposes of these rules.

(2) "Tri-county region" or "Tri-county regional" refers to the geographical area that includes Clackamas, Multnomah, and Washington counties.

Stat. Auth.: ORS 455.020 & 455.055
Stats. Implemented: ORS 455.020 & 455.055
Hist.: BCD 8-2000, f. 6-15-00, cert. ef. 7-1-00; BCD 20-2003, f. 12-31-03, cert. ef. 1-1-04; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0020
Standard Statewide Application Forms

(1) A municipality must use standard permit applications containing at least the minimum content required by the division.

(2) All municipalities within the Tri-County region shall use intake checklist forms approved by the division

(3) The division shall consider for adoption proposed amendments to the standard application and intake checklist forms.

(a) Proposals for amendment to the application forms must include:

(A) The existing unamended form(s);

(B) The form(s) containing the appropriate amendments; and

(C) A brief explanation of the need for the amendments.

(b) Proposals to amend the approved forms must be filed with the division no later than February 1 or August 1.

(c) The division will notify all municipalities and interested parties of the division's determination regarding proposed amendments and provide copies of the amended form(s).

(d) Any form changes will be effective in all regional municipalities on July 1 or January 1 following adoption.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 8-2000, f. 6-15-00, cert. ef. 7-1-00; BCD 20-2003, f. 12-31-03, cert. ef. 1-1-04; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0030
Standard Tri-County Regional Processes

All jurisdictions within the Tri-County region shall use uniform processes for permit application, plan review, permit issuance, and recording inspections as approved by the division, including, but not limited to:

(1) Minor labels;

(2) Issuing permits when no plan review is required;

(3) Recording inspections;

(4) Partial permits;

(5) Deferred submittals;

(6) Over-the-counter permits that require plan review; and

(7) Plan review issue resolution.

Stat. Auth.: ORS 455.048
Stats. Implemented: ORS 455.046
Hist.: BCD 8-2000, f. 6-15-00, cert. ef. 7-1-00; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0100
Statewide Fee Methodologies for Residential and Commercial Permits

(1) Residential construction permit fees shall be calculated using the following methodologies:

(a) A plumbing permit fee for new construction includes one kitchen and is based on the number of bathrooms, from one to three, on a graduated scale. An additional set fee shall be assessed for each additional bath or kitchen.

(A) No additional fee shall be charged for the first 100 feet of water and sewer lines, hose bibbs, icemakers, underfloor low-point drains, and rain drain packages that include the piping, gutters, downspouts, and perimeter system.

(B) The plumbing permit fee described in this section does not include:

(i) Any storm water retention/detention facility;

(ii) Irrigation and fire suppression systems; or

(iii) Additional water, sewer and service piping or private storm drainage systems exceeding the first 100 feet.

(C) Permit fees for an addition, alteration, or repair shall be calculated based on the number of fixtures, appurtenances, and piping, with a set minimum fee.

(b) A mechanical permit fee shall be calculated per appliance and related equipment, with a set minimum fee.

(c) Effective January 1, 2009, a structural permit fee for new construction and additions shall be calculated using the ICC Building Valuation Data Table current as of April 1 of each year, multiplied by the square footage of the dwelling to determine the valuation. The valuation shall then be applied to the municipality's fee schedule to determine the permit fee. The plan review fee shall be based on a predetermined percentage of the permit fee set by the municipality.

(A) The square footage of a dwelling, addition, or garage shall be determined from outside exterior wall to outside exterior wall for each level.

(B) The square footage of a carport, covered porch, patio, or deck shall be calculated separately at fifty percent of the value of a private garage from the ICC Building Valuation Data Table current as of April 1.

(C) Permit fees for an addition, alteration, or repair shall be calculated based on the fair market value as determined by the building official, and then applying the valuation to the municipality's fee schedule.

(2) Commercial construction permit fees shall be calculated using the following methodologies:

(a) A plumbing permit fee shall be calculated based on the number of fixtures and footage of piping, with a set minimum fee.

(b) A mechanical permit fee shall be calculated based on the value of the mechanical equipment and installation costs and applied to the municipality's fee schedule with a set minimum fee.

(c) A structural permit fee shall be calculated by applying the valuation to the municipality's fee schedule with a minimum set fee. Valuation shall be the greater of either:

(A) The valuation based on the ICC Building Valuation Data Table current as of April 1 of each year, using the occupancy and construction type as determined by the building official, multiplied by the square footage of the structure; or

(B) The value as stated by the applicant.

(C) When the construction or occupancy type does not fit the ICC Building Valuation Data Table, the valuation shall be determined by the building official with input from the applicant.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 9-2000, f. 6-15-00, cert. ef. 10-1-00; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 5-2007, f. 5-11-07, cert. ef. 7-1-07; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0110
Fees and Fee Schedules

(1) A municipality may develop its fee schedule in any reasonable manner to provide for the administration and enforcement of the building code program.

(2) Administrative fees assessed by a municipality to cover administration and enforcement shall be incorporated into a municipality's fee schedule or into the cost of an individual permit item as appropriate. Changes to a municipality's fee schedule must be adopted in accordance with OAR 918-020-0220.

(3) The plan review fees shall be based on a predetermined percentage of the permit fee set by the municipality.

Stat. Auth.: ORS 455.048, 455.055, & 455.210
Stats. Implemented: ORS 455.046, 455.055 & 455.210

Hist.: BCD 9-2000, f. 6-15-00, cert. ef. 10-1-00; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 5-2007, f. 5-11-07, cert. ef. 7-1-07; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0120
Statewide Fee Methodologies for Electrical Permits

An electrical permit fee shall be calculated based on the categories, procedures, and requirements established in OAR 918-309-0020 to 918-309-0070. A set minimum fee may be established.

Stat. Auth.: ORS 455.048, 455.055 & 479.870
Stats. Implemented: ORS 455.046, 455.055 & 479.870
Hist.: BCD 9-2000, f. 6-15-00, cert. ef. 10-1-00; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0130
Statewide Fee Methodologies for Manufactured Home Siting Permits

(1) A municipality shall charge a single fee for the installation and setup of manufactured homes. This fee shall include the concrete slab, runners or foundations when they comply with the prescriptive requirements of the **Oregon Manufactured Dwelling and Park Specialty Code**, electrical feeder and plumbing connections and all cross-over connections.

(2) Decks, other accessory structures and foundations that do not comply with the prescriptive requirements of the **Oregon Manufactured Dwelling and Park Specialty Code**, utility connections beyond 30 lineal feet, new electrical services or additional branch circuits, new plumbing, and other such items that fall under the building code may require separate permits.

(3) When a municipality has reason to believe that the existing electrical service to a manufactured dwelling may be unsafe or inadequate, the municipality may require a separate permit to inspect the electrical service.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 9-2000, f. 6-15-00, cert. ef. 10-1-00; BCD 26-2000(Temp), f. 10-4-00, cert. ef. 1-1-01 thru 6-29-01; BCD 31-2000, f. 12-27-00, cert. ef. 1-1-01; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0140
Statewide Fee Methodology for Residential Fire Suppression Systems

Stand-alone and multipurpose fire suppression system permit fees shall each be calculated as separate flat fees based on the square footage of the structure with graduated rates for dwellings with 0 to 2000 square feet, 2001 to 3600 square feet, 3601 to 7200 square feet, and 7201 square feet and greater. The permit fee shall be sufficient to cover the costs of inspection and plan review.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 19-2001, f. 12-21-01, cert. ef. 4-1-02; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0150
Statewide Fee Methodology for Medical Gas Installations

(1) A plumbing permit fee for the installation of a medical gas system shall be determined based on the value of installation costs and the system equipment, including but not limited to, inlets, outlets, fixtures, and appliances and applied to the municipality's fee schedule, with a set minimum fee.

(2) The plan review fee shall be based on a predetermined percentage of the permit fee as set by the municipality.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 19-2001, f. 12-21-01, cert. ef. 4-1-02; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0160
Statewide Fee Methodology for Phased Projects

A municipal plan review fee for a phased project is based on a minimum phasing fee, determined by the municipality, plus 10 percent of the total project building permit fee not to exceed $1,500 for each phase.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 11-2002, f. 6-28-02, cert. ef. 7-1-02; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

918-050-0170
Statewide Fee Methodology for Deferred Submittals

A fee charged for processing and reviewing deferred plan submittals shall be an amount equal to a percentage, determined by the municipality, of the building permit fee calculated according to OAR 918-050-0110(2) and (3) using the value of the particular deferred portion or portions of the project, with a set minimum fee. This fee is in addition to the project plan review fee based on the total project value.

Stat. Auth.: ORS 455.048 & 455.055
Stats. Implemented: ORS 455.046 & 455.055
Hist.: BCD 12-2002, f. 6-28-02, cert. ef. 7-1-02; BCD 31-2005, f. 12-30-05, cert. ef. 1-1-06; BCD 27-2008, f. ef.12-12-08, cert. ef. 1-1-09

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Department of Consumer and Business Services, Division of Finance and Corporate Securities
Chapter 441

Rule Caption: Adopts content of report of mortgage banker or broker's residential mortgage activity.
Adm. Order No.: FCS 12-2008
Filed with Sec. of State: 12-8-2008
Certified to be Effective: 12-10-08
Notice Publication Date: 11-1-2008
Rules Adopted: 441-865-0025
Subject: This rulemaking implements Senate Bill 1064, passed in 2008 supplemental legislative session. SB 1064 requires the Department of Consumer and Business Services to require reports from mortgage bankers and mortgage brokers concerning their residential mortgage activity, which includes specifying what loan information mortgage brokers and mortgage bankers must submit.
Rules Coordinator: Shelley Greiner—(503) 947-7484

441-865-0025
Residential Mortgage Lending Reports

On or before March 31 of each calendar year, a mortgage banker or a mortgage broker licensed at any time during the preceding calendar year must file a report concerning the banker's or broker's business and operations conducted during the preceding calendar year related to residential mortgage transactions.

(1) A licensee must report the total number and dollar amount of all loans made or funded by the licensee in any state and those loans that are Oregon residential mortgage transactions.

(2) For loans made or funded for a property located in Oregon, a licensee must report the total number and dollar amount of:

(a) First-lien mortgage loans.

(b) Subordinate-lien mortgage loans including, but not limited to, home equity lines of credit.

(c) Mortgage loans having a fixed periodic payment of principal and interest throughout the mortgage term.

(d) Interest-only first-lien mortgage loans having a fixed interest rate.

(e) Interest-only first-lien mortgage loans having an adjustable interest rate.

(f) Negative amortization mortgage loans.

(g) Adjustable rate first-lien mortgage loans.

(h) Adjustable rate subordinate-lien mortgage loans.

(i) Loans with a prepayment penalty in the contract at the time of closing.

(j) Mortgage loans closed for the purchase of a primary owner-occupied residential dwelling.

(k) Mortgage loans closed for the purchase of a secondary residence.

(L) Mortgage loans closed for the purchase of a non-owner occupied property that is a one-to-four family residential dwelling.

(m) Mortgage loans closed for the purpose of refinancing an existing mortgage loan secured by a primary owner-occupied residential dwelling.

(n) Mortgage loans closed for the purpose of refinancing an existing mortgage loan secured by a secondary residence.

(o) Mortgage loans closed for the purpose of refinance an existing mortgage loan secured by a non-owner occupied property that is a one-to-four family residential dwelling.

(p) Mortgage loans insured or guaranteed by a federal agency.

(3) For loans made or funded for a property located in Oregon, a licensee may report the total number and dollar amount of:

(a) Loans that were originated based on all of the following factors:

(A) Income documentation;

(B) Employment documentation; and

(C) Asset documentation.

(b) Loans that were originated based on one or two of the following factors:

(A) Income documentation;

(B) Employment documentation; or

(C) Asset documentation.

(c) Loans that were not originated based on any of the following factors:

(A) Income documentation;

(B) Employment documentation; or

(C) Asset documentation.

(d) Loans with a combined loan-to-value ratio of 80% or lower made to an individual having a middle credit bureau risk score of 620 or above.

(e) Loans with a combined loan-to-value ratio of 80% or lower made to an individual having a middle credit bureau risk score below 620.

(f) Loans with a loan-to-value ratio of greater than 80% made to an individual having a middle credit bureau risk score of 620 or above.

(g) Loans with a loan-to-value ratio of greater than 80% made to an individual having a middle credit bureau risk score below 620.

(4) For purposes of this rule:

(a) "Loan-to-value ratio" means the ratio between the amount of a mortgage loan and the value of the property pledged as security, expressed as a percentage.

(b) "Residential mortgage transaction" has the same meaning as ORS 59.840.

Stat. Auth.: ORS 59.860
Stat. Implemented: ORS 59.860
Hist.: FCS 12-2008, f. 12-8-08, cert. ef. 12-10-08

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Department of Consumer and Business Services, Insurance Division
Chapter 836

Rule Caption: Minimum Standards for Determining Reserve Liability and Nonforfeiture Values for Preneed Insurance.
Adm. Order No.: ID 17-2008
Filed with Sec. of State: 12-9-2008
Certified to be Effective: 12-9-08
Notice Publication Date: 11-1-2008
Rules Adopted: 836-051-0750, 836-051-0755, 836-051-0760, 836-051-0765, 836-051-0770, 836-051-0775
Rules Amended: 836-051-0106
Subject: This proposed rulemaking designates the 1980 CSO Mortality Table as the authority for establishing minimum standards of valuation and the minimum standard nonforfeiture value for preneed insurance, a form of life insurance that funds funeral services and expenses.
Rules Coordinator: Sue Munson—(503) 947-7272

836-051-0106
Life Insurance Valuation and Nonforfeiture Standards

(1) The following definitions apply in this rule:

(a) "2001 CSO Mortality Table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO Task Force from the Valuation Basic Mortality Table developed by the Society of Actuaries Individual Life Insurance Valuation Mortality Task Force, and adopted by the NAIC in December 2002. The 2001 CSO Mortality Table is included in the Proceedings of the NAIC (2nd Quarter 2002). Unless the context indicates otherwise, the "2001 CSO Mortality Table" includes both the ultimate form of that table and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and the age-last-birthday bases of the mortality tables.

(b) "2001 CSO Mortality Table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2001 CSO Mortality Table.

(c) "2001 CSO Mortality Table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2001 CSO Mortality Table.

(d) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(e) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

(2) Except as provided in OAR 836-051-0750 to 836-051-0775, the 2001 CSO Mortality Table may be used as follows:

(a) At the election of the insurer for any one or more specified plans of insurance and subject to the conditions stated in this rule, the 2001 CSO Mortality Table may be used as the minimum standard for policies issued on or after January 1, 2004 and before January 1, 2009 and to which ORS 733.306 and 743.215, and OAR 836-031-0765(1) and (2), are applicable. If the insurer elects to use the 2001 CSO Mortality Table, it shall do so for both valuation and nonforfeiture purposes.

(b) Subject to the conditions stated in this rule, the 2001 CSO Mortality Table shall be used in determining minimum standards for policies issued on and after January 1, 2009, to which ORS 733.306 and 743.215, and OAR 836-031-0765(1) and (2), are applicable.

(3) Conditions governing use of tables are as follows:

(a) For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(A) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(B) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by ORS 733.312 and 733.322 and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(C) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(b) For plans of insurance without separate rates for smokers and nonsmokers the composite mortality tables shall be used.

(c) For the purpose of determining minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits, the 2001 CSO Mortality Table may, at the option of the insurer for each plan of insurance, be used in its ultimate or select and ultimate form, subject to the restrictions of section 4 of this rule, ORS 733.306 and 743.215 and OAR 836-031-0770 relative to use of the select and ultimate form.

(d) When the 2001 CSO Mortality Table is the minimum reserve standard for any plan for an insurer, the actuarial opinion in the annual statement filed with the Director shall be based on an asset adequacy analysis as specified in OAR 836-031-0670. The Director may exempt an insurer from this requirement if it only does business in this state and in no other state.

(4) The 2001 CSO Mortality Table applies to OAR 836-031-0750 to 836-031-0775 as follows:

(a) The 2001 CSO Mortality Table may be used in applying OAR 836-031-0750 to 836-031-0775 in the following manner, subject to the transition dates for use of the 2001 CSO Mortality Table in section (2) of this rule:

(A) OAR 836-031-0755(1)(b)(B): The net level reserve premium is based on the ultimate mortality rates in the 2001 CSO Mortality Table.

(B) OAR 836-031-0760(2): All calculations are made using the 2001 CSO Mortality Rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in OAR 836-031-0770(1)(d). The value of "qx+k+t-1" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(C) OAR 836-031-0765(1): The 2001 CSO Mortality Table is the minimum standard for basic reserves.

(D) OAR 836-031-0765(2): The 2001 CSO Mortality Table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in OAR 836-031-0765(2)(c). In demonstrating compliance with these conditions, the demonstrations may not combine the results of tests that utilize the 1980 CSO Mortality Table with those tests that utilize the 2001 CSO Mortality Table, unless the combination is explicitly required by rule or necessary to be in compliance with relevant Actuarial Standards of Practice.

(E) OAR 836-031-0770(3): The valuation mortality table used in determining the tabular cost of insurance shall be the ultimate mortality rates in the 2001 CSO Mortality Table.

(F) OAR 836-031-0770(5)(d): The calculations specified in OAR 836-031-0770(5) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(G) OAR 836-031-0770(6)(d): The calculations specified in OAR 836-031-0770(6) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(H) OAR 836-031-0770(7)(b): The calculations specified in OAR 836-031-0770(7) shall use the ultimate mortality rates in the 2001 CSO Mortality Table.

(I) OAR 836-031-0775(1)(a)(B): The one-year valuation premium shall be calculated using the ultimate mortality rates in the 2001 CSO Mortality Table.

(b) Nothing in this section shall be construed to expand the applicability of OAR 836-031-0750 to 836-031-0775 to include life insurance policies exempted under OAR 836-031-0755(1).

(5) The following provisions apply to an insurer's use of Gender-Blended Tables

(a) For any ordinary life insurance policy delivered or issued for delivery in this state on and after January 1, 2004, that utilizes the same premium rates and charges for male and female lives or is issued in circumstances where applicable law does not permit distinctions on the basis of gender, a mortality table that is a blend of the 2001 CSO Mortality Table (M) and the 2001 CSO Mortality Table (F) may, at the option of the insurer for each plan of insurance, be substituted for the 2001 CSO Mortality Table for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. No change in minimum valuation standards is implied by this section of this rule.

(b) The insurer may choose from among the blended tables developed by the American Academy of Actuaries CSO Task Force and adopted by the NAIC in December 2002.

(c) It shall not, in and of itself, be a violation of ORS 746.015 for an insurer to issue the same kind of policy of life insurance on both a sex-distinct and sex-neutral basis.

[ED. NOTE: Table referenced are available from the agency.]

Stat. Auth.: ORS 731.244, 733.306 & 743.215

Stats. Implemented: ORS 733.306

Hist.: ID 9-2003, f. 12-26-03, cert. ef. 1-1-04; ID 17-2008, f. & cert. ef. 12-9-08

836-051-0750

Purpose; Authority; Applicability; and Effective Date

(1) OAR 836-051-0750 to 836-051-0775 are adopted pursuant to the general rulemaking authority of the Director in ORS 731.244, and specific authority of ORS 733.306 and 743.215 for approving mortality tables adopted by the National Association of Insurance Commissioners for use in determining minimum valuation and nonforfeiture standards.

(2) OAR 836-051-0750 to 836-051-0775 apply to preneed insurance and to similar policies and certificates used to fund funeral services and expenses as determined by the Director, issued on or after January 1, 2009.

(3) The purpose of OAR 836-051-0750 to 836-051-0775 is to establish for preneed insurance products minimum mortality standards for reserves and nonforfeiture values, and to require the use of the 1980 Commissioners Standard Ordinary (CSO) Life Valuation Mortality Table for use in determining the minimum standard of valuation of reserves and the minimum standard nonforfeiture values for preneed insurance products.

Stat. Authority: ORS 731.244, 733.306, 743.205

Stats. Implemented: ORS 733.306, 733.310, 743.215, 743.216, 743.221

Hist.: ID 17-2008, f. & cert. ef. 12-9-08

836-051-0755

Definitions

As used in OAR 836-051-0750 to 836-051-0775:

(1) "Preneed insurance" is any life insurance policy that is issued in combination with, in support of, with an assignment to, or as a guarantee for a prearrangement agreement for goods and services to be provided at the time of and immediately following the death of the insured. Goods and services may include, but are not limited to embalming, cremation, body preparation, viewing or visitation, coffin or urn, memorial stone, and transportation of the deceased. The status of the policy as preneed insurance is determined at the time of issue in accordance with the policy form filing.

(2) "Ultimate 1980 CSO" means the 1980 Commissioners' Standard Ordinary Life Valuation Mortality Tables (1980 CSO) without ten-year (10-year) selection factors, incorporated into the 1980 amendments to the NAIC Standard Valuation Law approved in December 1983.

Stat. Authority: ORS 731.244, 733.306, 743.205

Stats. Implemented: ORS 733.306, 733.310, 743.215, 743.216, 743.221

Hist.: ID 17-2008, f. & cert. ef. 12-9-08

836-051-0760

Minimum Valuation Mortality Standards

For preneed insurance and to similar policies and certificates used to fund funeral services and expenses, the minimum mortality standard for determining reserve liabilities and nonforfeiture values for both male and female insureds shall be the Ultimate 1980 CSO.

Stat. Authority: ORS 731.244, 733.306, 743.205

Stats. Implemented: ORS 733.306, 733.310, 743.215, 743.216, 743.221

Hist.: ID 17-2008, f. & cert. ef. 12-9-08

836-051-0765

Minimum Valuation Interest Rate Standards

(1) The interest rates used in determining the minimum standard for valuation of preneed insurance shall be the calendar year statutory valuation interest rates as defined in ORS 733.306 and 733.310.

(2) The interest rates used in determining the minimum standard for nonforfeiture values for preneed insurance shall be the calendar year statutory nonforfeiture interest rates as defined in ORS 743.215, 743.216 and 743.221.

Stat. Authority: ORS 731.244, 733.306, 743.205

Stats. Implemented: ORS 733.306, 733.310, 743.215, 743.216, 743.221

Hist.: ID 17-2008, f. & cert. ef. 12-9-08

836-051-0770

Minimum Valuation Method Standards

(1) The method used in determining the standard for the minimum valuation of reserves of preneed insurance shall be the method defined in ORS 733.306 and 733.310.

(2) The method used in determining the standard for the minimum nonforfeiture values for preneed insurance shall be the method defined in ORS 743.215, 743.216 and 743.221.

Stat. Authority: ORS 731.244, 733.306, 743.205

Stats. Implemented: ORS 733.306, 733.310, 743.215, 743.216, 743.221

Hist.: ID 17-2008, f. & cert. ef. 12-9-08

836-051-0775

Transition Rules

(1) For preneed insurance policies issued on or after the effective date of this rule and before January 1, 2012, the 2001 CSO may be used as the minimum standard for reserves and minimum standard for nonforfeiture benefits for both male and female insureds.

(2) If an insurer elects to use the 2001 CSO as a minimum standard for any preneed insurance policy issued on or after the effective date of this rule and before January 1, 2012, the insurer shall provide, as a part of the actuarial opinion memorandum submitted in support of the company's asset adequacy testing, an annual written notification to the Director. The notification shall include:

(a) A complete list of all preneed insurance policy forms that use the 2001 CSO as a minimum standard;

(b) A certification signed by the appointed actuary stating that the reserve methodology employed by the company in determining reserves for the preneed insurance policies issued after the effective date and using the 2001 CSO as a minimum standard, develops adequate reserves (For the purposes of this certification, the preneed insurance policies using the 2001 CSO as a minimum standard cannot be aggregated with any other policies.); and

(3) Supporting information regarding the adequacy of reserves for preneed insurance policies issued after the January 1, 2009, and using the 2001 CSO as a minimum standard for reserves.

(4) Preneed insurance policies issued on or after January 1, 2012, must use the Ultimate 1980 CSO in the calculation of minimum nonforfeiture values and minimum reserves.

Stat. Authority: ORS 731.244, 733.306, 743.205

Stats. Implemented: ORS 733.306, 733.310, 743.215, 743.216, 743.221

Hist.: ID 17-2008, f. & cert. ef. 12-9-08

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Rule Caption: Rating and Rating Organizations (Workers' Compensation Insurance Assigned Risk Plan.

Adm. Order No.: ID 18-2008

Filed with Sec. of State: 12-9-2008

Certified to be Effective: 1-1-09

Notice Publication Date: 11-1-2008

Rules Adopted: 836-043-0034, 836-043-0071, 836-043-0087

Rules Amended: 836-043-0005, 836-043-0009, 836-043-0017, 836-043-0021, 836-043-0024, 836-043-0028, 836-043-0032, 836-043-0041, 836-043-0044, 836-043-0046, 836-043-0048, 836-043-0050, 836-043-0053, 836-043-0060, 836-043-0062, 836-043-0064, 836-043-0066, 836-043-0068, 836-043-0076, 836-043-0079, 836-043-0082, 836-043-0089

Rules Repealed: 836-043-0036, 836-043-0037, 836-043-0070, 836-043-0086

Subject: This proposed rulemaking revises the workers' compensation insurance assigned risk plan to reflect changes to the governance and administration of that plan.

Rules Coordinator: Sue Munson—(503) 947-7272

836-043-0005
Definitions for the Workers' Compensation Insurance Plan

As used in OAR 836-043-0001 to 836-043-0091:

(1) "Affiliated insurer" or "affiliate" means an insurer that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, another insurer specified, and is required to participate in the Plan pursuant to OAR 836-043-0009. For purposes of this definition, "control" means possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an insurer, whether through the ownership of voting securities, by contract or otherwise. Control is deemed to exist if any person or business enterprise, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies, representing ten percent or more of the voting securities of any other insurer.

(2) "Application" means the form approved for use in the assigned risk market by the Plan Administrator for the purpose of securing workers compensation insurance under the Plan, which contains the required information as described in NCCI's Assigned Risk Supplement to the Basic Manual for Workers' Compensation and Employers Liability Insurance.

(3) "Assigned risk market" means a state insurance plan that provides employers unable to secure coverage in the voluntary market with a means for insuring their operations through a designated insurance carrier.

(4) "Assigned Carrier Performance Standards" means the minimum level of performance for servicing carriers writing coverage on behalf of the Plan. The purpose of the Assigned Carrier Performance Standards is to provide policy issuance and service level requirements that servicing carriers must adhere to in order to provide assigned risk market policyholders with uniform service while reducing the overall loss ratio.

(5) "Board" means the Board of Directors or governing entity of the reinsurance organization selected by the Director to implement the assigned risk plan under ORS 656.730.

(6) "Bona Fide Premium Dispute" means a disagreement relating to a workers' compensation premium established under OAR 836-043-0071(1).

(7) "Client" means any person to whom workers are provided under contract and for a fee on a leased basis.

(8) "Common management interest" means an interest that exists when one or more individuals are or were owners or officers of, or performs or performed management functions for, two or more entities, or for a succession of entities.

(9) "Employer" means any business organization or enterprise that has a statutory right to maintain workers' compensation insurance in Oregon. "Employer" includes:

(a) Any business organization or enterprise that is affiliated at any time as a result of common management or ownership; or

(b) A client business of a worker leasing company as established in ORS 656.850.

(10) "Governing state" means the state that generates the largest amount of payroll.

(11) "Insured" means the employer designated in the information page of a policy to which this Plan is applied and issued by a servicing carrier.

(12) "Insurance Commissioner" means the Director of the Department of Consumer and Business Services or the person appointed by the director to serve as Insurance Commissioner under ORS 705.115.

(13) "Insurer" means the State Accident Insurance Fund Corporation or a person licensed under ORS chapter 731 for workers' compensation that satisfies its participation obligation by subscribing to the organizing principles. By subscribing to the organizing principles, an insurer shares in the results of the reinsurance pooling mechanisms on a pro-rata basis of their net premiums written within the state. The insurer may be assessed or receive disbursements depending upon the reinsurance pooling mechanism's operating results.

(14) "National Council on Compensation Insurance, Inc." and "NCCI" mean a rating organization that is licensed in Oregon to make and file rates, rating values, classifications and rating plans for workers' compensation insurance, and is an organization that authorized workers' compensation insurers may be members for the purpose of satisfying ORS 737.560.

(15) "Net premiums written" means the gross direct premiums charged less all premiums (except dividends and savings refunded under participating policies) returned to insureds for all workers' compensation and occupational disease insurance, exclusive of premiums for employers subject to the Plan, and for employers written under the National Defense Projects Rating Plan and under excess policies.

(16) "Organizing principles" means the agreement and principles of the reinsurance organization, approved by the Director, that govern the management of and participation in the Plan. A carrier participating in the Plan subscribes to the organizing principles. "Organizing principles" may include any of the following, as applicable:

(a) The National Pool reinsurance mechanism that is filed with and approved by the Insurance Commissioner and that is authorized under the Plan to provide reinsurance to the servicing carriers on employers assigned to them under the Plan.

(b) The Bylaws of the National Workers' Compensation Reinsurance Association NFP (NWCRA or Association), whose member insurers participate in the Reinsurance Agreement(s) authorized under this Plan to provide reinsurance to the servicing carriers on employers assigned to them under this Plan. The Bylaws are the agreement subscribed to by insurers selecting Option 2 — Subscription to organizing principles as their means of satisfying their participation in the Plan.

(c) The agreement or management rules of any reinsurance organization selected by the Director to implement Oregon's assigned risk plan.

(17) "Plan" means the Oregon Workers' Compensation Insurance Plan.

(18) "Plan Administrator" means the organization designated in OAR 836-043-0017, and its agents.

(19) "Producer" means a person who is licensed as an insurance producer under ORS 744.052 to 744.089, whose privileges under this Plan have not been suspended or revoked, designated by the employer or applicant applying under this Plan to secure and maintain workers' compensation and employers liability insurance on behalf of the employer. For purposes of this Plan, the producer is considered to be acting on behalf of the insured or employer applying for coverage under this Plan and not as a producer of the Plan Administrator or of any servicing carrier for Plan business.

(20) "Reasonable offer of voluntary coverage" means any offer for voluntary coverage where the total estimated annual premium is less than or equal to the assigned risk total estimated annual premium including any applicable assigned risk surcharges or pricing programs for all comparable coverage. Subject to the Plan Administrator's discretion, "reasonable offer of coverage" does not include:

(a) An offer that does not provide all of the required coverage (e.g., carrier cannot provide federal coverage or limits of liability);

(b) An offer that includes a deductible or deposit that is a financial burden to the employer as determined by the producer or employer; or

(c) The carrier's financial rating status is below that required by the producer or employer.

(21) "Regulatory authority" means the commissioner, director or superintendent of a state's insurance regulatory agency, or a properly appointed designee of the commissioner, director or superintendent.

(22) "Reinsurance Agreement" means a contractual arrangement among association members providing a quota share reinsurance facility for workers' compensation insurance in a number of states and for which administrative services are provided by the National Council on Compensation Insurance, Inc. in its capacity as administrator as designated under the organizing principles.

(23) "Reinsurance Organization" means the entity selected by the Director to implement Oregon's workers compensation assigned risk plan under ORS 656.730. "Reinsurance Organization" may include:

(a) The National Workers' Compensation Reinsurance Association, a nonprofit corporation whose members provide for contractual quota share reinsurance through reinsurance agreements among themselves as workers' compensation insurers, which affords the insurers an option for complying with state insurance plan requirements by sharing in the experience of certain policies written pursuant to such insurance plans;

(b) The National Workers' Compensation Reinsurance Pool, a contractual reinsurance mechanism among participating workers' compensation insurers, that affords insurers in certain states an option for complying with state insurance plan requirements by sharing in the experience arising out of certain policies written pursuant to such insurance plans; or

(c) Any other entity selected by the Director to implement the Oregon assigned risk plan.

(24) "Servicing carrier" means an insurer, including the State Accident Insurance Fund Corporation, approved by the Insurance Commissioner that has been assigned to provide coverage to an eligible employer who has applied for workers' compensation insurance pursuant to the Plan.

(25) "State" means any state of the United States and the District of Columbia.

(26) "Undisputed premium obligation" means a workers' compensation insurance premium obligation that is not the subject of a bona fide dispute pursuant to ORS 737.318 or 737.505 or by a judicial action, and for which there is no written payment plan in effect between an insurer and employer.

(27) "Workers' compensation insurance" means:

(a) Statutory workers' compensation and occupational disease liability insurance, including insurance for liability under the Longshore and Harbor Workers' Compensation Act, as amended, and the Federal Coal Mine Health and Safety Act of 1969, as amended;

(b) Employers liability insurance written in connection with a workers' compensation insurance policy; and

(c) Such additional coverage as determined by the Plan Administrator and approved by the Insurance Commissioner.

(28) "Workers' Compensation Rating System Review and Advisory Committee" means the committee established pursuant to OAR 836-043-0200 to hear employer grievances pursuant to ORS 737.505.

Note: The Bylaws and the National Pool reinsurance mechanism (Articles of Agreement) are attached to this rule as Exhibit 4.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: IC 1-1979(Temp), f. & ef. 10-12-79; IC 1-1980, f. & ef. 1-15-80; IC 1-1982, f. 1-15-82, ef. 7-1-82; ID 10-1989(Temp), f. & cert. ef. 11-3-89; ID 7-1990, f. 4-30-90, cert. ef. 5-1-90; ID 18-1990(Temp), f. & cert. ef. 8-6-90; ID 1-1991, f. & cert. ef. 2-19-91; ID 13-1992, f. & cert. ef. 8-12-92; ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0009
Participation by Insurers and Insurance Producers

(1) All insurers authorized to transact workers' compensation insurance in Oregon are required to participate in the Plan and subscribe to the organizing principles for Oregon.

(2) Failure of an insurer to comply with the Plan is grounds for revocation of the insurer's certificate of authority to transact workers' compensation insurance.

(3) Each insurance producer who is authorized to transact the class of property and casualty insurance is authorized to transact workers' compensation insurance offered by the Plan. The Director of the Department of Consumer and Business Services may terminate a producer's authority under this section for cause.

(4) An insurer may terminate participation in this Plan as of the close of the calendar year in which its authority to write workers' compensation is terminated. With respect to all policies in force on the effective date of an insurer's termination, the liability of the terminating insurer will cease on the succeeding anniversary date of each such policy. Termination of participation does not discharge or otherwise affect liabilities incurred prior to the anniversary date of such policies, and the insurer will be charged or credited in due course with the insurer's proper share of all expenses, losses, and profits allocable thereof.

(5) All insurers participating in the Plan through the Reinsurance Agreements provided for in the organizing principles shall share in the writings, expenses, servicing allowance and losses. Each insurer's participation in the Plan shall:

(a) Be in the proportion that the total net premiums of all members participating in the Plan in Oregon during the preceding calendar years bear to the aggregate direct premiums written in Oregon during the preceding calendar years by all insurers participating through the Reinsurance Agreements;

(b) Except as provided in OAR 836-043-0017(2)(k), exclude that portion of the premiums attributable to the operation of the Plan; and

(c) Be determined on the basis of the direct premiums as reported in the most recent annual reports filed with the regulatory authority.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96, Renumbered from 836-043-0016; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0017
Plan Administrator

(1) The Plan Administrator is a rating organization for workers' compensation insurance in Oregon that is designated as the plan administrator by the Director. The National Council on Compensation Inc. is designated as the Plan Administrator. The Plan Administrator shall continue to serve from the effective date of the Plan unless the Plan Administrator resigns. The Plan Administrator must give advance written notice of its resignation to the Director at least one year in advance of the effective date of resignation.

(2) The Plan Administrator has the following duties and responsibilities in addition to any others set forth in the Plan and the organizing principles:

(a) Determining the methodology and formula for making assignments to servicing carriers pursuant to OAR 836-043-0060 and securing the necessary information in order to make the assignments;

(b) Developing and implementing assigned risk operating rules and forms approved by the Director to the extent necessary to carry out the purposes of the Plan;

(c) Processing assigned risk applications pursuant to OAR 836-043-0041;

(d) Establishing written Assigned Carrier Performance Standards for servicing carriers, subject to approval by the Insurance Commissioner, including, but not limited to:

(A) Verification of ongoing Plan eligibility of the employer;

(B) Issuance of policies and endorsements;

(C) Filings with administrative agencies;

(D) Maintenance of premiums on policies, consistent with manual rules, rates, rating plans, and classifications;

(E) Completion and billing of final audits;

(F) Collection of premium;

(G) Claim services, including investigation, disability management and medical cost control;

(H) Loss control services and safety information to encourage employers to make safety a part of their business;

(I) Payment of producer fees;

(J) Issuance of renewal proposals and non-renewal notices;

(K) Assurance of insured and insurer compliance with all terms and conditions of the policy contract;

(L) Resolution of complaints and response to insured and insurance producer inquiries; and

(M) Reporting financial and statistical data;

(e) Monitoring servicing carrier performance and enforcing Assigned Carrier Performance Standards and incentives;

(f) Administering the dispute resolution mechanism as provided in OAR 836-043-0070;

(g) Developing and implementing assigned risk operating rules and forms to the extent necessary to carry out the purposes of the Plan;

(h) Informing the Insurance Commissioner of any insurer that is not participating in this Plan;

(i) Monitoring the performance and operation of the Plan and initiating amendments thereto as appropriate;

(j) Determining the expenses for operation of the Plan, including but not limited to the Plan Administrator's fees or legal expenses associated with Plan matters, and assess each insurer participating in the Plan for those expenses on an equitable basis as determined by the Plan Administrator and approved by the Director; and

(k) Developing and administering a take-out credit program as provided in OAR 836-043-0076.

(3) The Plan Administrator shall also publish and make available to all affected insurers and producers, upon request and at no charge, both the necessary information for placement in the Plan and the listings of all employers that have been placed into the Plan. The listings shall include each employer's name, address, policy expiration date, latest experience modification, if applicable, the Simplified Assigned Risk Adjustment Program factor and the governing class code.

(4) The Plan Administrator shall monitor compliance by servicing carriers with occupational safety and health consultative service requirements of ORS 731.480. The Plan Administrator shall file with the Insurance Commissioner by May 1 of each year a report regarding such compliance for the preceding calendar year. The Plan Administrator shall also determine the expenses for operation of the Plan, not including the Plan Administrator's expenses incurred in connection with responsibilities it has under the Articles, and shall assess each insurer participating in the Plan for those expenses on an equitable basis as determined by the Plan Administrator.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96, Renumbered from 836-043-0030; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0021
Servicing Carriers

(1) The Plan Administrator shall establish written requirements that insurers must meet in order to be eligible to act as a servicing carrier. The Plan Administrator shall provide the written requirements to the board for

review and acceptance. From among those insurers that are eligible and have applied to act as a servicing carrier, and subject to approval by the Insurance Commissioner, the Plan Administrator shall select a sufficient number of servicing carriers that are needed to handle the assignments made pursuant to the Plan. The Plan Administrator may confer with the board in regard to the number of servicing carriers needed to handle the assignments made pursuant to this Plan. Subject to approval by the Insurance Commissioner, the Plan Administrator may terminate the servicing carrier status of any insurer that fails to meet the servicing carrier requirements on a continuing basis.

(2) In order to be a servicing carrier, an insurer must meet all of the following eligibility criteria:

(a) Be licensed to write workers' compensation and employers liability insurance in Oregon or be the State Accident Insurance Fund Corporation.

(b) Be writing or be an affiliated insurer of a carrier that is currently licensed and actively writing voluntary workers' compensation and employers liability insurance premium in Oregon and that has been licensed and writing in Oregon for each of the five calendar years immediately preceding the first effective year of the proposed contract, or be licensed and actively writing workers' compensation and employers liability insurance in Oregon for a minimum of the most recent three calendar years immediately preceding the first effective year of the proposed contract and active as a workers' compensation servicing carrier in any other national workers' compensation reinsurance organization in another state for a minimum of five calendar years immediately preceding the first effective year of the proposed contract.

(c) Be assigned and maintain at a minimum an "A-" rating as published by A.M. Best, except that such "A-" A.M. Best rating is not applicable to the State Accident Insurance Fund Corporation.

(d) Maintain the necessary staff and facilities to comply with the procedures, Assigned Carrier Performance Standards, financial reporting requirements, and Plan requirements.

(e) Comply with all applicable statutory and regulatory requirements, including but not limited to, statutes, regulations, codes, rules, acts, directives, bulletins, announcements and circulars.

(f) Be either precertified in writing by the Plan Administrator or have achieved and maintained and not be subject to a revocation of precertification or certification status as determined by the Plan Administrator under the applicable precertification or certification program established by the Plan Administrator.

(g) Comply with all mandatory electronic processing and reporting requirements of the Plan Administrator that are currently in effect.

(h) Comply with all federal and state laws and regulations, which relate to the policies applicable to the servicing carrier.

(3) Each servicing carrier shall provide a report to the Plan Administrator in such a format and for such a period as determined by the Plan Administrator, but not less than semiannually. This report, among other things, shall provide information on the servicing carrier's operations related to Plan business in the following areas: underwriting, auditing, claims, loss control, premium collection and customer service. A summary of such reports shall be provided to the Insurance Commissioner.

(4) The Plan Administrator shall establish written procedures for measuring servicing carrier performance. In recognition of the interests of the participating companies who have subscribed to the organizing principles, the Plan Administrator shall provide a copy of such written Assigned Carrier Performance Standards to the board for review and acceptance. Servicing carriers shall manage losses in compliance with the performance standards established hereunder. The Plan Administrator, with the approval of the Insurance Commissioner, shall also establish the compensation for servicing carriers, which shall take into consideration, among other things, provisions for:

(a) Rewarding servicing carriers for positive action targeted at reducing losses and costs;

(b) Disincentives for inefficiencies and service below the minimum Assigned Carrier Performance Standards; and

(c) Servicing carrier capacity.

(5) The Plan Administrator shall monitor and review servicing carrier performance by:

(a) Reviewing the operations reports;

(b) Requiring and reviewing self-audits;

(c) Conducting on-site audits; and

(d) Reviewing any other information available that relates to the servicing carrier.

(6) The Plan Administrator shall require servicing carriers to maintain desired performance levels and shall take appropriate remedial action where necessary including, but not limited to, establishment and administration of a progressive discipline program which may lead to terminating an insurer's servicing carrier status.

(7) Termination of an insurer's servicing carrier status is subject to Insurance Commissioner approval.

(8) Any formal action taken by the Plan Administrator under this rule shall be the exclusive remedy and in lieu of any other penalty or sanction that may apply under the Plan.

(9) Any action taken by the Plan Administrator under this provision is subject to review under OAR 836-043-0070.

(10) In order to fulfill its responsibilities under this Plan, the Plan Administrator shall have the right, itself or through authorized representatives, at all reasonable times during regular business hours, to audit and inspect the books and records of any servicing carrier with respect to any policies, claims, or related documents coming within the purview of the Plan, the organizing principles or the Reinsurance Agreement. Upon request, the Plan Administrator shall make available to the Insurance Commissioner and the board a formal written report on the Plan Administrator's monitoring and enforcement activities related to servicing carriers.

Stat.Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96, Renumbered from 836-043-0040; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0024
Right to Apply

(1) An employer who is eligible for workers' compensation insurance as set forth in this rule may apply to the Plan Administrator for workers' compensation insurance under the Plan as provided in this rule if the employer is unable to obtain a reasonable offer of voluntary coverage. The employer must apply on the forms and according to the directions prescribed in Exhibits 1, 2, and 3 to this rule.

(2) For purposes of section (1) of this rule, the offer of a rating plan approved by the Insurance Commissioner is considered an offer of voluntary coverage or insurance. Any dispute arising from the application or interpretation of this rule is subject to the dispute resolution procedure provided in OAR 836-043-0070. As used in this section, "reasonable rating plan" means any rating program approved for use in a state by the regulatory authority.

(3) An employer seeking coverage under the Plan or a representative of the employer must:

(a) Within 60 days before applying for coverage under the Plan, apply for workers' compensation insurance and receive a declination from at least one insurer licensed to write and actively writing workers' compensation insurance in Oregon. The declination must be from the insurer providing workers' compensation insurance to the employer at the time of application, if any. Proof of cancellation or nonrenewal from the insurer shall be considered to be the required declination.

(b) Maintain a record of all insurer declinations for the policy period in force. The employer must provide this information to the Plan Administrator or servicing carrier upon request. The information must include:

(A) Insurer name;

(B) Person contacted at insurer;

(C) Mailing address and phone number of insurer contact; and

(D) Date of declination.

(4) For purposes of section (1) of this rule, an employer is presumed to be eligible in the absence of clear and convincing evidence to the contrary. An employer is not eligible if any of the following circumstances exists at the time of application or thereafter:

(a) A self-insured employer knows and is aware of pending bankruptcy proceedings, insolvency, cessation of operations or conditions that will probably result in occupational disease or cumulative injury claims from exposures incurred while the employer was self-insured.

(b) The employer, while insurance issued under the Plan is in force:

(A) Knowingly refuses to meet reasonable health, safety or loss control requirements;

(B) Does not allow any insurer or the servicing carrier reasonable access to its records for audit or inspection under the policy; or

(C) Does not comply with any other policy obligation.

(c) The employer has an outstanding workers' compensation insurance premium obligation or other monetary policy obligation including but

not limited to an obligation under a deductible program, on previous workers' compensation insurance that is not subject to a bona fide dispute.

(d) The employer, a representative of the employer, or the producer knowingly fails to comply with Plan procedures, or knowingly makes a material misrepresentation on the application by express statement, omission or otherwise, including but not limited to:

(A) Estimated payroll;

(B) Offers of workers' compensation insurance;

(C) Nature of business;

(D) Name of business;

(E) Management or ownership of business;

(F) Previous insurance history;

(G) Avoidance of an experience rating modification;

(H) An outstanding workers' compensation insurance premium obligation or other monetary policy obligation of the employer;

(I) Noncompliance with any applicable state licensing or registration requirement;

(J) Fails to accept any reasonable offer of voluntary coverage; or

(K) Other evidence exists that shows the employer is not entitled to insurance

(5) An eligible employer may submit a completed application for assigned risk coverage through the Plan by any method approved by the Plan Administrator, including:

(a) Online — Through ncci.com ;

(b) Mail —The U.S. Postal Service or private overnight delivery service; or

(c) Telephone — By contacting the Plan Administrator.

(6) The Plan Administrator shall conditionally bind coverage of a worker leasing company applicant for an initial worker leasing company license under OAR 436-050-0440 pending issuance of the license by the Director.

(7) An eligible employer or the representative of the employer must submit the total initial or deposit premium by a method approved by the Plan Administrator including:

(a) Electronic fund transfer;

(b) Credit card; or

(c) Check.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 1-2003, f. & cert. ef. 1-17-03; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0028

Application by Electronic Transmission or Telephone

(1) An application made by electronic transmission or telephone must be completed in full and must be signed. The signature may be submitted by facsimile transmission. The effective date of coverage shall be determined in accordance with OAR 836-043-0044.

(2) An employer or the representative of an employer may apply for assigned risk coverage electronically by accessing NCCI's online application service. Upon receipt of an application submitted electronically, the Plan Administrator shall review the information to determine whether the employer is eligible. If the employer is eligible and the application is complete and accurate, the Plan Administrator shall calculate electronically the initial or deposit premium amount and request the employer to submit the amount to continue the application process. The amount of the initial or deposit premium shall be determined in accordance with rules set forth in Exhibit 3 to OAR 836-043-0024.

(3) The employer or its agent must submit the total required initial premium to the Plan Administrator by credit card or electronic funds transfer. A portion of the deposit premium may be satisfied with an authorized surety's financial guaranty bond as provided in OAR 836-043-0034.

(4) (a) The employer or the representative of the employer may contact the Plan Administrator by telephone to apply for assigned risk coverage. If the information provided by telephone is complete, accurate, and the employer is deemed eligible for coverage, the Plan Administrator shall:

(A) Advise the employer of the total estimated annual premium and required initial or deposit premium required to bind coverage; and

(B) Fax the employer a copy of the completed applications as set forth in **Exhibits 1** and **2** of OAR 836-043-0024 for review and signature.

(b) For a application made by telephone, the employer or the representative of the employer shall submit the total required initial or deposit premium by electronic funds transfer in accordance with rules set forth in **Exhibit 3** to OAR 836-0043-0028.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0032

Nonelectronic Application

(1) An employer or the representative of an employer may submit a signed and completed application as set forth in **Exhibits 1** and **2** of OAR 836-043-0024 by United States mail or a private overnight mail delivery service. The application must be sent to the Plan Administrator and must include the initial or deposit premium as calculated by the employer or its agent. The application may include a requested date for the coverage to become effective. A portion of the deposit premium may be satisfied with an authorized surety's financial guaranty bond as provided in OAR 836-043-0034.

(2) The employer or its agent shall refer to **Exhibit 3** to OAR 836-043-0024 of the application for the applicable deposit or initial premium rules.

[ED. NOTE: Exhibits referenced are available from the agency.]

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0034

Surety Bonds

For all submission options under OAR 836-043-0028 or 836-043-0032, the employer submitting an application may satisfy a portion of the deposit premium with an authorized surety's financial guaranty bond, but the cash portion of the deposit premium must be no less than either the minimum premium or 25 percent of the total estimated annual premium, whichever is greater. The employer may select any minimum deposit percentage listed in the NCCI Plan Oregon State Instructions page (Exhibit 3 to OAR 836-042-0024) and post a bond for the premium difference between that percentage and the minimum deposit percentage otherwise applicable.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0041

Application Review

(1) Upon receiving an application submitted under OAR 836-043-0028 or 836-043-0032, the Plan Administrator shall review the application for completeness and determine whether the employer is eligible for coverage under the Plan.

(2) The Plan Administrator may request additional information to establish eligibility, to assign appropriate classification codes, to calculate applicable premiums and to otherwise appropriately process the application. The additional information may include:

(a) Tax documentation;

(b) Ownership information, including a request to complete and sign a change of ownership form;

(c) Contracts, including worker leasing company arrangements, temporary employment agency contract or franchise agreements;

(d) Supplemental worker leasing company applications;

(e) Additional information regarding short-term policies requests, such as verification of annualized payroll;

(f) Proof of declination of voluntary coverage;

(g) Prior policy information including claims and audits, corporate charters, Dun & Bradstreet, Inc. reports, signed financial statements and signed letters of explanation; and

(h) Any other information that the Plan Administrator considers necessary to process the application.

(3) The employer or its agent shall provide information and documentation requested by the Plan Administrator or provide an acceptable explanation for failure to provide the requested items not later than the second business day after the request or upon the mutually agreed-upon date.

(4) The Plan Administrator may return an incomplete application to the employer or its agent for completion or, with notice to the employer or its agent, the Plan Administrator may retain the application pending receipt of further information. The Plan Administrator may reject an application and the previously established effective date if the employer fails to comply in a timely manner with a request from the Plan Administrator.

(5) An employer or a representative of an employer may resubmit a complete application to the Plan Administrator for an application review and establishment of a new effective date in accordance with 836-043-0044.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0044
Binding Coverage

(1) The Plan Administrator may issue binders to eligible employers in accordance with the provisions of this Plan. The servicing carrier shall provide coverage under any binder issued by the Plan Administrator, subject to the provisions of the Plan, any applicable policy terms or conditions, and any applicable laws, rules, or regulations. The Plan Administrator shall send copies of the binder to the employer's representative, if any, the servicing carrier to which the Plan Administrator assigned the employer and the Director of the Department of Consumer and Business Services.

(2) The Plan Administrator shall issue a binder for an employer when the Plan Administrator determines all of the following occur:

(a) The employer is eligible for coverage;

(b) The Plan Administrator has received an application that is complete and signed by an officer, owner or other designee with power of attorney and includes any additional information within the established time frame; and

(c) The Plan Administrator has received the total initial premium or deposit premium within the established time frame.

(3) After the Plan Administrator binds coverage, the Plan Administrator shall provide the servicing carrier with the following:

(a) A copy of the binder;

(b) The initial or deposit premium;

(c) The application forms as set forth in Exhibits 1 and 2 to OAR 836-043-0024;

(d) Copies of any provided election or rejection forms;

(e) Other forms submitted during the application review process; and

(f) Any information to assist the servicing carrier in providing the proper coverage and correct rates including but not limited to experience rating modification worksheet data, NCCI's Inspection and Classification Report, and change of ownership information form if applicable.

(4) Upon receipt of the assignment package, the servicing carrier shall review the documents to ensure that all documentation needed to properly issue the policy is attached. Based on the separate review of the servicing carrier , the servicing carrier may request additional information or premium from the employer. The servicing carrier must receive all additional requested information or premium before the servicing carrier issues a policy.

(5) The servicing carrier shall issue the policy in accordance with Plan rules, state law and the Assigned Carrier Performance Standards.

(6) The binder or verification page remains in effect until cancelled or until the servicing carrier issues a policy in accordance with the Assigned Carrier Performance Standards or state law. If the Plan Administrator does not issue a binder, coverage does not exist.

(7)(a) The employer or the representative of the employer may request an effective date no later than sixty days after the date of application. However, such requested effective date must be the later of the following:

(A) The established effective date as outlined in the tables set forth in subsection (8) of this rule;

(B) The date of expiration of existing coverage; or

(C) A date the employer requested.

(b) To secure a requested effective date, the employer or the representative of the employer shall:

(A) Submit to the Plan Administrator a signed and completed application as described in Exhibits 1 and 2 to OAR 836-043-0024 using one of the submission methods described in OAR 836-043-0024(5).

(B) For an application submitted by U.S. Postal Service or private overnight delivery service, at a minimum, include in the application submission the required critical threshold elements as defined in NCCI's Assigned Risk Supplement to the Basic Manual.

(C) If submitting an application via mail or an overnight delivery service, include the appropriate initial or deposit premium. The Plan Administrator will consider the receipt of the application at the specified mailing address receipt.

(8) The earliest effective date for coverage is dependent on the method used to submit the application and shall be determined in accordance with the following tables: [Table not included. See ED. NOTE.]

(9) If the Plan Administrator fails to issue a binder to an eligible employer by the 14th day after receiving a completed application and the total initial or deposit premium, coverage is bound at 12:01 a.m. on the later of the dates specified in section (8) of this rule.

(10) A binder issued to a worker leasing company applicant in compliance with requirements for an initial worker leasing company license under OAR 436-050-0440 is extended as provided in this section until the Director of the Department of Consumer and Business Services either licenses or refuses to license the applicant, as follows:

(a) The binder is conditional upon the subsequent initial worker leasing company licensing by the Director. The binder does not obligate the Plan to provide coverage to the worker leasing company for its clients until the worker leasing company is licensed by the Director of the Department of Consumer and Business Services.

(b) Upon the conditional binding of the applicant worker leasing company, the Plan Administrator shall send the binder to those entities listed in section (1) of this rule, except for the servicing carrier.

(c) Upon the initial licensing of a worker leasing company applicant by the Director of the Department of Consumer and Business Services, and receipt of proof of licensing, the Plan Administrator shall assign an unconditional binder to a servicing carrier and send an unconditional binder to all entities listed in section (1) of this rule.

(d) Upon the refusal to license a worker leasing company applicant by the Director of the Department of Consumer and Business Services, and upon receipt of proof of refusal, the Plan Administrator shall send notice to all entities listed in section (1) of this rule that the conditional binder has been rescinded and the applicant was not covered.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 1-2003, f. & cert. ef. 1-17-03; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0046
Rates and Forms, Policy Term, Additional Coverages and Other Provisions

(1) An insurer issuing a policy to an employer to which the Plan applies shall write the policy according to the classifications, forms including but not limited to policy endorsements, change of ownership forms, supplemental leasing forms, and rates and rating plans including retrospective rating plans authorized for use in the assigned risk market by the Plan Administrator and approved by the Insurance Commissioner as required in ORS 737.265(2).

(2) The policy information page and all endorsements must be properly identified as a Plan or AR (Assigned Risk) policy, and policy information submitted on hard copy must show the Plan or AR indicator with the policy number on the Information Page. The Policy Information Page and all endorsements must be submitted to the Plan Administrator or its designee within the time frame and in the format established by the Plan Administrator.

(3) The servicing carrier shall issue a policy and related guaranty contract or proof of coverage as required by ORS 656.419, for a term of at least one year, unless insurance for a shorter term has been requested. A short-term policy may be obtained only once within a 12-month period unless otherwise agreed by the servicing carrier.

(4) The servicing carrier may make additional coverages described in the Supplement to the Plan available to an employer.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0048
Additional States' Coverage

Except as shown on the binder or verification page, all assignments under the plan are to be made on an intrastate basis. An employer seeking insurance for operations in one or more states other than the state listed in the Policy Information Page may request its servicing carrier to furnish insurance in the additional states in accordance with OAR 836-043-0050 and the Interstate Assignments section of the Plan. A Plan policy that affords coverage on operations in more than one state shall clearly indicate the premium developed for each state separately.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0050
Interstate Assignments

(1) Any employer assigned under this Plan and desiring workers' compensation insurance for operations for physical locations in states other than that covered by the Plan may request its servicing carrier to furnish such insurance in such additional states. If the servicing carrier is licensed in those additional states and will write workers' compensation insurance on a voluntary basis, the servicing carrier must do so on a voluntary basis and in accordance with the law, rates, rules, classifications, and regulations applicable to the voluntary workers' compensation market in those states.

(2) If the servicing carrier does not wish to provide the insurance on a voluntary basis, the servicing carrier may provide assigned risk coverage in such additional states subject to the following:

(a) Workers' compensation insurance may be provided only in accordance with OAR 836-043-0001 to 836-043-0091 in those states that have a Workers' Compensation Insurance Plan that is similar to this Plan and that allows employers applying for coverage under those Plans to obtain coverage for operations in Oregon;

(b) A servicing carrier providing such insurance shall collect all premiums due based on the exposure for the physical operations in those other states. The effective date of such insurance in such additional states shall be the day after premium is received; however, in the event coverage in such additional states is on an "if any" basis, the effective date of such coverage shall be the day following receipt of an acceptable request for such insurance by the servicing carrier. A copy of the policy Information Page and all endorsements, properly identified as a Plan or AR (Assigned Risk) policy, shall be submitted to the appropriate Plan Administrator having jurisdiction in the state where the coverage is effected;

(c) The rates, rating plans, classifications, and policy forms used to provide coverage in such additional states shall be those that are:

(A) Applicable to the assigned risk market;

(B) On file and have been approved by the regulators in those additional states; and

(C) Authorized for use in the assigned risk market by the Plan Administrator;

(d) The servicing carrier must be a signatory to an agreement providing reinsurance for workers' compensation insurance policies issued to assigned risk market employers under the organizing principles in each state where the coverage shall be provided; and

(e) A servicing carrier unwilling or unable to provide insurance for an employer in additional states shall refer the employer to the Plan Administrator or appropriate administrative organization for the states where coverage is needed for instructions and applications.

(3)(a) An employer who applies for workers' compensation insurance under another state's workers' compensation insurance plan may purchase coverage for operations in Oregon without meeting the application requirements of this Plan, provided:

(A) The employer qualifies for such insurance under the other state's Plan;

(B) The employer is in good faith entitled to insurance under this Plan;

(C) The other state's Plan is similar to this Plan;

(D) That Plan also provides for interstate assignments; and

(E) The payroll for the employer's operation in Oregon is not greater than the payroll in the other state;

(b) The rates, rating plans, classifications and policy forms used to provide coverage in Oregon shall be those that are applicable to assigned risk market risks in Oregon and are on file and have been approved by the Insurance Commissioner and authorized for use in the assigned risk market by the Plan Administrator;

(c) The administrator of the other Plan is authorized to assign employers with operations in Oregon to the other Plan's servicing carriers, subject to the following conditions:

(A) The servicing carrier must be a signatory to the organizing principles in Oregon. In addition, if the payroll for the employer's operation in Oregon is greater than $250,000, the servicing carrier must also be a servicing carrier in Oregon. If there is no eligible servicing carrier in Oregon that is also an insurer in the state of assignment, then the Plan Administrator may remove the payroll limitation or may require the employer to submit a separate application for coverage in Oregon; and

(B) The other state's Plan must give the Plan Administrator in Oregon similar authority to make interstate assignments.

(d) With regard to interstate assignments and policies, this Plan shall have jurisdiction over all disputes resulting from the application of rules, programs, and procedures that are specific to Oregon. Disputes regarding application requirements shall be under the jurisdiction of the state's Plan where the application was filed.

(4) This section is not applicable for unknown or unanticipated operations or exposures for which coverage may be available under the Residual Market Limited Other States Coverage Endorsement.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 4-1994, f. & cert. ef. 4-19-94; ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0053
Premium Obligations

(1)(a) The Plan Administrator shall not knowingly make an assignment unless the employer has met all undisputed workers' compensation premium obligations on any previous workers' compensation insurance including but not limited to obligations to:

(A) Any servicing carrie;

(B) A direct assignment carrier; or

(C) A voluntary insurer.

(b) After policy issuance, if an employer does not meet all undisputed workers' compensation insurance premium obligations under the current policy or previous assigned risk or voluntary policies, the employer's present servicing carrier retains the right to cancel a policy currently in force under the plan in accordance with ORS 656.427.

(2) When an employer with a prior undisputed workers' compensation premium obligation is a client of a worker leasing company as established in ORS 656.850 that is insured by the Plan, the servicing carrier may instruct the worker leasing company to issue a client cancellation notice to the Director of the Department of Consumer and Business Services with a copy to the client and a copy to the servicing carrier. Such a cancellation is effective on the 30th day after receipt of notice by the Director of the Department of Consumer and Business Services unless the client pays the prior premium debt or obtains coverage in the voluntary insurance market before the 30th day. When a worker leasing company fails to issue the requested client cancellation notice within 20 days of the request, the servicing carrier may cancel the worker leasing company policy.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0060
Assignment Formula

(1) This rule describes the mechanism used to provide for the random and equitable distribution of employers under the Plan to servicing carriers. The Plan Administrator may override the random assignment process to ensure the availability of requested Plan coverages to the employer.

(2)(a) A servicing carrier is responsible for providing services on behalf of those insurers that have elected to meet their Plan participation requirements by subscribing to the organizing principles. The Plan Administrator shall determine the allocable percentage of the servicing carrier through an objective selection process. However, the combined allocable percentages for all servicing carriers must be equal to the combined net voluntary premiums written for all signatories to the organizing principles as compared to the total net premiums of all insurers participating in the Plan in Oregon. An approved servicing carrier may receive assignments for any risk eligible for coverage under the Plan.

(b) When assigning an employer to an insurer, the Plan Administrator shall consider the employer's prior Plan coverage, special requirements, including but not limited to additional states or federal coverage, and premium size.

(c) Any carrier authorized by the U.S. Department of Labor to provide coverage under the U.S. Longshore and Harbor Workers' Compensation Act (USL&HW) and extension acts is eligible to receive assignments requesting the same coverage in the assigned risk market. A carrier with USL&HW authorization is also eligible for assignments requesting Maritime, Program I or II. The Plan Administrator shall determine request for assignments under the USL&HW Act, Maritime, or extension acts coverage in accordance with the assignment methodology established by the Plan Administrator.

(d) A servicing carrier that has previously reported voluntary or assigned risk premium writing in any state, that is subject to the Federal Coal Mine Health and Safety Act or that has previously accepted assignments in any state for operations that are subject to the Federal Coal Mine Health and Safety Act, will receive assignments requesting such coverage in accordance with the assignment methodology established by the Plan Administrator.

(3) If an employer has prior assigned risk coverage, the Plan Administrator shall reassign the employer to the original servicing carrier as long as the carrier can provide the coverage requested by the employer. Circumstances may require the suspension of this criterion, such as when the suspension is warranted, in order to ensure that all servicing carriers achieve their allocable percentage of Plan business. The Plan Administrator shall provide a report of such suspensions to the regulatory authority upon request.

(4) The Plan Administrator shall identify those servicing carriers eligible to receive an assignment based on the following requirements of the employer and the capabilities of carriers:

(a) The Plan Administrator shall select a servicing carrier that is able to provide coverage in the additional states requested by the employer in accordance with Interstate Assignments section of the Plan.

(b) The Plan Administrator shall select a servicing carrier that is able to provide authorized additional coverage requested by the employer. The following coverages require assignment to a servicing carrier with special capabilities as indicated:

(A) For coverage under the USL&HW Act and its extension acts, including the Outer Continental Shelf Lands Act, Defense Base Act, and Nonappropriated Fund Instrumentalities Act, the Plan Administrator shall select a carrier authorized by the U.S. Department of Labor to provide these coverages.

(B) For Maritime coverage, the Plan Administrator shall select a carrier authorized by the Department of Labor to provide United States Longshore and Harbor Workers' Compensation Act coverage.

(C) For coal mine risks, the Plan Administrator shall select a carrier experienced in servicing coal mine risks, either through writing coal mine policies in the voluntary market or through prior servicing of assigned risk market coal mine risks.

(c) Under special circumstances, the Plan Administrator may establish a minimum or maximum number of assignments or premium in order to ensure equitable assignments. These numbers may vary and are based on the amount of business remaining to be assigned and the number of weeks remaining in the calendar year.

(d) A servicing carrier that meets or exceeds its maximum weekly number of risks is not considered eligible. Each employer is assigned to an eligible servicing carrier according to the following algorithm, considering all servicing carriers in the aggregate:

(A) Each servicing carrier's quota premium is calculated by multiplying total premium in the Plan at the time of the assignment by the carrier's quota percent. A servicing carrier's quota percent may be adjusted to allow for a more even distribution of assignments over a period of time.

(B) Each servicing carrier's remaining business to be assigned is calculated by subtracting its premium in force at the time of the assignment from its adjusted quota premium. In order to allow the flexibility of slightly larger assignments in the carrier assignment process, an adjustment is made to each carrier's quota premium. This adjustment consists of applying an "over-quota limit" of five percent or $5,000, whichever is greater, up to a maximum of $200,000. The Plan Administrator may lower this limit if circumstances warrant, such as when required to ensure that all servicing carriers achieve their allocable percentage of Plan business.

(C) Based on the difference between the percentage of a servicing carrier's premium in force and its quota premium, a range of numbers proportional in size to the percentage difference is assigned to each carrier. A random number is generated, and the assignment is made to the servicing carrier whose range encompasses the random number. Issuance and Continuation of Policy A policy must be issued, renewed or reinstated without a lapse in coverage when premium is received by the carrier or postmarked by the United States Postal Service prior to the policy effective date or cancellation date.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0062
Issuance and Continuation of Policy

(1) A policy must be issued, renewed or reinstated without a lapse in coverage when premium, including an interim premium audit or installment payment, is received by the carrier or postmarked by the United States Postal Service prior to the policy effective date or cancellation date.

(2) The following table establishes reinstatement provisions for a policy that is cancelled or renewed: [Table not included. See ED. NOTE.]

(3) A servicing carrier may impose additional requirements if necessary to effect the reinstatement of a policy. Effective or reinstatement dates for a lapse in coverage shall be determined in the same manner provided in OAR 836-043-0044.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0064
Renewal, Nonrenewal

(1) A servicing carrier shall send a renewal or nonrenewal notice of impending expiration of coverage to the insured, the representative of the insured and the Plan Administrator at least 45 days before the expiration date of insurance. Upon receipt of the required premium, the servicing carrier shall issue the policy in accordance with Oregon statutes and rules and furnish a copy of such policy and all endorsements, properly identified as a Plan or AR (Assigned Risk) policy, to the Plan Administrator or its designee within the time and in the format established by the Plan Administrator.

(2) The servicing carrier shall apply the deposit premium paid by an employer in the Plan against the deposit required for a renewal policy, if any. If the servicing carrier assigned the renewal policy is different from the previous servicing carrier, then the previous servicing carrier shall promptly bill the employer for the final billing period, including any audit adjustments. If the final billing is not paid on or before the 30th day after the billing, the renewal servicing carrier may immediately issue a cancellation notice.

(3) A servicing carrier may refuse to renew a policy if the servicing carrier is unable to supply a required type of coverage, including but not limited to longshore, coal mine, maritime or additional state exposures.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0066
Reassignment

(1) An employer may submit to the Plan Administrator a written request for reassignment to a different carrier, if available. The employer must submit the request in writing to the Plan Administrator not later than the 30th day and not earlier than the 60th day prior to the expiration of the current policy unless the Plan Administrator approves another request period or at the request of the regulatory authority. The employer must provide the Plan Administrator with an acceptable reason for the request with appropriate documentation. Acceptable reasons for an employer to request reassignment include:

(a) Documented poor servicing carrier service such as failure to provide timely issuance of statements, policies, and endorsements, or services not provided under the policy;

(b) Documented refusal of or inability of a servicing carrier to supply a required type of coverage including but not limited to longshore, coal mine, maritime or additional state exposures;

(c) Documented failure of a servicing carrier to return premium due to the insured, where there is no valid bona fide premium dispute;

(d) Based on the servicing carrier's A.M. Best Rating or financial size category, if appropriate documentation is provided to and approved by the Plan Administrator; or

(e) Any other substantial documented reason subject to approval of the Plan Administrator

(2) The request for reassignment is subject to approval by the Plan Administrator. If the Plan Administrator approves the reassignment request, the employer shall submit a new application as provided in OAR 836-043-0028 or 836-043-0032 along with the appropriate initial or deposit premium to the Plan Administrator and must be otherwise eligible for continued coverage through the Plan. The reassignment shall be made on a random basis.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0068
Cancellation

(1) The servicing carrier may cancel a policy after its issuance, with the approval of the Insurance Commissioner, for any of the reasons stated in this section. The servicing carrier must first provide an opportunity for cure and must file the reasons for cancellation with the Insurance Commissioner for necessary approval before issuance of the cancellation notice and inform the Plan Administrator of the reason for the cancellation. A proposed cancellation shall be deemed approved unless disapproved by the Insurance Commissioner on or before the 15th day after the servicing carrier filed the reasons for cancellation. A servicing carrier may initiate cancellation when the employer:

(a) Has failed to comply with reasonable health, safety or audit requirements;

(b) Has violated any of the terms and conditions under which the insurance was issued;

(c) Is not eligible for workers' compensation insurance under the Plan;

(d) Refuses to allow the servicing carrier or NCCI reasonable access to its facilities or its files and records for audit or inspection;

(e) Refuses to disclose to the servicing carrier the full nature and scope of the employer's exposure;

(f) Has had the employer's worker leasing company license denied, revoked or suspended; or

(g) The employer does not properly report changes in ownership.

(2) The servicing carrier may cancel a policy without the approval of the Insurance Commissioner when cancellation is for any of the following reasons:

(a) Nonpayment of Plan premium, except that a servicing carrier must provide a minimum of 10 days' notice of additional premium owed prior to the obligation becoming past due;

(b) Failure to complete, submit and pay a payroll report due the insurer, if the insurer has given the employer the following notice:

Important Notice: This Policy is subject to periodic payroll reporting. Reports will be sent to you in accordance with the section entitled "Reporting Frequency" on the Information Page of your policy. Your failure to complete, submit and pay these reports to the insurance company when due may result in cancellation of your policy.

(c) Nonpayment of a premium finance agreement, as defined in ORS 746.405 with notice pursuant to ORS 656.427; or

(d) The employer properly reported changes in ownership.

(3) An insured employer whose coverage is canceled as provided in this rule must reestablish eligibility or must demonstrate entitlement to the Plan Administrator before any further assignment can be made under the Plan.

(4) If an employer fails or refuses to file any report of payroll required by the servicing carrier, the servicing carrier may estimate the payroll and make demand for premiums due thereon. If the required report and the premium due thereon are not received within ten days of actual notice of demand, the employer shall be considered in default of premium payment.

(5) The servicing carrier shall keep the Plan Administrator fully informed of any cancellation and of any reestablishment of eligibility or of compliance by the employer. Any employer whose coverage is cancelled must reestablish eligibility or demonstrate eligibility for coverage under this Plan to the Plan Administrator before the Plan Administrator may make any further assignment under the Plan.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 3-2008, f. & cert. ef. 4-7-08; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0071

Dispute Resolution Procedures

(1)(a) A bona fide premium dispute is established when the employer or its representative provides:

(A) Written notice to the Plan Administrator that includes all of the following:

(i) All documentation relevant to the dispute, including written notice to the insurer or the servicing carrier detailing the specific areas of dispute;

(ii) Description of the attempts to reconcile the differences; and

(iii) A specific request for a review of all documentation, appropriate action to resolve the areas of dispute and if necessary, a hearing before the appropriate administrative or regulatory body having jurisdiction over assigned risk related appeals.

(B) An estimate of the premium the employer believes to be correct, with an explanation of the premium calculation.

(C) Verification of payment of the undisputed portion of the premium provided to the servicing carrier or insurer, and the Plan Administrator.

(b) If the premium in dispute is in litigation, the employer shall provide documentation to the Plan Administrator.

(c) The Plan Administrator shall notify the servicing carrier when a bona fide premium dispute is confirmed. Upon notification, the servicing carrier shall act according to the Plan Administrator's direction pending the resolution of the dispute. The Plan Administrator may direct the servicing carrier to:

(A) Suspend collection activity;

(B) Suspend cancellation if a dispute exists prior to the effective date of cancellation; or

(C) For policies already cancelled, refer to rules set forth in by the Plan Administrator.

(2) Any assigned risk policyholder and the producer of an assigned risk policyholder affected by the actions of their servicing carrier or NCCI shall follow the procedures set forth in ORS 731.240, 737.340 or 737.505 to review, resolve or request a hearing on any grievance.

(a) An individual employer dispute is subject to ORS 731.240, 737.340 or 737.505 as applicable and the conditions outlined in the Bona Fide Premium Dispute and Undisputed Premium Obligation. The intervention of the Plan Administrator in a dispute is limited to matters involving:

(A) Experience rating modification factors;

(B) Application of rules contained in NCCI manuals;

(C) Eligibility and assignment under the Workers' Compensation Insurance Plan;

(D) Classification assignments;

(E) Assigned risk pricing programs; or

(F) A dispute involving other matters arising under the Plan.

(b) Upon receipt of all necessary information regarding the dispute, the Plan Administrator shall review the matter and provide a written decision within 30 days.

(3)(a) When an employer dispute concerns any of the above matters, other than the application of NCCI's rating plan rules, or involves more than one state, the Plan Administrator shall determine the appropriate jurisdiction for the dispute to be heard, based upon the following factors:

(A) Governing state which shall be the state generating the greatest payroll;

(B) The state covered by the servicing carrier with the greatest exposure insured;

(C) The state where the operations are best represented; or

(D) In accordance with the following jurisdiction table: [Table not included. See ED. NOTE.]

(b) When a dispute concerns the application of NCCI's rules for interstate rated risks, the Plan Administrator shall determine the appropriate jurisdiction for the dispute to be heard.

(c) Unless state-specific rules apply, the ruling of the state appeals mechanism (as determined by the Plan Administrator to have jurisdiction over the dispute) will apply to all assigned risk policies whether written by one or more servicing carriers.

(4) Upon receipt of all necessary information regarding the dispute, the Plan Administrator shall review disputes relating to the calculation or payment of producer fees and producer of record changes and provide a written decision within 30 days.

(5)(a) Any Plan participant who has a dispute with respect to any aspect of the Plan or Reinsurance Agreement including any dispute arising out of the organizing principles must first seek a review of the matter under this section by providing the following to the Plan Administrator:

(A) Written documentation detailing specific areas of the dispute;

(B) Specific request for a review of all documentation; and

(C) Appropriate actions of areas to resolve the dispute.

(b) The Plan Administrator may request additional information necessary to make a decision. All disputes submitted to the Plan Administrator are governed as follows:

(A) For disputes relating to the general operation of the Plan, including but not limited to, performance standards for servicing carrier performance, compensation and incentives and application assignment determination, the Plan Administrator shall review the matter and provide a written decision within 30 days of receipt of all necessary information regarding the dispute.

(B) Within 30 days after the Plan Administrator makes a decision and at the expense of the party, a party affected by the decision may submit a written request for binding arbitration or the party may seek a de novo review by the Insurance Commissioner.

(C) For any de novo review, the Insurance Commissioner shall follow the procedures provided in ORS 183.310 to 183.540 and 737.360 for review of a contested case.

(D) For a dispute relating to the servicing carrier selection process, refer to the Bid Protest Procedures contained in the applicable servicing carrier Request for Proposal (RFP).

(6)(a) Within 30 days after receipt of all necessary information regarding a dispute that arises under the organizing principles or a Reinsurance Agreement, the Plan Administrator or the administrator of the Reinsurance Agreement shall review the matter and provide a detailed written decision. Any party affected by the decision may request the board to review the decision by submitting a written request for review within 30 days after the date of the decision by the Reinsurance Administrator under the organizing principles. The board may:

(A) Consider the matter and render its written decision pursuant to the procedures set forth in the organizing principles, or

(B) Waive its decision and offer the aggrieved party the option of appealing directly to the Insurance Commissioner or submitting the dispute

to arbitration in accordance with the terms and conditions established by the board.

(b) Any party affected by a decision of the board may seek a de novo review by the Insurance Commissioner by submitting a written request for review, within 30 days after the date of the board decision.

(c) If the dispute relates to the expulsion of a participating company under the organizing principles by the board or the noncontinuation of the reinsurance afforded under the organizing principles, the party may take the appeal directly to the Insurance Commissioner pursuant to ORS 737.360 without first complying with the procedures contained in this rule. The Insurance Commissioner has exclusive jurisdiction over all such disputes. For a review under this paragraph, the Insurance Commissioner shall follow the procedures provided in ORS 183.310 to 183.540 and 737.360 applicable to review of a contested case.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.527, 656.730 & 737.265

Hist.: ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0076

Takeout Credit

The Plan Administrator shall establish a take-out credit program. The take-out credit program shall operate in accordance with the following guidelines:

(1) Each insurer participating in the Plan who removes an employer insured through the Plan is eligible for a take-out credit application against the premium used to calculate the Plan participation base of the enrolled insurer. An insurer shall contact the take-out credit administrator to enroll in the program. Any insurer licensed in Oregon and writing workers' compensation insurance coverage is eligible to enroll in the take-out credit program.

(2) An insurer may not receive credit for any policy removed from the Plan within one calendar year after the insurer or its affiliate wrote the policy in the voluntary market. An insurer who does not enroll in the program cannot receive take-out credit.

(3) An insurer, other than the last voluntary insurer of record, may remove a policy without any restriction on the length of time the policy resided in the assigned risk market.

(4) For the purpose of the take-out credit program, the requirements of this rule apply to an insurer's affiliates as well as to the insurer.

(5) The kind and amount of coverage to be offered a voluntary employer shall not be less than those afforded by the policy being replaced unless the kinds and amounts of coverage are refused by the employer.

(6) The granting of credits is subject to the following provisions:

(a) An insurer who removes an employer from the assigned risk market is eligible for a take-out credit application equal to the annual premium from the voluntary policy times a credit factor from the following schedule: Total Premium — $5,000 or Less — Total Premium — Greater than $5,000:

(A) First Year — 3:1 — 1:1;

(B) Second Year — 3:1 — 1:1;

(C) Third Year — 3:1 — 1:1.

(b) Credits received under this rule are not subject to a maximum limit, except that the credits shall not reduce the participation base of an insurer below zero.

(c) An insurer shall receive a credit against the premium used to calculate its Plan participation base for the amount of verifiable annual premium reported in its Exhibit of Premiums and Losses (Statutory Page 14) of its Annual Statement for the respective calendar year. The reported premium must be stated on the same financial basis as the premiums that are reported for use in determining each insurer's Plan participation base and are subject to subsequent adjustments and audits. The definition of "net premiums written" in the Plan shall govern the description of premium used to calculate the Plan participation base. As audit premiums, retrospective adjustments and other items are developed, an insurer shall receive a credit against its participation base for the amount of the premium adjustment in the calendar year in which the adjustment is reported in the direct earned premium for Oregon entry in the Annual Statement. Regardless of when an adjustment was made or reported in the direct earned premium for Oregon entry, the adjustment shall be allowed if related to the first, second or third year of voluntary coverage by the insurer.

(d) If an insurer keeps an employer out of the assigned risk market for three consecutive years, the insurer shall receive credit for each of the three consecutive years. If the insurer does not write the insurance for three years, it shall receive credit only for the consecutive period of time that it covered the employer in the voluntary market. An insurer shall not receive any credit for an employer returned to the Plan within one calendar year of removal.

(e) An insurer must submit a request for credit annually during the three year period in order to qualify for the credit.

(f) Each year, the Plan Administrator shall perform a systematic search of policies submitted as voluntary that were previously assigned risk policies to determine their eligibility for take-out credit.

(g) The Plan Administrator shall provide enrolled insurers with a detailed Take-Out Credit Policy Report of eligible policies. The Plan Administrator shall provide the Take-Out Credit Policy Report to insurers in electronic format.

(h) Each insurer shall review and modify the Take-Out Credit Policy Report to ensure all eligible policies are included in the calculation of the credit.

(i) The Plan Administrator shall review any modifications to the Take-Out Credit Policy Report to ensure agreement. The Plan Administrator may eliminate any policy that is inaccurately reported or those modifications that the Plan Administrator cannot research for concurrence.

(j) Upon review and approval of the policies on the Take-Out Credit Policy Report, the enrolled insurer need only send an electronic reply of concurrence that indicates the official request of the insurer to receive the credit.

(k) The Plan Administrator shall grant credit only to enrolled insurers that provide electronic concurrence with the Take-Out Credit Policy Report.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; Administrative Reformatting 1-15-98; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0079

Notification of Outstanding Premium

A servicing carrier or its representative shall furnish information regarding outstanding assigned risk and voluntary workers' compensation insurance premium or other workers' compensation monetary policy obligations identified by the servicing carrier or its representative to the Plan Administrator or its designee in accordance with the appropriate Assigned Carrier Performance Standards or other state market conduct or regulatory requirements. A servicing carrier shall report to the Plan Administrator within five business days of the servicing carrier's determination all instances of noncompliance and of any compliance by the employer.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0082

Policyholder Services

A servicing carrier shall provide all of the following to each policyholder or a representative of the insured and its producer:

(1) Access to audit, loss control and safety services.

(2) Prompt, professional handling of claims, including investigation, resolution and communication.

(3) Fair and prompt responses to complaints and disputes.

(4) Access to appropriate information regarding the classification of the business and the factors influencing the policy premium.

Stat. Auth.: ORS 656.427, 656.730 & 731.244

Stats. Implemented: ORS 656.427, 656.730 & 737.265

Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0087

Producer Changes and Compensation

(1) The servicing carrier must pay a fee to the licensed agency on all new and renewal policies after the policy is issued. The servicing carrier shall pay the producer as premium is collected. The servicing carrier must process and mail fee payments within 30 days after the date the policy is issued or 30 days after the receipt of premium. The carrier may withhold payments until an accumulative total of $25 per agency is reached. However, the servicing carrier must pay the agency their fees upon request regardless of the amount or if the withholding time period exceeds six months. The fee payment also may be applied to return fees that the agency may owe to the servicing carrier from other assigned risk policies for that agency. The servicing carrier may not pay a producer fee on premium not actually collected.

(2) The producer fee paid by the servicing carrier shall be in accordance with the producer fee percentage scales and shall be paid at the rate filed by the Plan Administrator with the Director.

(3) It is the responsibility of the servicing carrier to determine whether the producer is properly licensed in the appropriate jurisdictions for payment of producer fees. If the producer listed on the application is not prop-

erly licensed, or if the employer designates a representative other than a licensed producer, the servicing carrier shall accept the assignment but the producer fee will not be paid. For all other purposes, the producer shall be treated as the producer of record.

(4) The employer may request a change to the licensed producer. The employer shall provide written notice to the servicing carrier, generally in the form of a "producer of record" letter. The request must be made prior to the date of renewal, or with the consent of the servicing carrier at another agreed upon time.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

836-043-0089
Confidentiality of Information

The servicing carrier shall keep in confidence and must not, except as directed by the insured or the producer of record, or as otherwise may be required by law or the Insurance Commissioner, disclose to any third party, or use for the benefit of itself or any third party, such detailed information as it may obtain by virtue of its position as the servicing carrier. Such information may be used solely for the evaluation, underwriting, and insuring of coverage under this Plan and not for any other purpose. The servicing carrier may not use any information the servicing carrier obtains in its capacity as the servicing carrier to request, encourage, or solicit employers it insures under this Plan to use the services of any specific insurance producer, agency, insurer or group of insurers, including but not limited to direct writers affiliated with the servicing carrier, for purposes of providing voluntary workers' compensation insurance or other lines of insurance to such employer.

Stat. Auth.: ORS 656.427, 656.730 & 731.244
Stats. Implemented: ORS 656.427, 656.730 & 737.265
Hist.: ID 10-1996, f. 6-27-96, cert. ef. 7-1-96; ID 18-2008, f. 12-9-08, cert. ef. 1-1-09

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Rule Caption: Criminal Record Checks and Fingerprinting of Licensees under the Insurance Code.
Adm. Order No.: ID 19-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 12-10-08
Notice Publication Date: 5-1-2008
Rules Adopted: 836-072-0001, 836-072-0005, 836-072-0010, 836-072-0015, 836-072-0020, 836-072-0025, 836-072-0030, 836-072-0035, 836-072-0040, 836-072-0045
Subject: This rulemaking implements ORS 705.141, which authorizes the Department of Consumer and Business Services to require fingerprints of a person applying for issuance or renewal of a license as an insurance producer, insurance consultant, adjuster, life settlement provider or life settlement broker, in connection with a request for a state or nationwide criminal records check.
Rules Coordinator: Sue Munson—(503) 947-7272

836-072-0001
Applicability of and authority for OAR 836-072-0001 to 836-072-0045

(1) OAR 836-072-0001 to 836-072-0045 are adopted to carry out the authority of the Department of Consumer and Business Services under ORS 181.534 to request an Oregon LEDS-based criminal history check, a fingerprint-based Oregon criminal history check or a nationwide criminal history check and, pursuant to ORS 705.141, to require fingerprints of an applicant for any of the following licenses:

(a) Adjuster license.
(b) Insurance consultant license.
(c) Insurance producer license.
(d) Viatical settlement provider license.
(e) Viatical settlement broker license.

(2) OAR 836-072-0001 to 836-072-0045 apply to an application for a licenses set forth in section (1) of this rule submitted on and after September 1, 2009.

(3) The fact that the Department approves an applicant as fit to be a licensee under OAR 836-072-0001 to 836-072-0045 does not guarantee that the Department will issue or amend the license of the applicant.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0005
Definitions

(1) "Applicant" means an applicant applying for any of the following:

(a) An initial resident license.
(b) A renewal of a resident license.
(c) An additional line of authority under an existing resident license when a criminal history record check has not been obtained.
(d) A resident license under a change of resident license application pursuant to ORS 744.067.

(2) "Authorized designee" means a Department employee authorized to obtain and review criminal offender information and other criminal records information about an applicant through criminal records checks and other means, and to conduct a fitness determination in accordance with OAR 836-072-0015.

(3) "Criminal records check" means a fingerprint-based Oregon criminal history check or a nationwide criminal history check..

(4) "LEDS" means the Law Enforcement Data System.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0010
Criminal Records Check Process

(1) An authorized designee:

(a) Shall conduct a LEDS-based criminal history check and request that the Oregon Department of State Police conduct a criminal records check for all applicants for an initial license; and

(b) May conduct a LEDS-based criminal history check, or request that the Oregon Department of State Police conduct, a criminal records check of an applicant for renewal of a license to whom OAR 836-072-0001 to 836-072-0045 apply.

(2) Prior to a LEDS-based criminal history check or a criminal records check, an applicant to whom OAR 836-072-0001 to 836-072-0045 apply shall complete and sign the DCBS Criminal Records Request form and, if requested by the Department, a fingerprint card. The applicant shall submit the form, and the card if requested, within three business days of receiving them. The Department may extend the deadline for good cause.

(3) An applicant to whom OAR 836-072-0001 to 836-072-0045 apply must provide identifying information requested by the DCBS Criminal Records Request form and fingerprint card, which includes but is not limited to name, birth date, Social Security number, physical characteristics, marital status, driver's license or identification card number and current address, and information about prior residences as requested in the DCBS Criminal Records Request form. The applicant shall submit the information and obtain the fingerprints in accordance with directions provided by the Department. An applicant, with the written consent of the authorized designee, may submit the materials necessary for the authorized designee to conduct a LEDS-based criminal history check or a criminal records check up to six months before the applicant intends to submit an application for a new license or for renewal of an existing license.

(4) If the Department and a vendor agree by contract that the vendor will perform duties of obtaining fingerprints of applicants and submitting the fingerprints for Oregon or nationwide criminal history checks, an applicant shall submit the fingerprint card according to the requirements and instructions of the vendor.

(5) Within a reasonable period of time established by an authorized designee, an applicant shall disclose additional information as requested by the Department to resolve an issue hindering the completion of either a LEDS-based criminal history check or a criminal records check, such as providing additional proof of identity.

(6) When an authorized designee determines under section (1) of this rule that a criminal records check is needed:

(a) The authorized designee shall conduct a LEDS -based criminal records check as part of any fitness determination conducted in regard to an applicant.

(b) The authorized designee may request that the Oregon Department of State Police conduct an Oregon criminal history check when:

(A) The authorized designee determines that an Oregon criminal history check is warranted after review of the information provided by the applicant, the results of a LEDS-based criminal history check or other criminal records information;

(B) The authorized designee requests a nationwide criminal history check; or

(C) Upon application for renewal, the Director has reason to believe an additional check is necessary based on information obtained by the Insurance Division.

(7) An authorized designee may request that the Oregon Department of State Police conduct a nationwide criminal history check when:

(a) An applicant for license issuance has lived outside Oregon continuously for nine years;

(b) An applicant for resident license renewal has lived outside Oregon for 60 or more consecutive days during the previous three years;

(c) For a renewal application, the Director has reason to believe an additional check is necessary based on information obtained by the Insurance Division;

(d) Information provided by the applicant or the results of a LEDS-based criminal history check or Oregon criminal history check gives reason to believe, as determined by an authorized designee, that the applicant has a criminal history outside of Oregon;

(e) As determined by an authorized designee, there is reason to question the identity of, or information provided by, an applicant, including but not limited to failure to disclose a Social Security Number, disclosure of a Social Security Number that appears to be invalid or lack of an Oregon driver's license or identification card; or

(f) A check is required by federal law or regulation, by state law or administrative rule, or by contract or written agreement with the Department.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0015
Fitness Determination

(1) An authorized designee shall make a fitness determination about an applicant based on information provided by the applicant under OAR 836-072-0010, any LEDS-based criminal history check or other criminal history check conducted and any false statements made by the applicant.

(2) When making a fitness determination about an applicant, an authorized designee shall also consider the factors in this section in relation to information provided by the applicant under OAR 836-072-0010, any LEDS-based criminal history report or criminal offender information obtained through a criminal records check and any false statement made by the applicant. To assist in considering these factors, the authorized designee may obtain other criminal records information from the applicant or any other source, including law enforcement agencies or courts within or outside of Oregon. To acquire other criminal offender information from the applicant, an authorized designee may request a meeting with the applicant and may request from the applicant written materials or authorization to obtain criminal offender information. The applicant must meet with the authorized designee if requested and provide additional information or authorization within a reasonable period of time, as established by the authorized designee. The authorized designee shall use all collected information in considering the following factors:

(a) Whether the applicant has been convicted of, found guilty except for insanity (or a comparable disposition) of, or has a pending indictment for a crime listed in OAR 836-072-0020;

(b) The nature of any crime identified under subsection (a) of this section;

(c) The facts that support the conviction, finding of guilty except for insanity or pending indictment;

(d) The facts that indicate the applicant made a false statement;

(e) The relevance, if any, of a crime identified under subsection (a) of this section or of a false statement made by the applicant to the specific requirements of the applicant's present or proposed employment; and

(f) The following intervening circumstances, to the extent that they are relevant to the responsibilities and circumstances of the license application or renewal for which the fitness determination is being made:

(A) The passage of time since the commission or alleged commission of a crime identified under subsection (a) of this section;

(B) The age of the applicant at the time of the commission or alleged commission of a crime identified under subsection (a) of this section;

(C) The likelihood of a repetition of offenses or of the commission of another crime;

(D) The subsequent commission of another crime listed in OAR 836-072-0020;

(E) Whether a conviction identified under subsection (a) of this section has been set aside or pardoned, and the legal effect of setting aside the conviction or of a pardon;

(F) A recommendation of an employer;

(G) The disposition of a pending indictment identified under subsection (a) of this section;

(H) Whether the applicant has been arrested for or charged with a crime listed under OAR 836-072-0020 within the last five years;

(I) Whether the applicant is being investigated, or has an outstanding warrant, for a crime listed under OAR 836-072-0020;

(J) Whether the applicant is currently on probation, parole or another form of post-prison supervision for a crime listed under OAR 836-072-0020;

(K) Whether the applicant has a deferred sentence or conditional discharge or is participating in a diversion program in connection with a crime listed under OAR 836-072-0020;

(L) Whether the applicant has been adjudicated in a juvenile court and found to be within the court's jurisdiction for an offense that would have constituted a crime listed in OAR 836-072-0020 if committed by an adult, unless that adjudication has been reversed or set aside by a subsequent court decision;

(M) Periods of incarceration of the applicant;

(N) Whether the applicant has a history of drug or alcohol abuse that relates to the applicant's criminal activity, and the applicant's history of treatment or rehabilitation for such abuse; and

(O) The education and work history (paid or volunteer) of the applicant since the commission or alleged commission of a crime.

(3) The following are possible outcomes of a final fitness determination:

(a) An authorized designee shall approve an applicant if the authorized designee determines pursuant to sections (1) and (2) of this rule that:

(A) No credible evidence that the applicant has been convicted of, or found guilty except for insanity (or comparable disposition) of a crime listed as a permanent review crime in OAR 836-072-0020;

(B) No credible evidence that the applicant had been convicted of, or found guilty except for insanity (or comparable disposition) of a crime listed as a ten-year review crime in OAR 836-072-0020 within ten years of the date that the applicant signed the DCBS Criminal Records Request form;

(C) No credible evidence that the applicant had been convicted of, or found guilty except for insanity (or comparable disposition) of a crime listed as a five-year review crime in OAR 836-072-0020(3) within five years of the date that the applicant signed the DCBS Criminal Records Request form;

(D) No credible evidence that the applicant has a pending indictment for a crime listed in OAR 836-072-0020;

(E) No credible evidence of the applicant having made a false statement; and

(F) No discrepancies exist between the criminal offender information, other criminal records information and information obtained from the applicant.

(b) An authorized designee shall deny issuance or renewal of a license to an applicant:

(A) If a fitness determination under this rule shows credible evidence of any of the factors identified in subsection (a) of this section and, after evaluating the information described in sections (1) and (2) of this rule, an authorized designee concludes that the applicant acting in the scope of the license for which the fitness determination is being conducted would pose a risk of harm to the insurance-buying public.

(B) If the applicant refuses to submit or consent to a criminal records check including fingerprint identification.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0020
Crimes Relevant to a Fitness Determination

The following crimes are relevant to a fitness determination under OAR 836-072-0001 to 836-072-0045, to the extent not inconsistent with ORS 670.280:

(1) Permanent review crimes.

ORS 162.015, Bribe giving; ORS 162.025, Bribe receiving; ORS 162.065, Perjury; ORS 162.117, Public investment fraud; ORS 162.235, Obstructing governmental or judicial administration; ORS 162.265, Bribing a witness; ORS 162.275, Bribe receiving by a witness; ORS 162.285, Tampering with a witness; ORS 162.305, Tampering with public records;ORS 162.325, Hindering prosecution; ORS 162.355, Simulating legal process; ORS 162.365, Criminal impersonation; ORS 162.367, Criminal impersonation of peace officer; ORS 162.405, Official misconduct II; ORS 162.415, Official misconduct I; ORS 162.425, Misuse of confidential information; ORS 163.005, Criminal homicide; ORS 163.095, Aggravated murder; ORS 163.115, Murder; ORS 163.118, Manslaughter I; ORS 163.125, Manslaughter II; ORS 163.145, Criminally negligent homicide; ORS 163.160, Assault IV; ORS 163.165, Assault III; ORS 163.175, Assault II; ORS 163.185, Assault I; ORS 163.187, Strangulation; ORS 163.200, Criminal mistreatment II; ORS 163.205, Criminal mistreatment I; ORS 163.207, Female genital mutilation; ORS 163.208, Assault of Public Safety Officer; ORS 163.225, Kidnapping II; ORS 163.235, Kidnapping I; ORS 163.257, Custodial interference I; ORS 163.275, Coercion; ORS 163.355, Rape III; ORS 163.365, Rape II; ORS 163.375, Rape I; ORS 163.385, Sodomy III; ORS 163.395, Sodomy II; ORS 163.405, Sodomy I; ORS 163.408, Unlawful Sexual penetration II; ORS 163.411, Unlawful Sexual penetration I; ORS 163.425, Sexual abuse

II; ORS 163.427, Sexual abuse I; ORS 163.452, Custodial sexual misconduct I; ORS 163.454, Custodial sexual misconduct II; ORS 163.465, Public indecency; ORS 163.479, Unlawful contact with child; ORS 163.515, Bigamy; ORS 163.525, Incest; ORS 163.535, Abandonment of a child; ORS 163.537, Buying or selling a person under 18 years of age; ORS 163.547, Child neglect I; ORS 163.670, Using child in display of sexually explicit conduct; ORS 163.684, Encouraging child sexual abuse I; ORS 163.686, Encouraging child sexual abuse II; ORS 163.687, Encouraging child sexual abuse III; ORS 163.688, Possession of materials depicting sexually explicit conduct of a child I; ORS 163.689, Possession of materials depicting sexually explicit conduct of a child II; ORS 163.732, Stalking; ORS 164.055, Theft I; ORS 164.057, Aggravated theft I; ORS 164.075, Theft by extortion; ORS 164.085, Theft by deception; ORS 164.095, Theft by receiving, if a felony; ORS 164.125, Theft of services; ORS 164.135, Unauthorized use of a vehicle; ORS 164.140, Criminal possession of rented or leased personal property, if a felony; ORS 164.162, Mail theft or receipt of stolen mail; ORS 164.170, Laundering a monetary instrument; ORS 164.172, Engaging in a financial transaction in property derived from unlawful activity; ORS 164.215, Burglary II; ORS 164.225, Burglary I; ORS 164.325, Arson I; ORS 164.377, Computer crime; ORS 164.395, Robbery III; ORS 164.405, Robbery II; ORS 164.415, Robbery I; ORS 165.007, Forgery II; ORS 165.013, Forgery I; ORS 165.017, Criminal possession of a forged instrument II; ORS 165.022, Criminal possession of a forged instrument I; ORS 165.032, Criminal possession of a forgery device; ORS 165.042, Fraudulently obtaining a signature; ORS 165.055, Fraudulent use of a credit card; ORS 165.065, Negotiating a bad check, if a felony; ORS 165.070, Possessing fraudulent communications device; ORS 165.074, Unlawful factoring of payment card transaction; ORS 165.080, Falsifying business records; ORS 165.085, Sports bribery; ORS 165.090, Sports bribe receiving; ORS 165.095, Misapplication of entrusted property; ORS 165.100, Issuing a false financial statement; ORS 165.577, Cellular counterfeiting III; ORS 165.579, Cellular counterfeiting II; ORS 165.581, Cellular counterfeiting I; ORS 165.692, Making false claim for health care payment, if a felony; ORS 165.800, Identity theft; ORS 165.810, Unlawful possession of a personal identification device; ORS 165.813, Unlawful possession of fictitious identification; ORS 166.155, Intimidation II; ORS 166.165, Intimidation I; ORS 166.270, Possession of weapons by certain felons; ORS 166.272, Unlawful possession of machine guns, certain short-barreled firearms and firearm silencers; ORS 166.350, Unlawful possession of armor piercing ammunition; ORS 166.370, Possession of firearm or dangerous weapon in public building or court facility; exceptions; discharging firearm at school; ORS 166.410, Manufacturing, importation or sale of firearms; ORS 166.429, Firearms used in felony; ORS 166.720, Racketeering activity unlawful; ORS 167.167, Cheating ORS 167.212, Tampering with drug records; ORS 181.599, Failure to report as sex offender; ORS 192.852/865, Prohibition on obtaining or disclosing of protected information; ORS 475.840, Prohibited acts generally (regarding drug crimes); ORS 475.904, Unlawful manufacture or delivery of controlled substance within 1000 feet of school; ORS 475.906, Penalties for distribution to minors; ORS 475.908, Causing another person to ingest a controlled substance; ORS 475.910, Application of controlled substance to the body of another person; ORS 475.914, Prohibited acts for registrants (with the State Board of Pharmacy; regarding felony crimes); ORS 475.916, Prohibited acts involving records and fraud; ORS 475.918, Falsifying drug test results; ORS 475.920, Providing drug test falsification equipment; ORS 475.967, Possession of precursor substance with intent to manufacture controlled substance; Any felony under the Oregon Labor Code (ORS Chapters 651-663), the Oregon Vehicle Code (ORS Chapter 801-826), or the Occupations and Professions Code (ORS Chapters 670-704); Any federal crime, US Military crime, or international crime; Any unclassified felony defined in Oregon Revised Statutes not listed elsewhere in this rule; Any other felony under the statutes of Oregon or any other jurisdiction not listed elsewhere in this rule that the authorized designee determines is relevant to performance of the applicant within the scope of the license for which issuance or renewal has been applied, subject to ORS 670.280; Any crime of attempt, solicitation or conspiracy to commit a crime listed in this section pursuant to ORS 161.405, 161.435, or 161.450; Any crime based on criminal liability for conduct of another pursuant to ORS 161.155, when the underlying crime is listed in this section; Any crime in any other jurisdiction that is the substantial equivalent of any of the Oregon crimes listed in this section as determined by the authorized designee;

(2) Ten-year review crimes:

ORS 133.076, Failure to appear on criminal citation; ORS 162.075, False swearing; ORS 162.085, Unsworn falsification; ORS 162.145, Escape III; ORS 162.175, Unauthorized departure; ORS 162.185, Supplying contraband; ORS 162.195, Failure to appear II; ORS 162.205, Failure to appear I; ORS 162.247, Interfering with a peace officer or parole & probation officer; ORS 162.295, Tampering with physical evidence; ORS 162.369, Possession of false law enforcement identification card; ORS 162.385, Giving false information to police officer for a citation or arrest warrant; ORS 163.245, Custodial interference II; ORS 163.415, Sexual abuse III; ORS 163.435, Contributing to the sexual delinquency of a minor; ORS 163.445, Sexual misconduct; ORS 163.467, Private indecency; ORS 163.476, Unlawfully being in a location where children congregate; ORS 163.545, Child neglect II; ORS 163.555, Criminal nonsupport; ORS 163.575, Endangering the welfare of a minor; ORS 163.693, Failure to report child pornography; ORS 163.700, Invasion of personal privacy; ORS 163.750, Violating court's stalking protective order; ORS 164.043, Theft III; ORS 164.045, Theft II; ORS 164.095, Theft by receiving, if a misdemeanor; ORS 164.140, Criminal possession of rented or leased personal property, if a misdemeanor; ORS 164.235, Possession of burglar's tools or theft device; ORS 164.255, Criminal trespass I; ORS 164.265, Criminal trespass while in possession of firearm; ORS 164.272, Unlawful entry into motor vehicle; ORS 164.315, Arson II; ORS 164.335, Reckless burning; ORS 164.354, Criminal Mischief II; ORS 164.365, Criminal Mischief I; ORS 165.037, Criminal simulation; ORS 165.065, Negotiating a bad check, if a misdemeanor; ORS 165.102, Obtaining execution of documents by deception; ORS 165.540, Obtaining contents of communication; ORS 165.543, Interception of communications; ORS 165.570, Improper use of emergency reporting system; ORS 165.572, Interference with making a report; ORS 165.577, Cellular counterfeiting III; ORS 165.579, Cellular counterfeiting II; ORS 165.692, Making false claim for health care payment, if a misdemeanor; ORS 166.065, Harassment; ORS 166.076, Abuse of a memorial to the dead; ORS 166.190, Pointing firearm at another; ORS 166.220, Unlawful use of weapon; ORS 166.240, Carrying of concealed weapon; ORS 166.250, Unlawful possession of firearms; ORS 166.382, Possession of destructive device prohibited; ORS 166.416, Providing false information in connection with a transfer of a firearm; ORS 167.065, Furnishing obscene materials to minors; ORS 167.070, Sending obscene materials to minors; ORS 167.075, Exhibiting an obscene performance to a minor; ORS 167.080, Displaying obscene materials to minors; ORS 167.090, Publicly displaying nudity or sex for advertising purposes; ORS 167.222, Frequenting a place where controlled substances are used; ORS 167.322, Aggravated animal abuse I; ORS 411.630, Unlawfully obtaining public assistance; ORS 411.640, Unlawfully receiving public assistance; ORS 411.675, Submitting wrongful claim or payment (e.g., public assistance); ORS 411.840, Unlawfully obtaining or disposing of food stamp benefits; Any Class A misdemeanor under the Oregon Labor Code (ORS Chapters 651-663), the Oregon Vehicle Code (ORS Chapter 801-826), or the Occupations and Professions Code (ORS Chapters 670-704); Any unclassified misdemeanor defined in Oregon's or any other jurisdiction's statutes and not listed elsewhere in this rule; Any other misdemeanor under the statutes of Oregon or any other jurisdiction and not listed elsewhere in this rule that the authorized designee determines is relevant to performance of the applicant within the scope of the license for which application is made, subject to ORS 670.280; Any crime of attempt, solicitation or conspiracy to commit a crime listed in this section pursuant to ORS 161.405, 161.435, or 161.450; Any crime based on criminal liability for conduct of another pursuant to ORS 161.155, when the underlying crime is listed in this section; Any crime in any other jurisdiction that is the substantial equivalent of any of the Oregon crimes listed in this section as determined by the authorized designee;

(3) Five-year review crimes.

ORS 162.365, Criminal impersonation; ORS 162.375, Initiating a false report; ORS 163.190, Menacing; ORS 163.195, Recklessly endangering another person; ORS 164.243, Criminal trespass II by a guest; ORS 164.245, Criminal trespass II; ORS 164.345, Criminal mischief III; ORS 166.180, Negligently wounding another; ORS 412.074, Unauthorized use and custody of records of temporary assistance for needy families program; ORS 412.099, Sharing assistance prohibited; ORS 416.990, False or fraudulent statements/information; ORS 830.053, Fraudulent report of theft of boat; ORS 830.475(1), Failure to perform the duties of an operator (boat); ORS 830.730, False information to peace officer or State Marine Board; Any crime of attempt, solicitation or conspiracy to commit a crime listed in this section pursuant to ORS 161.405, 161.435 or 161.450;Any crime based on criminal liability for conduct of another pursuant to ORS 161.155, when the underlying crime is listed in this section; Any crime in any other jurisdiction that is the substantial equivalent of any of the Oregon crimes listed in this section as determined by the authorized designee.

(4) An authorized designee shall evaluate a crime on the basis of Oregon laws and, if applicable, federal laws or the laws of any other jurisdiction in which a criminal records check indicates an applicant may have committed a crime, as those laws are in effect at the time of the fitness determination.

(5) An applicant may not be denied issuance or renewal of a license on the basis of the existence or contents of a juvenile record that has been expunged pursuant to ORS 419A.260 and 419A.262.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0025
Incomplete Fitness Determination

(1) The Department may close a final fitness determination as incomplete when:

(a) Circumstances change so that an applicant is no longer subject to OAR 836-072-0001 to 836-072-0045;

(b) The applicant does not provide materials or information under OAR 836-072-0020 within the time required under that rule;

(c) An authorized designee cannot locate or contact the applicant;

(d) The applicant fails or refuses to cooperate with an authorized designee's attempts to acquire other criminal records information under OAR 836-072-0015; or

(e) The Department determines that the applicant is not eligible or not qualified for the license for a reason unrelated to the fitness determination process.

(2) An applicant does not have a right to a contested case hearing under OAR 836-072-0035 to challenge the closing of a fitness determination as incomplete.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0030
Notice to Applicant of Fitness Determination

(1) An authorized designee shall provide, in a format approved by the Department, written notice to an applicant upon completion of a final fitness determination that denies issuance or renewal of a license, or upon the closing of a fitness determination due to incompleteness. In addition:

(a) The authorized designee shall record on the notice the date on which the fitness determination was either closed as incomplete or completed.

(b) A notice pertaining to a completed final fitness determination must be accompanied by a separate notice addressing the applicant's right to appeal the Department's determination under OAR 836-072-0035 and containing the information required by OAR 137-003-0505.

(2) An authorized designee shall provide for hand delivery or first class mail delivery of the notice under section (1) of this section as soon as possible after completion or closure of a fitness determination, but in no

case later than 14 calendar days after the date of completion or closure, to the address provided by the applicant on the DCBS Criminal Records Request form, or to an updated address as provided in writing by the applicant.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0035
Appealing a Fitness Determination

(1) This rule establishes a contested case hearing process by which an applicant may appeal a completed final fitness determination made under OAR 836-072-0015 that the applicant is fit or not fit for a license described in OAR 836-072-0001 on the basis of information obtained as the result of a LEDS-based criminal history check or criminal records check conducted by or at the request of the Department pursuant to ORS 181.534.

(2) An applicant may appeal a fitness determination by submitting a written request for a contested case hearing to the address specified in the notice provided under OAR 836-072-0030. To be timely, a request for hearing must be received by the Department not later than the 10th day after the date of the notice. The Department shall address a request received after the 10th day as provided under OAR 137-003-0528.

(3) When a timely request is received by the Department under section (2) of this rule, a contested case hearing shall be conducted by an administrative law judge assigned by the Office of Administrative Hearings, pursuant to the Attorney General's Uniform and Model Rules, "Procedural Rules, Office of Administrative Hearings," OAR 137-003-0501 to 137-003-0700, as supplemented by this rule.

(4) An applicant's timely hearing request under section (2) of this rule constitutes a discovery request for any records that the applicant may inspect under OAR 836-072-0040(2)(e). The Department or the administrative law judge may protect information made confidential by ORS 181.534(15) or other applicable laws as provided in OAR 137-003-0570(7) or (8).

(5) A contested case hearing on a fitness determination under this rule is closed to non-participants.

(6) After a hearing, the administrative law judge shall issue a proposed order. Exceptions, if any, are due not later than the 14th day after service of the proposed order. The proposed order must provide an address to which exceptions may be sent.

(7) A completed final fitness determination made under OAR 836-072-0015 constitutes a final order without a hearing as provided under OAR 137-003-0672.

(8) An applicant may not use the appeals process established by this rule to challenge the accuracy or completeness of information provided by the Oregon Department of State Police, the Federal Bureau of Investigation, or agencies reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation. To challenge the accuracy or completeness of any such information, an applicant may use any process made available by the agency that provided the information.

(9) If an applicant successfully challenges the accuracy or completeness of information provided by the Oregon Department of State Police, the Federal Bureau of Investigation, or an agency reporting information to the Oregon Department of State Police or the Federal Bureau of Investigation, the applicant may request that the Department conduct a new criminal records check and re-evaluate the original fitness determination made under OAR 836-072-0015 by submitting a new DCBS Criminal Records Request form.

(10) An appeal of a fitness determination under this rule, a challenge of criminal offender information with the agency that provided the information or a request for a new LEDS-based criminal history check or criminal records check and re-evaluation of the original fitness determination under section (9) of this rule does not delay or postpone a licensing decision by the Department unless the authorized designee decides that a delay or postponement should occur.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0040
Recordkeeping and Confidentiality

(1) An authorized designee must document in writing a preliminary or final fitness determination or the closing of a fitness determination due to incompleteness.

(2) All records that the Department receives from the Oregon Department of State Police resulting from a criminal records check, including but not limited to LEDS reports and state or federal criminal offender information originating with the Oregon Department of State Police or the Federal Bureau of Investigation, are confidential pursuant to ORS 181.534(15) and federal laws and regulations.

(3) Within the Department, only authorized designees may have access to records the Department receives from the Oregon Department of State Police resulting from a criminal records check.

(4) An authorized designee has access to records received from the Oregon Department of State Police in response to a criminal records check only if the authorized designee has a demonstrated and legitimate need to know the information contained in the records.

(5) An authorized designee must maintain and disclose records received from the Oregon Department of State Police resulting from a criminal records check in accordance with applicable requirements and restrictions in ORS chapter 181 and other applicable federal and state laws, rules adopted by the Oregon Department of State Police pursuant to ORS chapter 181 (see OAR chapter 257, division 15), OAR 836-072-0001 to 836-072-0045, federal regulations and any written agreement between the Department and the Oregon Department of State Police.

(6) If a fingerprint-based criminal records check was conducted with regard to an applicant, the Department shall permit the applicant to inspect the applicant's own state and federal criminal offender information, unless prohibited by federal law.

(7) If an applicant asks to inspect criminal offender information under section (6) of this rule requests, the Department shall provide the applicant with a copy of the applicant's own state and federal criminal offender information, unless prohibited by law. The Department shall require sufficient identification from the applicant to determine the applicant's identity before providing the criminal offender information to the applicant. The Department shall require that the applicant sign a receipt confirming the applicant's receipt of the criminal offender information, except that if the criminal offender information is provided through discovery under OAR 836-072-0035, the Department must keep a record of the information provided to the applicant.

(8) The Department shall treat all records received or created under OAR 836-072-0001 to 836-072-0045 that concern the criminal history of an applicant, other than records received from the Oregon Department of State Police, including DCBS Criminal Records Request forms and fingerprint cards, as confidential pursuant to ORS 181.534(15). Within the Department, only authorized designees may have access to the records. An authorized designee may have access to the records only if the authorized designee has a demonstrated and legitimate need to know the information contained in the records.

(9) Except as otherwise provided by law, an applicant shall have access to the records referred to in section (8) of this section pursuant to the terms of the Public Records Law, ORS 192.410 to 192.505.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

836-072-0045
Authorized Designees

(1) Authorized designees shall be employees holding positions within the Department that have been designated by the Director to include the responsibilities of an authorized designee.

(2) Appointment to a position designated under section (1) of this rule is contingent upon approval of the employee under the Department's nationwide criminal history check and fitness determination processes and any process required by the Department of Oregon State Police or Federal Bureau of Investigations rules, regulations or policies. An appointment under this section is at the Director's discretion.

(3) The Director and Deputy Director may also serve as authorized designees, contingent on being approved under the Department's nationwide criminal history check and fitness determination processes and any process required by Department of Oregon State Police or Federal Bureau of Investigation rules, regulations or policies.

(3) An authorized designee may not participate in a fitness determination or review any information associated with a fitness determination for an applicant if either of the following is true:

(a) The authorized designee is related to the applicant; or

(b) The authorized designee has a financial or close personal relationship with the applicant. If an authorized designee is uncertain whether a relationship with an applicant qualifies as a financial or close personal relationship under this subsection, the authorized designee must consult with the authorized designee's supervisor before taking any action that would violate this rule if such a relationship were determined to exist.

(4) When an authorized designee's employment in a designated position ends, the authorized designee's status as an authorized designee is automatically terminated.

(5) The Department shall suspend or terminate a Department employee's appointment to a designated position and suspend or terminate the employee's status as an authorized designee if:

(a) The employee fails to comply with OAR 836-072-0001 to 836-072-0045 in conducting criminal history checks and fitness determinations;

(b) The employee loses access to LEDS or criminal offender information received from the Department of Oregon State Police or the Federal Bureau of Investigation; or

(c) The employee is prohibited by section (3) of this rule.

(6) An authorized designee must immediately report to the authorized designee's supervisor if the authorized designee is arrested for or charged with, is being investigated for or has an outstanding warrant or pending indictment for a crime listed in OAR 836-072-0020. Failure to make the required report is grounds for termination of the applicant's appointment to a designated position and termination of status as an authorized designee.

(7) The Department must review and update an authorized designee's eligibility for service in a designated position and may require a new criminal history check and fitness determination:

(a) Every three years; or

(b) At any time the Department has reason to believe that the authorized designee has violated OAR 836-072-0001 to 836-072-0045, has committed a crime listed in OAR 836-072-0020, or is or may no longer be eligible to serve in the current position or as an authorized designee.

Stat. Auth.: ORS 181.534, 705.135, 731.244
Stats. Implemented: ORS 181.534, 705.141, 744.001, 744.059, 744.326
Hist.: ID 19-2008, f. & cert. ef 12-10-08

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Department of Consumer and Business Services, Workers' Compensation Division
Chapter 436

Rule Caption: Rules affecting the processing of workers' compensation claims and the payment of medical fees.
Adm. Order No.: WCD 5-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 11-1-2008
Rules Adopted: 436-009-0018, 436-009-0095, 436-015-0007, 436-060-0153
Rules Amended: 436-009-0005, 436-009-0008, 436-009-0020, 436-009-0022, 436-009-0030, 436-009-0035, 436-009-0040, 436-009-0070, 436-009-0080, 436-009-0090, 436-009-0100, 436-015-0120, 436-060-0005, 436-060-0009, 436-060-0010, 436-060-0015, 436-060-0017, 436-060-0018, 436-060-0020, 436-060-0025, 436-060-0035, 436-060-0060, 436-060-0105, 436-060-0135, 436-060-0137, 436-060-0147, 436-060-0150, 436-060-0155, 436-060-0500
Subject: Amendments to OAR 436-009, "Oregon Medical Fee and Payment Rules":

• A payer may not apply a provider network contractual discount, except for a managed care organization (MCO) discount, to fees paid to a medical service provider or clinic, or to a rural hospital that qualifies for the rural exemption, or to certain examinations or reviews ordered by the director. Otherwise, a payer may apply provider network contractual discounts to fees for medical services, including hospital, ambulatory surgical center, durable medical equipment, and pharmacy services.

• A payer may apply only one contractual discount to a payment, even if multiple contracts are in place.

• A payer must apply only the MCO discount to payment for services to a worker enrolled in the MCO, regardless of any other contracts in place.

• Medical service providers and insurers may enter into "fee discount agreements," using a form and procedures prescribed by the director. Discounts cannot exceed 10% of fee schedule maximums.

• With each payment or denied payment, the payer must give the medical provider written reasons for non-payment, reduced payment, or discounted payment for each medical service. The written explanation must also include a contact number for billing inquiries and a notice of appeal rights specified by rule.

• An insurer must respond to a medical provider's inquiries about a medical payment within 48 hours (excluding weekends and legal holidays).

• Insurers that violate rules regarding fee discounts may be subject to civil penalties.

Amendments to OAR 436-015, "Managed Care Organizations" (MCOs):

• MCOs have certain exclusive rights under ORS 656.260 to manage care.

• If a person or business other than an MCO engages in activities that may only be performed by an MCO, the director may impose a sanction or civil penalty against the person or business.

Amendments to OAR 436-060, "Claims Administration":

• The insurer must print the mailing address of the claim processing location on all forms it issues.

• The insurer must provide certain data on each Form 1502, to include the worker's legal name, social security number, insurer's claim number, date of injury, and the employer's legal name.

• The insurer must send an additional Form 1502 to the Workers' Compensation Division when first payment of temporary disability occurs after the insurer has filed a Form 1502.

• The insurer will be allowed 14 days, rather than 21 days, to respond to notice from the director that a complaint has been filed about the insurer's release of claim documents.

• The Hearings Division of the Workers' Compensation Board, not the Workers' Compensation Division, will resolve wage disputes.

• The insurer must send a copy to the worker's attending physician of any notice that the worker is engaging in behaviors that may imperil or retard recovery.

• The worker and the insurer must notify the Workers' Compensation Division when the worker, whose benefits have been suspended under OAR 436-060-0135, cooperates with the investigation.

• The insurer must pay fatal benefits no later then the 30th day after the insurer accepts the claim or the filing date of a litigation order that orders acceptance of the claim.

• Although insurers must provide a written explanation with each initial benefit payment, for permanent disability and fatal benefits the insurer is not required to provide an explanation with subsequent payments. However, the insurer must provide a written explanation to the worker or beneficiary if the benefit amount, time period covered, or payment schedule changes.

• The insurer may pay benefits by electronic methods if the worker agrees in writing and the insurer meets payment criteria prescribed by the rules.

• When an attorney requests payment of an attorney fee for prevailing in a case under ORS 656.262(11), the attorney must send to the director a retainer agreement, a statement of hours worked, and the requested fee amount.

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7514; or e-mail fred.h.bruyns@state.or.us. Rules are available on the Internet: http://www.wcd.oregon.gov/policy/rules/rules.html

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630
Rules Coordinator: Fred Bruyns—(503) 947-7717

436-009-0005
Definitions

(1) Unless a term is specifically defined elsewhere in these rules or the context otherwise requires, the definitions of ORS chapter 656 and OAR 436-010-0005 are hereby incorporated by reference and made part of these rules.

(2) "Clinic" means a group practice in which several medical service providers work cooperatively.

(3) "Fee Discount Agreement" means a direct contract entered into between a medical service provider or clinic and an insurer to discount fees to the medical service provider or clinic under OAR 436-009-0018.

(4) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS chapter 731 to transact workers' compensation insurance in the state; an assigned claims agent selected by the direc-

tor under ORS 656.054; or, an employer or employer group that has been certified under ORS 656.430 meeting the qualifications of a self-insured employer under ORS 656.407.

(5) "Provider network" means a health service intermediary other than an MCO that facilitates transactions between medical providers and insurers through a series of contractual arrangements.

(6) Abbreviations used in these rules are either defined in the rules in which they are used or defined as follows:

(a) ANSI means the American National Standards Institute.

(b) CMS means Centers for Medicare & Medicaid Services.

(c) CPT® means Current Procedural Terminology published by the American Medical Association.

(d) DME means durable medical equipment.

(e) DRG means diagnosis related group.

(f) EDI means electronic data interchange.

(g) HCPCS means Healthcare Common Procedure Coding System published by CMS.

(h) IAIABC means International Association of Industrial Accident Boards and Commissions.

(i) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3 by US Department of Health and Human Services.

(j) MCO means managed care organization certified by the director.

(k) NPI means National Provider Identifier.

(l) OSC means Oregon specific code.

(m) PCE means physical capacity evaluation.

(n) RBRVS means Medicare Resource-Based Relative Value Scale published by CMS.

(o) RVU means relative value unit.

(p) WCE means work capacity evaluation.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.726(4)

Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0008

Administrative Review Before the Director

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical services including treatment, medical fees and nonpayment of compensable medical bills. The director may, on the director's own motion, initiate a medical service review at any time. A party need not be represented to participate in the administrative review before the director.

(b) Any party may request the director provide voluntary alternative dispute resolution after a request for administrative review or hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, the director will put the agreement in writing; or the parties shall put any agreement in writing for approval by the director. If the dispute is not resolved through alternative dispute resolution, the director will issue an order.

(2) The medical provider, worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or nonpayment of bills for medical services on a compensable injury. The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all MCO enrolled claims where a party disagrees with an action or decision of the MCO, the aggrieved party shall first apply to the MCO for dispute resolution within 30 days pursuant to OAR 436-015-0110. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 30 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. Administrative review by the director must be requested within 60 days of issuance of the MCO's final decision under the MCO's dispute resolution process. If a party has been denied access to the MCO dispute process or the process has not been completed for reasons beyond a party's control, the party may request director review within 60 days of the failure of the MCO process. If the MCO does not have a process for resolving fee and billing disputes, the insurer shall advise the medical provider or worker that they may request review by the director.

(b) For all claims not enrolled in an MCO, or for disputes which do not involve an action or decision of the MCO, the aggrieved party must request administrative review by the director within 90 days of the date the party knew, or should have known, there was a dispute over the provision of medical services. Absent a showing of good cause, the date a medical provider should have known is the date the provider received payment or was notified the bill would not be paid. The date the insurer should have known is the date action on the bill was due under OAR 436-009-0030. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR chapter 438, division 005.

(c) An insurer may request a refund from a provider for any amount it determines was overpaid for a compensable medical service. The insurer must make the request within 180 days of the payment date. If the provider does not respond to the request, or disagrees that a service was overpaid, the insurer may request director review within 90 days of requesting the refund.

(d) Under ORS 656.704(3)(c), when there is a formal denial of the underlying condition or a denial of the causal relationship between the medical service and the accepted condition, the issue may first be decided by the Hearings Division of the Workers' Compensation Board.

(3) Parties must submit requests for administrative review to the director in the form and format prescribed by the director. When an insurer or the worker's representative submits a request without the required information, at the director's discretion the administrative review may not be initiated until the information is submitted. Unrepresented workers may contact the director for help in meeting the filing requirements. The requesting party must simultaneously notify all other interested parties of the dispute, and their representatives, if known, as follows:

(a) Identify the worker's name, date of injury, insurer, and claim number.

(b) Specify the issues in dispute and the relief sought.

(c) Provide the specific dates of the unpaid disputed treatment or services.

(d) If the request for review is submitted by either the insurer or medical provider, it shall state specific code(s) of service(s) in dispute and include sufficient documentation to support the review request, including but not limited to copies of original CMS bills, chart notes, bill analyses, operative reports, any correspondence between the parties regarding the dispute, and any other documentation necessary to evaluate the dispute. The insurer or medical provider requesting review shall certify that they have provided all involved parties a copy of:

(A) The request for review; and

(B) Any attached supporting documentation; and

(C) If known, an indication of whether or not there is an issue of causation or compensability of the underlying claim or condition.

(4) The division will investigate the matter upon which review was requested.

(a) The investigation may include, but not be limited to, request for and review of pertinent medical treatment and payment records, interviews with the parties to the dispute, or consultation with an appropriate committee of the medical provider's peers.

(b) Upon receipt of a written request for additional information, the party must respond within 14 days.

(c) A dispute may be resolved by agreement between the parties to the dispute. When the parties agree, the director may issue a letter of agreement in lieu of an administrative order, which will become final on the 10th day after the letter of agreement is issued unless the agreement specifies otherwise. Once the agreement becomes final, the director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) A party fails to honor the agreement;

(B) The agreement was based on misrepresentation;

(C) Implementation of the agreement is not feasible because of unforeseen circumstances; or

(D) All parties request revision or reinstatement.

(5) The director may on the director's own motion reconsider or withdraw any order that has not become final by operation of law. A party may also request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new information which could not reasonably have been discovered and produced during the review. The director may grant or deny a request for reconsideration at the director's sole discretion. A request must be mailed to the director before the administrative order becomes final.

(6) Hearings before an administrative law judge: Under ORS 656.704(2), any party that disagrees with an action or order of the director under these rules may request a hearing by filing a request for hearing as provided in OAR 436-001-0019 within 30 days of the mailing date of the order or notice of action. OAR 436-001 applies to the hearing.

(7) Contested case hearings of sanction and civil penalties: Under ORS 656.740, any party that disagrees with a proposed order or proposed

assessment of a civil penalty issued by the director under ORS 656.254, or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as described in OAR 436-010-0008(14).

(8) Director's administrative review of other actions: Any party seeking an action or decision by the director or aggrieved by an action taken by any other party, not covered under sections (1) through (7) of this rule, according to these rules, may request administrative review by the director as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within 90 days of the disputed action and must specify the grounds upon which the action is contested.

(b) The division may require and allow such input and information as it deems appropriate to complete the review.

Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented: ORS 656.704
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0901, 5-1-85 WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-89, (Former sections (3), (4), & (7) Renumbered to 436-010-0130); WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90;WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0110; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 7-2005, f. 10-20-05, cert. ef. 1-2-06; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0018
Fee Discount Agreements

(1) An insurer may only apply the following discounts to a medical service provider's or clinic's fee:

(a) A fee agreed to under a fee discount agreement that conforms to this rule and has been reported to the director; or

(b) A fee agreed to by the medical service provider or clinic under an MCO contract to cover services provided to a worker enrolled in the MCO.

(2) Any discount under a fee discount agreement cannot be more than 10 percent of the fee schedule.

(3) An insurer may not apply a discount under a fee discount agreement until the medical service provider or clinic and the insurer have signed the fee discount agreement. Parties to the fee discount agreement must use Form 440-3659. The form must be reproduced on the medical service provider's or clinic's letterhead. The agreement must include the following:

(a) A statement that the medical service provider or clinic understands and voluntarily agrees with the terms of the fee discount agreement;

(b) The effective and end dates of the agreement;

(c) The discount rate or rates under the agreement;

(d) A statement that the insurer or employer may not direct patients to the provider or clinic, and that the insurer or employer may not direct or manage the care a worker receives;

(e) A statement that the agreement only applies to patients being treated for Oregon workers' compensation claims;

(f) A statement that the fee discount agreement may not be amended. A new fee discount agreement must be executed to change the terms between the parties.

(g) A statement that either party may terminate the agreement by providing the other party with 30 days written notice;

(h) The name and address of the singular insurer or self-insured employer that will apply the discounts;

(i) The National Provider Identifier for the provider or clinic; and

(j) Other terms and conditions to which the medical service provider or clinic and the insurer agree and that are consistent with these rules.

(4) Once the fee discount agreement has been signed by the medical service provider or clinic and the insurer, the insurer must report the fee discount agreement to the director by completing the director's online form. The following information must be included:

(a) The insurer's name that will apply the discounts under the fee discount agreement;

(b) The medical service provider's or clinic's name;

(c) The effective date of the agreement;

(d) The end date of the agreement;

(e) The discount rate under the agreement and;

(f) An indication that all the terms required under section (3) of this rule are included in the signed fee discount agreement.

(5) When the medical service provider or clinic and the insurer agree to changes under an existing fee discount agreement, the parties must enter into a new fee discount agreement. Bulletin 352, dated December 18, 2008, provides further information on the required form.

(6) Either party to the fee discount agreement may terminate the agreement by providing 30 days written notice. The insurer must report the termination to the director prior to the termination taking effect by completing the director's online form. The following information must be reported:

(a) The insurer's name;

(b) The medical service provider's or clinic's name; and

(c) The termination date of the agreement.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0020
Hospital Fees

(1) Hospital inpatient charges billed to insurers must include ICD-9-CM diagnostic and procedural codes. Hospitals must include their NPI on all bills. For purposes of this rule, hospital inpatient services include, but are not limited to, those bills coded "111" through "118" in space #4 on the UB-04 billing form. The audited bill must be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers must include revenue codes, ICD-9-CM diagnostic and procedural codes, CPT® codes, HCPCS codes, and National Drug Codes (NDC), where applicable. Hospitals must include their NPI on all bills.

(3) Unless otherwise provided by contract, the insurer must pay for hospital inpatient services at the allowable payment amount as calculated by multiplying the hospital's adjusted cost/charge ratio by the amount billed (See Bulletin 290).

(4) The insurer must pay for hospital outpatient services as follows:

(a) Separate and pay charges for services by physicians and other medical service providers assigned a code under the CPT® and assigned a value in the RBRVS for physician fees as identified by the revenue codes indicating professional services. These charges must be subtracted from the total bill. All outpatient therapy services (physical therapy, occupational therapy, and speech language pathology) must be paid using the Physician work RVUs, Year 2008 transitional non-facility PE RVUs, and Malpractice RVUs columns.

(b) Unless otherwise provided by contract, the balance of the hospital total bill for outpatient services must be paid at the allowable payment amount as calculated by multiplying the hospital's adjusted cost/charge ratio by the amount billed (See Bulletin 290).

(c) Unless otherwise provided by contract, all other charges billed using both the hospital name and tax identification number must be paid at the allowable payment amount as calculated by multiplying the hospital's adjusted cost/charge ratio by the amount billed.

(5) If a hospital qualifies for a rural exemption under (6)(k), the insurer may only apply an MCO contract to discount the fees calculated under this rule.

(6) Each hospital's CMS 2552 form and financial statement shall be the basis for determining its adjusted cost/charge ratio. If a current form 2552 is not available, then financial statements may be used to develop estimated data. If the adjusted cost/charge ratio is determined from estimated data, the hospital will receive the lower ratio of either the hospital's last published cost/charge ratio or the hospital's cost/charge ratio based on estimated data.

(a) The basic cost/charge ratio shall be developed by dividing the total net expenses for allocation shown on Worksheet A, and as modified in subsection (b), by the total patient revenues from Worksheet G-2.

(b) The net expenses for allocation derived from Worksheet A shall be modified by adding, from Worksheet A-8, the expenses for:

(A) Provider-based physician adjustment;

(B) Patient expenses such as telephone, television, radio service, and other expenses determined by the department to be patient-related expenses; and

(C) Expenses identified as for physician recruitment.

(c) The basic cost/charge ratio shall be further modified to allow a factor for bad debt and the charity care provided by each hospital. The adjustment for bad debt and charity care is calculated in two steps. Step one: Add the dollar amount for net bad debt to the dollar amount for charity care. Divide this sum by the dollar amount of the total patient revenues, from Worksheet G-2, to compute the bad debt and charity ratio. Step two: Multiply the bad debt and charity ratio by the basic cost/charge ratio calculated in subsection (6)(a) to obtain the factor for bad debt and charity care.

(d) The basic cost/charge ratio shall be further modified to allow an adequate return on assets. The director will determine a historic real growth rate in the gross fixed assets of Oregon hospitals from the audited financial statements. This real growth rate and the projected growth in a national fixed weight price deflator will be added together to form a growth factor. This growth factor will be multiplied by the total fund balance, from Worksheet G of each hospital's CMS 2552 to produce a fund balance amount. The fund balance amount is then divided by the total patient revenues from Worksheet G-2, to compute the fund balance factor.

(e) The factors resulting from subsections (6)(c) and (6)(d) of this rule will be added to the ratio calculated in subsection (6)(a) of this rule to obtain the adjusted cost/charge ratio. In no event will the adjusted cost/charge ratio exceed 1.00.

(f) The adjusted cost/charge ratio for each hospital will be revised annually, at a time based on their fiscal year, as described by bulletin. Each hospital must submit a copy of their CMS 2552 and financial statements each year within 150 days of the end of their fiscal year to the Information Management Division, Department of Consumer and Business Services. The adjusted cost/charge ratio schedule will be published by bulletin twice yearly, effective for the six-month period beginning April 1 and the six-month period beginning October 1.

(g) For newly formed or established hospitals for which no CMS 2552 has been filed or for which there is insufficient data, or for those hospitals that do not file Worksheet G-2 with the submission of their CMS 2552, the division shall determine an adjusted cost/charge ratio for the hospital based upon the adjusted cost/charge ratios of a group of hospitals of similar size or geographic location.

(h) If the financial circumstances of a hospital unexpectedly or dramatically change, the division may revise the hospital's adjusted cost/charge ratio to allow equitable payment.

(i) If audit of a hospital's CMS 2552 by the CMS produces significantly different data from that obtained from the initial filing, the division may revise the hospital's adjusted cost/charge ratio to reflect the data developed subsequent to the initial calculation.

(j) Notwithstanding subsections (c) through (i) of this section the payment to out-of-state hospitals, may be negotiated between the insurer and the hospital.

(A) Any agreement for payment less than the billed amount must be in writing and signed by a hospital and insurer representative.

(B) The agreement must include language that the hospital will not bill the worker any remaining balance and that the negotiated amount is considered payment in full.

(C) If the insurer and the hospital are unable to reach agreement within 60 days of the insurer's receipt of the bill, either party may bring the issue to the director for resolution. The director may order payment up to the amount billed considering factors such as, but not limited to, reasonableness, usual fees for similar services by facilities in similar geographic areas, case specific services, and any extenuating circumstances.

(k) Notwithstanding sections (3) and (4) of this rule, the director may exclude rural hospitals from imposition of the adjusted cost/charge ratio based upon a determination of economic necessity. The rural hospital exclusion will be based on the financial health of the hospital reflected by its financial flexibility index, as originally developed by Dr. William Cleverley. All rural hospitals having a financial flexibility index at or below the median for hospitals nationwide with a bond rating of BBB+, BBB, or BBB- will qualify for the rural exemption. Rural hospitals that are designated as critical access hospitals under the Oregon Medicare Rural Hospital Flexibility Program are automatically exempt from imposition of the adjusted cost/charge ratio.

[ED. NOTE: Forms referenced are available from the agency.]
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4), also see 656.012, 656.236(5), 656.327(2) & 656.313(4)(d)
Stats. Implemented: ORS 656.248, 656.252, 656.256 & 1991 OL Ch. 771, Sec. 2
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0701, 5-1-85; WCD 3-1985(Admin)(Temp), f. & ef. 9-4-85; WCD 4-1985(Admin)(Temp), f. & ef. 9-11-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1986(Admin)(Temp), f. 2-5-86, ef. 2-6-86; WCD 2-1986(Admin), f. 3-10-86, ef. 3-17-86; WCD 2-1987(Admin), f. 2-20-87, ef. 3-16-87; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; WCD 2-1989, f. 8-21-89, cert. ef. 9-1-89; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 12-1990(Temp), f. 6-20-90, cert. ef. 7-1-90; WCD 15-1990, f. & cert. ef. 8-7-90; WCD 30-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 11-1992, f. 6-11-92, cert. ef. 7-1-92; WCD 13-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 18-1995(Temp), f. & cert. ef. 12-4-95; WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96, Renumbered from 436-010-0090; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1997, f. 4-21-97, cert. ef. 7-1-97; Administrative correction 6-18-97; WCD 8-1997(Temp), f. & cert. ef. 7-9-97; WCD 16-1997, f. & cert. ef. 12-15-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0022
Ambulatory Surgical Center Fees

(1) An ambulatory surgical center (ASC) is any distinct entity licensed by the state of Oregon, and operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

(a) Any ASC outside of Oregon must meet similar licensing requirements, or be certified by Medicare or a nationally recognized agency.

(b) Bills from an ASC shall be submitted on CMS 1500 form. The modifier "SG" shall be used to identify facility charges.

(2) Unless otherwise provided by contract, insurers must pay an ASC at the ASC's usual fee, or the amount set by the fee schedule, whichever is less.

(3) Payment shall be made using the Medicare ASC groups, except:

(a) Arthroscopies (CPT® codes 29819 through 29898 except 29888 and 29889) are paid as Group 6.

(b) Arthroscopies (CPT® codes 29888 and 29889) are paid as Group 7.

(c) Services not listed in the Medicare ASC groups 1 through 9 shall be paid at the provider's usual rate.

(4) The ASC fee schedule is:

Group 1 — $853.28
Group 2 — $1,143.88
Group 3 — $1,307.68
Group 4 — $1,616.75
Group 5 — $1,838.68
Group 6 — $2,108.00
Group 7 — $2,551.95
Group 8 — $2,485.78
Group 9 — $3,444.43

(5) The ASC fee includes services, such as:

(a) Nursing, technical, and related services;

(b) Use of the facility where the surgical procedure is performed;

(c) Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of the surgical procedure;

(d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

(e) Administrative, record-keeping, and housekeeping items and services;

(f) Materials for anesthesia;

(g) Supervision of the services of an anesthetist by the operating surgeon.

(6) The ASC fee does not include services, such as physicians' services, laboratory, x-ray or diagnostic procedures not directly related to the surgical procedure, prosthetic devices, orthotic devices, durable medical equipment (DME), or anesthetists' services. The insurer shall pay for prosthetic devices, orthotic devices, and DME as provided in OAR 436-009-0080.

(7) When multiple procedures are performed, the highest payment group shall be paid at 100% of the maximum allowed fee. Each additional procedure shall be paid at 50% of the maximum allowed fee.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248 & 656.252
Hist.: WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0030
Insurer's Duties and Responsibilities

(1) The insurer must pay for medical services related to a compensable injury claim, except as provided by OAR 436-060-0055.

(2) The insurer, or its designated agent, may request from the medical provider, any and all necessary records needed to review accuracy of billings. The medical provider may charge an appropriate fee for copying documents in accordance with OAR 436-009-0070(1). If the evaluation of the records must be conducted on-site, the provider must furnish a reasonable work-site for the records to be reviewed at no cost. These records must be provided or made available for review within 14 days of a request.

(3) Insurers must date stamp medical bills and reports upon receipt and pay bills for medical services on accepted claims within 45 days of receipt of the bill, if the billing is submitted in proper form in accordance with OAR 436-009-0010(2) through (4) and clearly shows that the treatment is related to the accepted compensable injury or disease. Billings not submitted in the proper form must be returned to the medical provider within 20 days of receipt of the bill with a written explanation describing why

the bill was not paid or what needs to be corrected. A request for chart notes on EDI billings must be made to the medical provider within 20 days of receipt of the bill. The number of days between the date the insurer returns the billing or requests for chart notes from the provider and the date the insurer receives the corrected billing or chart notes, shall not apply toward the 45 days within which the insurer is required to make payment.

(a) The insurer must retain a copy of each medical provider's bill received by the insurer or must be able to reproduce upon request data relevant to the bill, including but not limited to, provider name, date of service, date the insurer received the bill, type of service, billed amount, coding submitted by the medical provider as described in OAR 436-009-0010(2), and insurer action, for any non-payment or fee reduction. This includes all bills submitted to the insurer even when the insurer determines no payment is due.

(b) Any service billed with a code number commanding a higher fee than the services provided shall be returned to the medical provider for correction or paid at the value of the service provided.

(c) When a medical provider submits a bill electronically, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) With each payment or denied payment, the insurer or its representative must provide the medical provider a written explanation of the specific reason(s) for non-payment, reduced payment, or discounted payment for each service billed by the medical provider. The written explanation must also include:

(a) An Oregon or toll-free contact phone number for the insurer for billing inquiries from medical providers;

(b) A notice of right to administrative review as follows: "If you disagree with this decision about this payment, you may request administrative review by the Director of the Department of Consumer and Business Services. Your request for review must be made within 90 days of receipt of this explanation. To request review, sign and date this document in the space provided, indicate which decisions you disagree with, and mail this document to the Workers' Compensation Division, Medical Section/ Resolution Team, PO Box 14480, Salem, OR 97309-0405. Or you may fax the request to the director at 503-934-6050. You must also send a copy of the request to the insurer. You should keep a copy of this document for your records."

(c) Space for the medical provider's signature and the date.

(5) An insurer must answer a medical provider's inquiry about a medical payment within 48 hours, not including weekends or legal holidays, of the medical provider's inquiry.

(6) Payment of medical bills is required within 14 days of any action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later.

(7) Failure to pay for medical services timely may render the insurer liable to pay a reasonable monthly service charge for the period payment was delayed, if the provider customarily levies such a service charge to the general public.

(8) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer must, within 45 days, pay the undisputed portion of the bill and at the same time provide specific reasons for non-payment or reduction of each medical service code. Resolution of billing disputes, including possible overpayment disputes, must be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(9) Bills for medical services rendered at the request of the insurer and bills for information submitted at the request of the insurer, which are in addition to those required in OAR 436-010-0240 must be paid for within 45 days of receipt by the insurer even if the claim is denied.

(10) The insurer must establish an audit program for bills for all medical services to determine that the bill reflects the services provided, that appropriate prescriptions and treatment plans are completed in a timely manner, that payments do not exceed the maximum fees adopted by the director, and that bills are submitted in a timely manner. The audit shall be continuous and shall include no fewer than 10 percent of medical bills. The insurer must provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation must include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(11) The insurer must pay a medical provider for any bill related to the claimed condition received by the insurer on or before the date the terms of a disputed claim settlement (DCS) were agreed on, but was either not listed in the approved DCS or was not paid to the medical provider as set forth in the approved DCS. Payment must be made by the insurer as prescribed by ORS 656.313(4)(d) and OAR 438-009-0010(2)(g) as if the bill had been listed in the approved settlement or as set forth in the approved DCS, except if the DCS payments have already been made, the payment must not be deducted from the settlement proceeds. Payment must be made within 45 days of the insurer's knowledge of the outstanding bill.

(12) Insurers that had at least 100 accepted disabling claims in the previous calendar year, as determined by the director, are required to submit detailed medical bill payment data to the Information Management Division of the Department of Consumer and Business Services at 350 Winter St NE, Room 300, PO Box 14480, Salem OR 97309-0405. Once an insurer has reached the minimum number of accepted disabling claims, they must continue to report in subsequent years unless there is a significant decrease below the 100 claim minimum which is expected to continue. The director will notify the affected insurers when they reach the minimum. If the insurer drops below the 100 disabling claim level or encounters other significant hardships, the insurer may apply to the director for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The transmission data and format requirements are included in Appendix A of these rules and Appendix B of OAR 436-160. OAR 436-160 explains the IAIABC ANSI 837 medical bill reporting requirements. To determine which appendix applies to required reporting insurers, see below.

(b) Each insurer must continue to report according to Appendix A until successfully completing IAIABC ANSI 837 testing under OAR 436-160. Once successfully completing testing, the insurer may only report via IAIABC ANSI 837.

(c) Group 1 is all required reporting insurers who are currently reporting data via IAIABC ANSI 837 in another jurisdiction. Each insurer in Group 1 must begin testing on July 1, 2008.

(d) Group 2 is the State Accident Insurance Fund Corporation. Group 2 must begin testing on April 1, 2009.

(e) Group 3 is all other required reporting insurers. Each insurer in Group 3 must begin testing on October 1, 2009.

(13) An insurer may request, in writing, additional time to report the requested data elements according to OAR 436-160. The insurer must demonstrate that the date to begin testing creates an undue hardship. The request must include a plan to begin testing within 12 months of the group's testing date, and may not extend beyond January 1, 2010.

(14) Undue hardship is demonstrated by providing the total required expenses to begin testing; the reporting cost per bill if transmitted directly by the insurer; and the total cost per bill if reported by a vendor.

(15) If the director allows additional time, the insurer must continue to report all medical billing data under Appendix A during the testing.

(16) The director may audit an insurer's actual payments reported for individual claims. An insurer is subject to a civil penalty if an audit determines that the insurer's error rate is 15 percent or higher in any field.

[ED. NOTE: Appendix referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260 & 656.264

Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1997, f. 4-21-97, cert. ef. 7-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0035

Interim Medical Benefits

(1) Interim medical benefits are not due on claims:

(a) When the worker is enrolled in an MCO prior to claim acceptance pursuant to ORS 656.245(4)(b)(B).

(b) When the insurer denies the claim within 14 days of the employer's notice.

(c) With dates of injury prior to January 1, 2002.

(2) Interim medical benefits include:

(a) Diagnostic services required to identify appropriate treatment or prevent disability.

(b) Medication required to alleviate pain.

(c) Services required to stabilize the worker's claimed condition and to prevent further disability. Examples of such services may include, but are not limited to: antibiotic or anti-inflammatory medication; physical therapy and other conservative therapies; and necessary surgical procedures.

(3) If the medical service provider has knowledge that the worker filed a work related claim, the medical service provider shall not collect health benefit plan co-payment from the worker.

(4) The medical service provider shall submit a copy of the bill to the workers' compensation insurer in accordance with OAR 436-009-0010, and the health benefit plan(s) in accordance with the plan's requirements.

(5) The insurer shall notify the medical service provider when an initial claim is denied.

(6) When the claim is denied, the medical service provider shall first bill the health benefit plan(s) with a copy of the workers' compensation denial letter.

(7) After payment is received from the health benefit plan(s), the medical service provider may bill the workers' compensation insurer, according to OAR 436-009-0010, for any remaining balance. The provider shall include a copy of the health benefit plan(s)' explanation of benefits with the bill. If the worker has no health benefit plan, the workers' compensation insurer is not required to pay for interim medical benefits.

(8) The workers' compensation insurer shall pay in accordance with the Oregon fee rules, any amount not reimbursed by the health benefit plan within 45 days of receipt of the bill with the health plan's explanation of benefits, in accordance with OAR 436-009-0030(8).

Stat. Auth.: ORS 656.245, 656.704, 656.726(4)
Stats. Implemented: ORS 656.247
Hist.: WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0040
Calculating Medical Provider Fees

(1) Insurers must pay for medical services at the provider's usual fee or according to the fee schedule, whichever is less, unless otherwise provided by contract or fee discount agreement permitted by these rules.

(2) If a billed service is not covered by a contract permitted by these rules or the fee schedule, then the insurer must pay for the medical services at the provider's usual fee. When there is no maximum payment established by the fee schedule, an insurer may challenge the reasonableness of a provider's billing on a case by case basis by asking the director to review the billing under OAR 436-009-0008. If the director determines the amount billed is unreasonable, the director may establish a different fee to be paid to the provider based on at least one of, but not limited to, the following: reasonableness, the usual fees of similar providers, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances.

(3)(a) When using RBRVS, the total RVU is determined by reference to the appropriate CPT® code and by adding the values of the Physician work RVU, Year 2008 transitional non-facility PE RVU or Year 2008 transitional facility PE RVU, and Malpractice RVU. The PE RVU is determined by the location where the procedure is performed: If the procedure is performed inside the medical service provider's office, use Year 2008 transitional non-facility PE RVUs column; if the procedure is performed outside the medical service provider's office, use Year 2008 transitional facility PE RVUs column. Use the global column to identify the follow up days when applicable. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the Physician work RVUs, Year 2008 transitional non-facility PE RVUs, and Malpractice RVUs columns.

(b) When an Oregon Specific Code is assigned, the RVU for multidisciplinary program services is found in OAR 436-009-0060(5), or for other services in 436-009-0070(13).

(c) When using the American Society of Anesthesiologists Relative Value Guide, a basic unit value is determined by reference to the appropriate Anesthesia code. The anesthesia value includes the basic unit value, time units, and modifying units.

(4) Payment according to the fee schedule must be determined by multiplying the assigned RVU or basic unit value by the applicable conversion factor. Where the code is designated by an RVU of "0.00" or IC (individual consideration) for Anesthesia codes, the insurer must pay at the provider's usual rate.

(5) The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical providers.

Service Categories, Conversion Factors
Evaluation / Management, $64.79
Anesthesiology, $53.45
Surgery, $86.44
Radiology, $68.00
Lab & Pathology, $60.00
Medicine, $75.04
Physical Medicine and Rehabilitation, $65.79
Multidisciplinary and Other Oregon-Specific Codes, $60.00
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0070
Oregon Specific Code, Other Services

(1) Except for records required in OAR 436-009-0010(3), copies of requested medical records shall be paid under OSC-R0001.

(2) A brief narrative by the attending physician or authorized nurse practitioner, including a summary of treatment to date and current status, and, if requested, brief answers to one to five specific questions related to the attending physician's or authorized nurse practitioner's current or proposed treatment, shall be paid under OSC-N0001.

(3) A complex narrative by the attending physician or authorized nurse practitioner, may include past history, history of present illness, attending physician's or authorized nurse practitioner's treatment to date, current status, impairment, prognosis, and medically stationary information, shall be paid under OSC-N0002.

(4) Fees for a PCE and a WCE shall be based upon the type of evaluation requested. The description of each level of evaluation and the maximum allowable payment shall be as follows:

(a) FIRST LEVEL PCE: This is a limited evaluation primarily to measure musculoskeletal components of a specific body part. These components include such tests as active range of motion, motor power using the 5/5 scale, and sensation. This level requires not less than 45 minutes of actual patient contact. A first level PCE shall be paid under OSC-99196 which includes the evaluation and report. Additional 15-minute increments may be added if multiple body parts are reviewed and time exceeds 45 minutes. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(b) SECOND LEVEL PCE: This is a PCE to measure general residual functional capacity to perform work or provide other general evaluation information, including musculoskeletal evaluation. It may be used to establish Residual Functional Capacities for claim closure. This level requires not less than two hours of actual patient contact. The second level PCE shall be paid under OSC-99197 which includes the evaluation and report. Additional 15 minute increments may be added to measure additional body parts, to establish endurance and to project tolerances. Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report.

(c) WCE: This is a residual functional capacity evaluation which requires not less than 4 hours of actual patient contact. The evaluation may include a musculoskeletal evaluation for a single body part. A WCE shall be paid under OSC-99198 which includes the evaluation and report. Additional 15 minute increments (per additional body part) may be added to determine endurance (e.g. cardiovascular) or to project tolerances (e.g., repetitive motion). Each additional 15 minutes shall be paid under OSC-99193 which includes the evaluation and report. Special emphasis should be given to:

(A) The ability to perform essential physical functions of the job based on a specific job analysis as related to the accepted condition;

(B) The ability to sustain activity over time; and

(C) The reliability of the evaluation findings.

(5) When an attorney requires a consultation with a medical provider, the medical provider shall bill under OSC-D0001.

(6) When an insurer requires a consultation with a medical provider, the medical provider shall bill under OSC-D0030.

(7) The fee for a deposition shall be billed under OSC-D0002. This code should include time for preparation, travel and deposition. Upon request of one of the parties, the director may limit payment of the provider's hourly rate to a fee charged by similar providers.

(8) When an insurer obtains an Independent Medical Examination (IME):

(a) The medical service provider doing the IME shall bill under OSC-D0003. This code shall be used for a report, file review or examination;

(b) If the insurer asks the medical service provider to review the IME report and respond, the medical service provider shall bill for the time spent reviewing and responding using OSC-D0019. Billing should include documentation of time spent.

(9) The fee for interpretive services shall be billed under OSC-D0004.

(10) Fees for all arbiters and panel of arbiters used for director reviews pursuant to OAR 436-030-0165 shall be established by the director. This fee determination will be based on the complexity of the examination, the report requirements and the extent of the record review. The level of each category is determined by the director based on the individual

complexities of each case as compared to the universe of claims in the medical arbiter process. When the examination is scheduled, the director shall notify the medical arbiter and the parties of the authorized fee for that medical arbiter review based on a combination of separate components.

(a) Level 1 OSC-AR001 Exam; Level 2 OSC-AR002 Exam; Level 3 OSC-AR003 Exam; Limited OSC-AR004 Exam As determined by the director, a level 1 exam generally involves a basic medical exam with no complicating factors. A level 2 exam generally involves a moderately complex exam and may have complicating factors. A level 3 exam generally involves a very complex exam and may have several complicating factors. A limited exam generally involves a newly accepted condition, or some other partial exam.

(b) Level 1 OSC-AR011 Report; Level 2 OSC-AR012 Report Level 3 OSC-AR013 Report As determined by the director, a level 1 report generally includes standard questions. A level 2 report generally includes questions regarding complicating factors. A level 3 report generally includes questions regarding multiple complicating factors.

(c) Level 1 OSC-AR021 File Review; Level 2 OSC-AR022 File Review; Level 3 OSC-AR023 File Review; Level 4 OSC-AR024 File Review; Level 5 OSC-AR025 File Review As determined by the director, a level 1 file review generally includes review of a limited record. A level 2 file review generally includes review of an average record. A level 3 file review generally includes review of a large record or disability evaluation without an exam. A level 4 file review generally includes an extensive record. A level 5 file review generally includes an extensive record with unique factors.

(d) The director will notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review. If a worker fails to appear for a medical arbiter examination without giving each medical arbiter at least 48 hours notice, each medical arbiter shall be paid at 50 percent of the examination or testing fee. A medical arbiter must also be paid for any file review completed prior to cancellation.

(e) If the director determines that a supplemental medical arbiter report is necessary to clarify information or address additional issues, an additional report fee may be established. The fee is based on the complexity of the supplemental report as determined by the director. The additional fees are established as follows:

Limited OSC-AR031
Complex OSC-AR032

(f) Prior to completion of the reconsideration process, the medical arbiter may request the director to redetermine the authorized fee by providing the director with rationale explaining why the physician believes the fee should be different than authorized.

(g) The director may authorize testing which shall be paid according to OAR 436-009.

(h) Should an advance of costs be necessary for the worker to attend a medical arbiter exam, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(11) A single physician selected under ORS 656.327 or 656.260, to review treatment, perform reasonable and appropriate tests, or examine the worker, and submit a report to the director shall be paid at an hourly rate up to a maximum of 4 hours for record review and examination.

(a) The physician will be paid for preparation and submission of the report. Billings for services by a single physician shall be billed under OSC-P0001 for the examination and under OSC-P0003 for the report.

(b) Physicians selected under OAR 436-010-0008, to serve on a panel of physicians shall each receive payment based on an hourly rate up to a maximum of 4 hours for record review and panel examination. Each physician shall bill for the record review and panel examination under OSC-P0002. The panel member who prepares and submits the panel report shall receive an additional payment under OSC-P0003.

(c) The director may in a complex case requiring extensive review by a physician pre-authorize an additional fee. Complex case review shall be billed under OSC-P0004.

(d) An insurer may not discount or reduce fees related to examinations or reviews performed by medical providers under OAR 436-010-0330.

(e) If a worker fails to appear for a director required examination without providing the physician with at least 48 hours notice, each physician shall bill under OSC-P0005. The insurer must pay the physician for the appointment time and any time spent reviewing the record completed prior to the examination time. The billing must document the physician's time spent reviewing the record.

(f) Should an advance of costs be necessary for the worker to attend an exam under ORS 656.327 or 656.260, a request for advancement shall be made in sufficient time to ensure a timely appearance. After receiving a request, the insurer must advance the costs in a manner sufficient to enable the worker to appear on time for the exam. If the insurer believes the request is unreasonable, the insurer shall contact the director in writing. If the director agrees the request is unreasonable, the insurer may decline to advance the costs. Otherwise, the advance must be made timely as required in this subsection.

(12) The fee for a Worker Requested Medical Examination shall be billed under OSC-W0001. This code shall be used for a report, file review, or examination.

(13) The table below lists the Oregon Specific Codes for Other Services. [Table not included. See ED. NOTE.]

[ED. NOTE: Table referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0080
Durable Medical Equipment and Medical Supplies

(1) Durable medical equipment (DME) is equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, could normally be rented and used by successive patients, is appropriate for use in the home, and not generally useful to a person in the absence of an illness or injury. For example: Transcutaneous Electrical Nerve Stimulation (TENS), MicroCurrent Electrical Nerve Stimulation (MENS), home traction devices, heating pads, reusable hot/cold packs, etc. Unless otherwise provided by contract, fees for durable medical equipment shall be paid as follows:

(a) The insurer shall pay for the purchase of all compensable DME that are ordered and approved by the physician, at 85% of the manufacturer's suggested retail price (MSRP). If no MSRP is available or the provider can demonstrate that 85% of the MSRP is less than 140% of the actual cost to the provider, the insurer shall pay the provider 140% of the actual cost to the provider for the item as documented on a receipt of sale.

(b) The DME provider is entitled to payment for any labor and reasonable expenses directly related to any subsequent modifications other than those performed at the time of purchase, or repairs. A subsequent modification is one done other than as a part of the initial set-up at the time of purchase. The insurer shall pay for labor at the provider's usual rate.

(c) The provider may offer a service agreement at an additional cost.

(d) Rental of all compensable DME shall be billed at the provider's usual rate. Within 90 days of the beginning of the rental, the insurer may purchase the DME or device at the fee provided in this rule, with a credit for rental paid up to 2 months.

(2) A prosthetic is an artificial substitute for a missing body part or any device aiding performance of a natural function. For example: hearing aids, eye glasses, crutches, wheelchairs, scooters, artificial limbs, etc. Unless otherwise provided by contract, the insurer shall pay the fee for a prosthetic at the provider's usual rate.

(a) Testing for hearing aids must be done by a licensed audiologist or an otolaryngologist.

(b) Based on current technology, the preferred types of hearing aids for most workers are programmable BTE, ITE, and CIC multi channel. Any other types of hearing aids needed for medical conditions will be considered based on justification from the attending physician or authorized nurse practitioner.

(c) Without approval from the insurer or director, hearing aids should not exceed $5000 for a pair of hearing aids, or $2500 for a single hearing aid.

(3) An orthosis is an orthopedic appliance or apparatus used to support, align, prevent or correct deformities, or to improve the function of a moveable body part. For example: brace, splint, shoe insert or modification, etc. Unless otherwise provided by contract, the insurer shall pay the fee for an orthosis at the provider's usual rate.

(4) Medical supplies are materials that may be reused multiple times by the same person, but a single supply is not intended to be used by more than one person, including, but not limited to incontinent pads, catheters,

bandages, elastic stockings, irrigating kits, sheets, and bags. Unless otherwise provided by contract, the insurer shall pay the fees for medical supplies at the provider's usual rate.

(5) The worker may select the service provider, except for claims enrolled in a managed care organization (MCO) where service providers are specified by the MCO contract.

(6) Except as provided in subsection (2)(c) of this rule, this rule does not apply to a worker's direct purchase of DME and medical supplies, and does not limit a worker's right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(7) DME, medical supplies and other devices dispensed by a hospital (inpatient or outpatient) shall be billed and paid according to OAR 436-009-0020.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-04; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 2-2007, f. 5-23-07, cert. ef. 7-1-07; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0090
Pharmacy Fees

(1) Except for in-patient hospital charges or unless otherwise provided by contract, insurers must pay medical providers for prescription medication at the medical provider's usual fee, or the amount set by the fee schedule, whichever is less.

(a) "AWP" means the Average Wholesale Price effective on the day the drug was dispensed.

(b) The maximum allowable fee is calculated according to the following table: [Table not included. See ED. NOTE.]

(2) All prescription medications are required medical services and do not require prior approval under the palliative care provisions of OAR 436-010-0290.

(3) Under ORS 689.515(2) licensed providers may dispense generic drugs to injured workers.

(4) Payment for Oxycontin, and COX-2 inhibitors is limited to an initial five-day supply unless the prescribing medical service provider writes a clinical justification for prescribing that drug rather than a less costly drug with a similar therapeutic effect.

(a) The clinical justification may accompany the prescription and be submitted by the pharmacist or may be given directly to the insurer by the medical provider.

(b) Clinical justification means a written document from the medical service provider stating the reason he or she believes the drug ordered is the one the patient should have. The justification may be included on the prescription itself and may simply be a brief statement. Insurers and self-insured employers cannot challenge the adequacy of the clinical justification. However, they can challenge whether or not the medication is excessive, inappropriate, or ineffectual in accordance with ORS 656.327.

(c) An additional clinical justification is not necessary for refills of that medication.

(5) Insurers shall use the prescription pricing guide published by First DataBank Inc, Thomson Healthcare, Inc., or Facts & Comparisons (a Wolters Kluwer Health, Inc., Company) for calculating payments to the licensed provider. Insurers must update their source at least monthly.

(6) The worker may select the pharmacy, except for claims enrolled in a managed care organization (MCO) where pharmacy service providers are specified by the MCO contract.

(7) Except for sections 2, 3, 4 and 6 of this rule, this rule does not apply to a worker's direct purchase of prescription medications, and does not limit a worker's right to reimbursement for actual out-of-pocket expenses under OAR 436-009-0025.

(8) The insurer shall pay the retail-based fee for over-the-counter medications.

(9) Drugs dispensed by a hospital (inpatient or outpatient) shall be billed and paid according to OAR 436-009-0020.

[ED. NOTE: Table referenced are available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2001, f. 3-8-01, cert. ef. 4-1-01; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04; WCD 2-2005, f. 3-24-05, cert. ef. 4-1-05; WCD 3-2006, f. 3-14-06, cert. ef. 4-1-06; WCD 1-2008, f. 6-13-08, cert. ef. 7-1-08; WCD 3-2008(Temp), f. & cert. ef. 7-7-08 thru 1-2-09; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0095
Application of Fee Discounts

If a medical fee is covered by multiple contracts allowed under these rules, the insurer may apply only one discount to the provider's fee. If a provider's fee is covered by multiple contracts, and one of the contracts is with a certified managed care organization for services provided to an enrolled worker, only the discount under the managed care organization's contract must be applied.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-009-0100
Sanctions and Civil Penalties

(1) The director may impose sanctions upon a medical provider or insurer for violation of OAR 436-009 in accordance with OAR 436-010-0340.

(2) If an insurer applies a contract or fee discount agreement to a provider's bill that is incorrect, the insurer must pay the provider's bill at the provider's usual fee or according to the fee schedule, whichever is less, and the insurer may be subject to a civil penalty

(3) Although insurers may contract with provider networks for certain services, the insurer is responsible for their own actions as well as the actions of others acting on the insurer's behalf. If an insurer or someone acting on the insurer's behalf violates any provisions of these rules, the director may impose a civil penalty against the insurer.

(4) If the director finds a pattern and practice, or an egregious violation of applying incorrect discounts to providers' fees under these rules, by an insurer or someone acting on the insurer's behalf, the director may issue a civil penalty up to the amount allowed under ORS Chapter 656.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.245, 656.254 & 656.745
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 20-1996, f. 10-2-96, cert. ef. 1-1-97; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 9-1999, f. 5-27-99, cert. ef. 7-1-99; WCD 2-2000, f. 3-15-00, cert. ef. 4-1-00; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-015-0007
Entities Allowed to Manage Care

Only an MCO may provide managed care services as described in ORS 656.260(4)(d) and under these rules, except as allowed under 436-015-0009. An insurer or someone acting on behalf of an insurer may not manage the care of non-MCO enrolled workers by limiting choice of medical providers, except as allowed under ORS chapter 656, or by requiring medical providers to abide by specific treatment standards, treatment guidelines, and treatment protocols.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-015-0120
Sanctions and Civil Penalties

(1) If the director finds any violation of OAR 436-015, or if the MCO fails to meet any of the requirements of the certified plan, the director may impose one or more of the following sanctions against any MCO:

(a) Reprimand by the director;

(b) Civil penalty as provided under ORS 656.745(2) and (3). All penalties collected under this section shall be paid into the Department of Consumer and Business Services Fund. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker, insurer, or medical provider;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violation.

(c) Suspension or revocation of the MCO's certification pursuant to OAR 436-015-0080.

(2) If the director determines that an insurer has entered into a contract with an MCO which violates OAR 436-015 or the MCO's certified plan, the insurer shall be subject to civil penalties as provided in ORS 656.745.

(3) If an insurer or someone who is not a certified MCO acting on the insurer's behalf engages in managed care activities prohibited under these rules, the director may impose a sanction or civil penalty.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260
Hist.: WCD 11-1990(Temp), f. 6-19-90, cert. ef. 7-1-90; WCD 33-1990, f. 12-12-90, cert. ef. 12-26-90; WCD 4-1991, f. & cert. ef. 6-14-91; WCD 2-1992, f. 1-10-92, cert. ef. 2-1-92; WCD 14-1994, f. 12-20-94, cert. ef. 2-1-95; WCD 13-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 12-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-2002, f. 2-25-02 cert. ef. 4-1-02; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0005
Definitions

For the purpose of these rules unless the context requires otherwise:

(1) "Aggravation" means an actual worsening of the compensable condition(s) after the last award or arrangement of compensation, which is established by medical evidence supported by objective findings, and otherwise satisfies the statutory requirements of ORS 656.273.

(2) "Authorized nurse practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 and OAR 436-010.

(3) "Designated Paying Agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury under ORS 656.307.

(4) "Director" means the Director of the Department of Consumer and Business Services or the director's designee for the matter, unless the context requires otherwise.

(5) "Disposition" or "claim disposition" means the written agreement as provided in ORS 656.236 in which a claimant agrees to release rights, or agrees to release an insurer or self-insured employer from obligations, under ORS 656.001 to 656.794, except for medical services, in an accepted claim. The term "compromise and release" has the same meaning.

(6) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(7) "Employer" means a subject employer as defined in ORS 656.023.

(8) "Employment on call" means sporadic, unscheduled employment at the call of an employer without recourse if the worker is unavailable.

(9) "Health insurance," as defined under ORS 731.162, means all insurance against bodily injury, illness or disability, and the resultant expenses, except for workers' compensation coverage.

(10) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(11) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon; or, an employer or employer group which has been certified under ORS 656.430 that it meets the qualifications of a self-insured employer under ORS 656.407.

(12) "Lump sum" means the payment of all or any part of a permanent partial disability award in one payment.

(13) "Physical rehabilitation program" means any services provided to an injured worker to prevent the injury from causing continuing disability.

(14) "Suspension of compensation" means:

(a) No temporary disability, permanent total disability or medical and related service benefits shall accrue or be payable during the period of suspension; and

(b) Vocational assistance and payment of permanent partial disability benefits shall be stayed during the period of suspension.

(15) "Third party administrator" is the contracted agent for an insurer, as defined by these rules, authorized to process claims and make payment of compensation on behalf of the insurer.

(16) "Written" and its variations mean that which is expressed in writing, including electronic transmission.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0005, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-922; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0009
Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

(1) Under ORS 192.430 and OAR 440-005-0015(1) the director, as custodian of public records, promulgates this rule to protect the integrity of claim file records and prevent interference with the regular discharge of the department's duties.

(2) The department rules on Access of Public Records, Fees for Record Search and Copies of Public Records are found in OAR 440-005. Payment of fees for access to records must be made in advance unless the director determines otherwise. Workers and insurers of record, their legal representatives and third-party administrators shall receive a first copy of any document free. Additional copies shall be provided at the rates set forth in OAR 440-005.

(3) Any person has a right to inspect nonexempt public records. The statutory right to "inspect" encompasses a right to examine original records. It does not include a right to request blind searches for records not known to exist. The director will retain or destroy records according to retention schedules published by the Secretary of State, Archives Division.

(4) Under ORS 192.502(20) workers' compensation claims records are exempt from public disclosure. Access to workers' compensation claims records will be granted at the sole discretion of the director in accordance with this rule, under the following circumstances:

(a) When necessary for insurers, self-insured employers and third-party claims administrators and their legal representatives for the sole purpose of processing workers' compensation claims. A request by telephone or facsimile transmission will be accepted, but requires provision of the claimant's social security number and insurer claim number in addition to the information required in section (7).

(b) When necessary for the director, other governmental agencies of this state or the United States to carry out their duties, functions or powers.

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim. Such circumstances include when workers' compensation claims file information is required by a public or private research organization in order to contact injured workers in order to conduct its research. The director may enter into such agreements with such institutions or persons as are necessary to secure the confidentiality of the disclosed records.

(d) When a worker or the worker's representative requests review of the workers' claim record.

(5) The director may release workers' compensation claims records to persons other than those described in section (4) when the director determines such release is in the public interest.

(a) For the purpose of these rules, a "public interest" exists when the conditions set forth in ORS 192.502(20) and subsections (4)(a) through (d) of this rule have been met. The determination whether the request to release workers' compensation claims records meets those conditions shall be at the sole discretion of the director.

(b) The director may enter into written agreements as necessary to ensure that the recipient of workers' compensation claims records under this section uses or provides the information to others only in accordance with these rules and the agreement with the director. The director may terminate such agreements at any time the director determines that one or more of the conditions of the agreement have been violated.

(6) The director may deny or revoke access to workers' compensation claims records at any time the director determines such access is no longer in the public interest or is being used in a manner which violates these rules or any law of the State of Oregon or the United States.

(7) Requests to inspect or obtain copies of workers' compensation claim records must be made in writing or in person and must include:

(a) The name, address and telephone number of the requester;

(b) The reason for requesting the records;

(c) A specific identification of the public record(s) required and the format in which they are required;

(d) The number of copies required;

(e) The account number of the requester, when applicable.

(8) Except as prescribed in subsections (4)(a) through (d), a person must submit to the division an attorney retainer agreement or release signed by the claimant in order to inspect or obtain copies of workers' compensation claims records. The director may refuse to honor any release which the director determines is likely to result in disclosed records being used in a manner contrary to these rules. Upon request, the director will review proposed release forms to determine whether the proposed release is consistent with the law and this rule.

Stat. Auth.: ORS 192.502, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.704 & 656.726(4)
Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0010
Reporting Requirements

(1) A subject employer must accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative. The employer must provide a copy of the "Report of Job Injury or Illness," Form 440-801 (Form 801) to the worker immediately upon request; the form must be readily available for workers to report their injuries. Proper use of this form satisfies ORS 656.265.

(2) A "First Medical Report," Form 440-827 (Form 827), signed by the worker, is written notice of an accident, which may involve a compensable injury under ORS 656.265. The signed Form 827 shall start the claim process, but shall not relieve the worker or employer of the responsibility of filing a Form 801. If a worker reports a claim electronically, the insurer may require the worker to sign a medical release form, so the insurer can obtain medical records, under OAR 436-010-0240, necessary to process the claim.

(3) Employers, except self-insured employers, must report the claim to their insurers no later than five days after notice or knowledge of any claim or accident, which may result in a compensable injury. The employer's knowledge date is the earliest of the date the employer (any supervisor or manager) first knew of a claim, or of when the employer has enough facts to reasonably conclude that workers' compensation liability is a possibility. The report must provide the information requested on the Form 801, and include, but not be limited to, the worker's name, address, and social security number, the employer's legal name and address, and the data specified by ORS 656.262 and 656.265.

(4) For the purpose of this section, "first aid" means any treatment provided by a person who does not require a license in order to provide the service. If an injured worker requires only first aid, no notice need be given the insurer, unless the worker chooses to file a claim. If a worker signs a Form 801, the claim must be reported to the insurer. If the person must be licensed to legally provide the treatment or if a bill for the service will result, notice must be given to the insurer. When the worker requires only first aid and chooses not to file a claim, the employer must maintain records showing the name of the worker, the date, nature of the injury and first aid provided for five years. These records shall be open to inspection by the director, or any party or its representative. If an employer subsequently learns that such an injury has resulted in medical services, disability or death, the date of that knowledge will be considered as the date on which the employer received notice or knowledge of the claim for the purposes of processing under ORS 656.262.

(5) The director may assess a civil penalty against an employer delinquent in reporting claims to its insurer in excess of ten percent of the employer's total claims during any quarter.

(6) An employer intentionally or repeatedly paying compensation in lieu of reporting to its insurer claims or accidents which may result in a compensable injury claim may be assessed a civil penalty by the director.

(7) The insurer must process and file claims and reports required by the director in compliance with ORS chapter 656, WCD administrative rules, and WCD bulletins. Such filings shall not be made by computer-printed forms, facsimile transmission (FAX), electronic data interchange (EDI), or other electronic means, unless specifically authorized by the director.

(8) When a claim is received and the insurer does not provide insurance coverage for the worker's employer on the date of injury, the insurer may check for other coverage or forward it to the director. The insurer must do one or the other within three days of determining they did not provide coverage on the date of injury. If the insurer checks for coverage and coverage exists, the insurer must send the claim to the correct insurer within the same three day period. If the insurer checks for coverage and coverage cannot be found, the insurer must forward the claim to the director within the same three-day period.

(9) The insurer or self-insured employer and third party administrator, if any, must be identified on all insurer generated workers' compensation forms, including insurer name, third party administrator name (if applicable), and the mailing address and phone number of the location responsible for processing the claim.

(10) The insurer must file all disabling claims with the director within 14 days of the insurer's initial decision either to accept or deny the claim. To meet this filing requirement, the Insurer's Report, Form 440-1502 (Form 1502) accompanied by the Form 801, or its electronic equivalent, is to be submitted to the director. However, when the Form 801 is not available within a time frame that would allow a timely filing, a Form 1502, accompanied by a signed Form 827 when available, will satisfy the initial reporting requirement. If the Form 801 is not submitted at the time of the initial filing of the claim, the Form 801 must be submitted within 30 days from the filing of the Form 1502. A Form 801 prepared by the insurer in place of obtaining the form from the employer/worker does not satisfy the filing requirement of the Form 801, unless the employer/worker cannot be located, or the form cannot be obtained from the employer/worker due to lack of cooperation, or the form is computer-printed based upon information obtained from the employer and worker. The insurer must submit copies of all acceptance or denial notices not previously submitted to the director with the Form 1502. Form 1502 is used to report claim status and activity to the director.

(11) When submitting a Form 1502 the minimum data elements an insurer must provide are the worker's legal name, social security number, insurer's claim number, date of injury, and the employer's legal name.

(12) When submitting an initial compensability decision Form 1502, the insurer must report:

(a) The status of the claim;

(b) Reason for filing;

(c) Whether first payment of compensation was timely, if applicable;

(d) Whether the claim was accepted or denied timely; and

(e) Any Managed Care Organization (MCO) enrollment, and the date of enrollment, if applicable.

(13) The insurer must file an additional Form 1502 with the director within 14 days of:

(a) The date of any reopening of the claim;

(b) Changes in the acceptance or disability status;

(c) Any litigation order or insurer's decision that causes reopening of the claim or changes the acceptance or disability status;

(d) MCO enrollment that occurs after the initial Form 1502 has been filed;

(e) The insurer's knowledge that a previous Form 1502 contained erroneous information;

(f) The date of any denial; or

(g) The date the first payment of temporary disability was issued.

(14) A nondisabling claim must only be reported to the director if it is denied, in part or whole. It must be reported to the director within 14 days of the date of denial. A nondisabling claim which becomes disabling must be reported to the director within 14 days of the date of the status change.

(15) If the insurer voluntarily reopens a qualified claim under ORS 656.278, it must file a Form 3501 with the director within 14 days of the date the insurer reopens the claim.

(16) The insurer must report a new medical condition reopening on the Form 1502 if the claim cannot be closed within 14 days of the first to occur: acceptance of the new condition, or the insurer's knowledge that interim temporary disability compensation is due and payable.

(17) New condition claims that are ready to be closed within 14 days must be reported on the "Insurer Notice of Closure Summary," Form 440-1503 (Form 1503) at the time the insurer closes the claim. The "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" letter must accompany the Form 1503.

(18) If, after receiving a claim from a worker or from someone other than the worker on the worker's behalf, the insurer receives written communication from the worker stating the worker never intended to file a claim and wants the claim "withdrawn," the insurer must submit a Form 1502 with a copy of the worker's communication to the director, if the claim had previously been reported.

(19) The director may issue a civil penalty against any insurer delinquent in reporting or in submitting Forms 801, 1502, 1503 or 1644 with a late or error ratio in excess of twenty percent during any quarter. For the purposes of this section, a claim or form shall be deemed to have been reported or submitted timely according to the provisions of ORS 656.726(4).

(20) Insurers must make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid under ORS chapter 656. The report must be submitted on forms furnished by the director for that purpose. Reports for each calendar year must be filed not later than March 1 of the following year.

(21) If an insurer elects to process and pay supplemental disability benefits, under ORS 656.210(5)(a), the insurer does not need to inform the director of their election. The insurer must request reimbursement, under OAR 436-060-0500, by filing Form 3504 "Supplemental Disability Benefits Quarterly Reimbursement Request" with the director for any quarter during which they processed and paid supplemental disability benefits. If an insurer elects not to process and pay supplemental disability benefits, the insurer must submit Form 3530, "Supplemental Disability Election Notification," to the director. The election remains in effect for all supplemental disability claims the insurer receives until the insurer changes its election. The election is made by the insurer and applies to all third party administrators an insurer may use for processing claims.

(22) An insurer may change its election made under section (20):

(a) Annually and

(b) Once after the division completes its first audit of supplemental disability payments made by the insurer.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.262, 656.264, 656.265(6), 656.704, 656.726(4), 656.745

Stats. Implemented: ORS 656.210, 656.262, 656.264, 656.265, 656.704, 656.726(4)
Hist.: WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0100, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0015
Required Notice and Information

(1) When an injured worker's attorney has given written notice of representation, prior or simultaneous written notice must be given to the worker's attorney under ORS 656.331:

(a) When the director or insurer requests the worker to submit to a medical examination;

(b) When the insurer contacts the worker regarding any matter which may result in denial, reduction or termination of the worker's benefits; or

(c) When the insurer contacts the worker regarding any matter relating to disposition of a claim under ORS 656.236.

(2) The director shall assess a civil penalty against an insurer who intentionally or repeatedly fails to give notice as required under section (1) of this rule.

(3) The insurer or the third party administrator must provide the pamphlet, "What Happens if I'm Hurt on the Job?," Form 440-1138 (Form 1138), to every injured worker who has a disabling claim with the first time-loss check or earliest written correspondence. For nondisabling claims, the information page, "A Guide for Workers Hurt on the Job," Form 440-3283 (Form 3283) may be provided in lieu of Form 1138, unless the worker specifically requests Form 1138.

(4) The insurer must provide Form 3283 to their insured employers for distribution to workers at the time a worker files a claim for workers' compensation benefits. The Form 3283 may be printed on the back of the Form 801.

(5) The insurer must provide the "Notice to Worker," Form 440-3058 (Form 3058) or its equivalent to the worker with the initial notice of acceptance on the claim under OAR 436-060-0140(7). For the purpose of this rule, an equivalent to the Form 3058 must include all of the statutory and rule requirements.

(6) Additional notices the insurer must send to a worker are contained in OAR 436-060-0018, 436-060-0030, 436-060-0035, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, and 436-060-0180.

(7) When an insurer changes claims processing locations, third party administrators, or self-administration, the insurer must provide at least 10 days prior notice to workers with open or active claims, their attorneys, and attending physicians. The notice must provide the name of a contact person, telephone number, and mailing address of the new claim processor.

(8) The insurer must provide the worker an explanation of any change in the wage used that differs from what was initially reported in writing to the insurer. Prior to claim closure on a disabling claim, the insurer must send the worker a notice documenting the wage upon which benefits were based and work disability, if applicable, will be determined when the claim is closed. The notice must also explain how the worker can appeal the insurer's wage calculation if the worker disagrees with the wage.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.331, 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.331, 656.704 & 656.726(4)
Hist.: WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0017
Release of Claim Document

(1) For the purpose of this rule:

(a) "Documents" include, but are not limited to, medical records, vocational records, written and automated payment ledgers for both time loss and medical services, payroll records, recorded statements, insurer generated records (insurer generated records exclude a claim examiner's generated file notes, such as documentation or justification concerning setting or adjusting reserves, claims management strategy, or any privileged communications), all forms required to be filed with the director, notices of closure, electronic transmissions, and correspondence between the insurer, service providers, claimant, the division and/or the Workers' Compensation Board.

(b) "Possession" means documents making up, or relating to, the insurer's claim record on the date of mailing the documents to the claimant, claimant's attorney or claimant's beneficiary. Any documents that have been received by the insurer five or more working days prior to the date of mailing shall be considered as part of the insurer's claim record even though the documents may not have yet reached the insurer's claim file.

(2) The insurer must date stamp each document upon receipt with the date it is received. The date stamp must include the month, day, year of receipt, and name of the company, unless the document already contains the date information and name of recipient company, as in faxes, e-mail and other electronically transmitted communications.

(3) A request for copies of claim documents must be submitted to the insurer, self-insured employer, or their respective third party administrator, and copied simultaneously to defense counsel, if known.

(4) The insurer must furnish, without cost, legible copies of documents in its possession relating to a claim, upon request of the claimant, claimant's attorney or claimant's beneficiary, at times other than those provided for under ORS 656.268 and OAR chapter 438, as provided in this rule. Except as provided in OAR 436-060-0180, an initial request by anyone other than the claimant or claimant's beneficiary must be accompanied by a worker signed attorney retention agreement or a medical release signed by the worker. The signed medical release must be in a form or format as the director may provide by bulletin. Information not otherwise available through this release, but relevant to the claim, may only be obtained in compliance with applicable state or federal laws. Upon the request of the claimant's attorney, a request for documents shall be considered an ongoing request for future documents received and generated by the insurer for 90 days after the initial mailing date under section (7) or until a hearing is requested before the Workers' Compensation Board. The insurer must provide such new documents to claimant's attorney every 30 days, unless specific documents are requested sooner by the attorney. Such documents must be provided within the time frame of section (7).

(5) Once a hearing is requested before the Workers' Compensation Board, the release of documents is controlled by OAR chapter 438. This rule applies subsequently if the hearing request is withdrawn or when the hearing record is closed, provided a request for documents is renewed.

(6) Upon request, the entire health information record in the possession of the insurer will be provided to the worker or the worker's representative. This includes records from all healthcare providers, except that the following may be withheld:

(a) Information which was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the information would likely reveal the source of the information,

(b) Psychotherapy notes,

(c) Information compiled for use in a civil, criminal, or administration action or proceeding; and

(d) Other reasons specified by federal regulation.

(7) The insurer must furnish copies of documents within the following time frames:

(a) The documents of open and closed files, and/or microfilmed files must be mailed within 14 days of receipt of a request, and copies of documents of archived files within 30 days of receipt of a request.

(b) If a claim is lost or has been destroyed, the insurer must so notify the requester in writing within 14 days of receiving the request for claim documents. The insurer must reconstruct and mail the file within 30 days from the date of the lost or destroyed file notice.

(c) If no documents are in the insurer's possession at the time the request is received, the 14 days within which to provide copies of documents starts when the insurer does receive some documentation on the claim if that occurs within 90 days of receipt of the request.

(d) Documents are deemed mailed when addressed to the last known address of the claimant, claimant's beneficiary or claimant's attorney and deposited in the U.S. Mail.

(8) The documents must be mailed directly to the claimant's or beneficiary's attorney, when the claimant or beneficiary is represented. If the documents have been requested by the claimant or beneficiary, the insurer must inform the claimant or beneficiary of the mailing of the documents to the attorney. The insurer is not required to furnish copies to both the claimant or beneficiary and the attorney. However, if a claimant or beneficiary changes attorneys, the insurer must furnish the new attorney copies upon request.

(9) The director may assess a civil penalty against an insurer who fails to furnish documents as required under this rule. The matrix attached to these rules in Appendix "A" will be used in assessing penalties.

(10) Rule violation complaints about release of requested claims documents must be in writing, mailed or delivered to the division within 180 days of the request for documents, and must include a copy of the request submitted under section (3). When notified by the director that a complaint has been filed, the insurer must respond in writing to the division. The response must be mailed or delivered to the director within 14 days of the date of the division's inquiry letter. A copy of the response, including any attachments, must be sent simultaneously to the requester of claim documents. If the division does not receive a timely response or the insurer provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), a civil penalty may be assessed under OAR 436-060-0200 against the insurer. Assessment of a penalty does not relieve the insurer of the obligation to provide a response.

[ED. NOTE: Appendices referenced are available from the agency.]

Stat. Auth.: ORS 656.360, 656.362, 656.704, 656.726(4) & 656.745

Stats. Implemented: ORS 656.704 & 656.726(4)

Hist.: WCD 3-1991, f. 4-18-91, cert. ef. 6-1-91; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0018

Nondisabling/Disabling Reclassification

(1) When the insurer changes the classification of an accepted claim, the insurer must submit an "Insurer's Report," Form 440-1502 to the director, indicating a change in status within 14 days from the date of the new classification. A notice of change of classification must be communicated by issuing a Modified Notice of Acceptance. This notice must include an explanation of the change in status and must be sent to the director, the worker, and the worker's attorney if the worker is represented. If the claim qualifies for closure, the insurer must close the claim under ORS 656.268(5).

(2) The insurer must reclassify a nondisabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria in this rule. A claim is disabling if any of the following criteria apply:

(a) Temporary disability is due and payable; or

(b) The worker is medically stationary within one year of the date of injury and the worker will be entitled to an award of permanent disability; or

(c) The worker is not medically stationary, but there is a reasonable expectation that the worker will be entitled to an award of permanent disability when the worker does become medically stationary.

(3) Under ORS 656.262 (6)(b)(F) and (7)(a) the insurer must issue a Modified Notice of Acceptance and change the classification from nondisabling to disabling upon acceptance of a new or omitted condition that meets the disabling criteria in this rule.

(4) If a claim has been classified as nondisabling for one year or less after the date of acceptance and the worker believes the claim was or has become disabling, the worker may request reclassification by submitting a written request for review of the classification status to the insurer under ORS 656.277.

(5) Within 14 days of the worker's request, the insurer must review the claim and,

(a) If the classification is changed to disabling, provide notice under this rule; or

(b) If the insurer believes evidence supports denying the worker's request to reclassify the claim, the insurer must send a Notice of Refusal to Reclassify to the worker and the worker's attorney, if the worker is represented. The notice must include the following statement, in bold print:

"If you disagree with this Notice of Refusal to Reclassify, you must appeal by contacting the Workers' Compensation Division within sixty (60) days of the mailing of this notice or you will lose your right to appeal. The address and telephone number of the Workers' Compensation Division are: [INSURER: Insert current address and telephone number of the Workers' Compensation Division, Appellate Review Unit, here.]."

(6) A worker dissatisfied with the decision in the Notice of Refusal to Reclassify may appeal to the director. Such appeal must be made no later than the 60th day after the Notice is mailed. The appeal must include a copy of the insurer's Notice of Refusal to Reclassify.

(7) For claims that are reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights begin with the first valid closure of the claim.

(8) For claims that are not reclassified from nondisabling to disabling within one year from the date of acceptance, the aggravation rights continue to run from the date of injury.

(9) When a claim has been classified as nondisabling for at least one year after the date of acceptance, a worker who believes the claim was or has become disabling may submit a claim for aggravation according to the provisions of ORS 656.273.

(10) Failure of the insurer or self-insured employer to respond timely to a request for reclassification may result in penalties under OAR 436-060-0200.

(11) Notwithstanding (12), once a claim has been accepted and classified as disabling for more than one year from date of acceptance, all aspects of the claim are classified as disabling and remain disabling. Any additional conditions or aggravations subsequently accepted must be processed according to provisions governing disabling claims, including closure under ORS 656.268.

(12) If a claim has been classified as disabling and the insurer determines the criteria for a disabling claim were never satisfied, the insurer may reclassify the claim to nondisabling. The insurer must notify the worker and the worker's representative, if applicable, by issuing a Modified Notice of Acceptance.

(a) The Modified Notice of Acceptance must advise the worker that he or she has 60 days from the date of the notice to appeal the decision.

(b) Appeals of such reclassification decisions are made to the Appellate Review Unit for issuance of a Director's Review order.

(13) The worker's appeal must be in writing. The worker may use the form specified by the director for requesting review of the insurer's claim classification decision.

(14) The worker's appeal under section (6) or (12) must be copied to the insurer.

(15) A worker need not be represented by an attorney to appeal the insurer's classification decision.

(16) The director will acknowledge receipt of the request in writing to the injured worker, the worker's attorney, if any, and the insurer, and initiate the review.

(17) Within 14 days of the director's acknowledgement, the insurer must provide the director and all other parties with the complete medical record and all official actions and notices on the claim. The insurer may be subject to penalties under OAR 436-060-0200 for failure to provide claim documents in a timely manner.

(18) Within the same 14 days, the worker may submit any additional evidence for the director to consider. Copies must be provided to all other parties at the same time.

(19) After receiving and reviewing the required documents, the director will issue a Director's Review order.

(20) The worker and the insurer have 30 days from the mailing date of the Director's Review order to appeal the director's decision to the Hearings Division of the Workers' Compensation Board.

(21) The director may reconsider, abate, or withdraw any Director's Review order before the order becomes final by operation of law.

Stat. Auth.: ORS 656.268, 656.726

Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656. 273, 656.277, 656.745, 656.726,

Hist.: WCD 2-2004, f. 2-19-04, cert. ef. 2-29-04, Renumbered from 436-030-0045; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0020

Payment of Temporary Total Disability Compensation

(1) An employer may pay compensation under ORS 656.262(4) with the approval of the insurer under ORS 656.262(12). Making such payments does not constitute a waiver or transfer of the insurer's duty to determine the worker's entitlement to benefits, or responsibility for the claim to ensure timely benefit payments. The employer must provide adequate payment documentation as the insurer may require to meet its responsibilities.

(2) Under ORS 656.005(30), no temporary disability is due and payable for any period of time in which the person has withdrawn from the workforce. For the purpose of this rule, a person who has withdrawn from the workforce, includes, but is not limited to:

(a) A person who, prior to reopening under ORS 656.267, 656.273 or 656.278, was not working and had not made reasonable efforts to obtain employment, unless such efforts would be futile as a result of the compensable injury.

(b) A person who was a full time student for at least six months in the 52 weeks prior to injury elects to return to school full time, unless the person can establish a prior customary pattern of working while attending

school. For purposes of this subsection, "full time" is defined as twelve or more quarter hours or the equivalent.

(3) No temporary disability is due and payable for any period of time where the insurer has requested from the worker's attending physician or authorized nurse practitioner verification of the worker's inability to work and the physician or authorized nurse practitioner cannot verify it under ORS 656.262(4)(d), unless the worker has been unable to receive treatment for reasons beyond the worker's control. Before withholding temporary disability under this section, the insurer must inquire of the worker whether a reason beyond the worker's control prevented the worker from receiving treatment. If no valid reason is found or the worker refuses to respond or cannot be located, the insurer must document its file regarding those findings. The insurer must provide the division a copy of the documentation within 20 days, if requested. If the attending physician or authorized nurse practitioner is unable to verify the worker's inability to work, the insurer may stop temporary disability payments and, in place of the scheduled payment, must send the worker an explanation for stopping the temporary disability payments. When verification of temporary disability is received from the attending physician or authorized nurse practitioner, the insurer must pay temporary disability within 14 days of receiving the verification of any authorized period of time loss, unless otherwise denied.

(4) Authorization from the attending physician or authorized nurse practitioner may be oral or written. The insurer at claim closure, or the division at reconsideration of the claim closure, may infer authorization from such medical records as a surgery report or hospitalization record that reasonably reflects an inability to work because of the compensable claim, or from a medical report or chart note generated at the time of, and indicating, the worker's inability to work. No compensation is due and payable after the worker's attending physician or authorized nurse practitioner ceases to authorize temporary disability or for any period of time not authorized by the attending physician or authorized nurse practitioner under ORS 656.262(4)(g).

(5) An insurer may suspend temporary disability benefits without authorization from the division under ORS 656.262(4)(e) when all of the following circumstances apply:

(a) The worker has missed a regularly scheduled appointment with the attending physician or authorized nurse practitioner.

(b) The insurer has sent a certified letter to the worker and a letter to the worker's attorney, at least ten days in advance of a rescheduled appointment, stating that the appointment has been rescheduled with the worker's attending physician or authorized nurse practitioner; stating the time and date of the appointment; and giving the following notice, in prominent or bold face type:

"You must attend this appointment. If there is any reason you cannot attend, you must tell us before the date of the appointment. If you do not attend, your temporary disability benefits will be suspended without further notice, as provided by ORS 656.262(4)(e)."

(c) The insurer verifies that the worker has missed the rescheduled appointment.

(d) The insurer sends a letter to the worker, the worker's attorney and the division giving the date of the regularly scheduled appointment that was missed, the date of the rescheduled appointment that was missed, the date of the letter being the day benefits are suspended, and the following notice, in prominent or bold face type:

"Since you missed a regular appointment with your doctor, we arranged a new appointment. We notified you of the new appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the new appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must schedule and attend an appointment with your doctor who must verify your continued inability to work."

(6) If temporary disability benefits end because the insurer or employer:

(a) Speaks by telephone with the attending physician or authorized nurse practitioner, or the attending physician's or authorized nurse practitioner's office, and negotiates a verbal release of the worker to return to any type of work as a result, when no return to work was previously authorized; and

(b) The worker has not already been informed of the release by the attending physician or authorized nurse practitioner or returned to work; then

(c) The insurer must:

(A) Document the facts;

(B) Communicate the release to the worker by mail within 7 days; the communication to the worker of the negotiated return to work release may be contained in an offer of modified employment; and

(C) Advise the worker of their reinstatement rights under ORS chapter 659A.

(7) When concurrent temporary disability is due the worker as a result of two or more accepted claims, the insurers may petition the division to make a pro rata distribution of compensation due under ORS 656.210 and 656.212. The insurer must provide a copy of the request to the worker, and the worker's attorney if represented. The division's pro rata order shall not apply to any periods of interim compensation payable under ORS 656.262 and also does not apply to benefits under ORS 656.214 and 656.245. Claims subject to the pro rata order approved by the division must be closed under OAR 436-030 and ORS 656.268, when appropriate. The insurers shall not unilaterally prorate temporary disability without the approval of the division, except as provided in section (8) of this rule. The division may order one of the insurers to pay the entire amount of temporary disability due or make a pro rata distribution between two or more of the insurers. The pro rata distribution ordered by the division shall be effective only for benefits due as of the date all claims involved are in an accepted status. The order pro rating compensation will not apply to periods where any claim involved is in a deferred status.

(8) When concurrent temporary disability is due the worker as a result of two or more accepted claims involving the same worker, the same employer and the same insurer, the insurer may make a pro rata distribution of compensation due under ORS 656.210 and 656.212 without an order by the division. The worker must receive compensation at the highest temporary disability rate of the claims involved.

(9) If a closure under ORS 656.268 has been found to be premature and there was an open ended authorization of temporary disability at the time of closure, the insurer must begin payments under ORS 656.262, including retroactive periods, and pay temporary disability for as long as authorization exists or until there are other lawful bases to terminate temporary disability.

(10) If a denied claim has been determined to be compensable, the insurer must begin temporary disability payments under ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability.

Stat. Auth.: ORS 656.210(2), 656.245, 656.262, 656.307(1)(c), 656.704, 656.726(4)
Stats. Implemented: ORS 656.210, 656.212, 656.262, 656.307, 656.704, 656.726(4)
Hist.: WCB 12-1970, f. 9-21-70, ef. 10-25-70; 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0212, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90, Former sec. (6), (7), (8), (9) & (10) Renumbered to 436-060-0025(1) - (10); WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 10-1995(Temp), f. & cert. ef. 8-18-95; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 14-1996(Temp), f. & cert. ef. 5-31-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0025
Rate of Temporary Disability Compensation

(1) The rate of compensation shall be based on the wage of the worker at the time of injury, except in the case of an occupational disease, for which the rate of compensation will be based on the wage as outlined in ORS 656.210(2)(d)(B). Employers shall not continue to pay wages in lieu of statutory temporary total disability payments due. However, under ORS 656.018(6) the employer is not precluded from supplementing the amount of temporary total disability paid the worker. Employers must separately identify workers' compensation benefits from other payments and shall not have payroll deductions withheld from such benefits.

(2) Notwithstanding section (1), under ORS 656.262(4)(b), a self-insured employer may continue the same wage with normal deductions withheld (e.g. taxes, medical, and other voluntary deductions) at the same pay interval that the worker received at the time of injury. If the pay interval or amount of wage changes (excluding wage increases), the worker must be paid temporary disability as otherwise prescribed by the workers' compensation law. The claim shall be classified as disabling. The rate of temporary total disability that would have otherwise been paid had continued wages not occurred and the period of disability will be reported to the division.

(3) The rate of compensation for regularly employed workers shall be computed as outlined in ORS 656.210 and this rule. "Regularly employed" means actual employment or availability for such employment.

(a) Monthly wages shall be divided by 4.35 to determine weekly wages. Seasonal workers paid monthly must have their weekly wages determined under OAR 436-060-0025(5).

(b) For workers employed through union hall call board insurers must compute the rate of compensation on the basis of a five-day work week at

40 hours a week, regardless of the number of days actually worked per week.

(4) The insurer shall resolve wage disputes by contacting the employer to confirm the correct wage and then contacting the worker with that information. If the worker does not agree with the wage calculated by the insurer, the worker may request a hearing with the Hearings Division of the Workers' Compensation Board.

(5) The rate of compensation for workers regularly employed, but paid on other than a daily or weekly basis, or employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule.

(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

(A) Insurers must use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers with multiple employers at the time of injury who qualify under ORS 656.210(2)(b) and OAR 436-060-0035, insurers shall average all earnings for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers must use the actual weeks of employment (excluding any extended gaps) with the employer at injury or all earnings, if the worker qualifies under ORS 656.210(2)(b) and OAR 436-060-0035, up to the previous 52 weeks. For the purpose of this rule, gaps shall not be added together and must be considered on a claim-by-claim basis; the determination of whether a gap is extended must be made in light of its length and of the circumstances of the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker. For the purpose of this section, the wage earning agreement may be either oral or in writing.

(B)(i) Where there has been a change in the wage earning agreement due only to a pay increase or decrease during the 52 weeks prior to the date of injury, insurers must use the worker's average weekly hours worked for the 52 week period, or lesser period as required in (5)(a)(A) of this section, multiplied by the wage at injury to determine the worker's current average weekly earnings.

(ii) Where there has been a change in the wage earning agreement due to a change of hours worked, change of job duties, or for other reasons either with or without a pay increase or decrease, during the 52 weeks prior to the date of injury, insurers must average earnings for the weeks worked under the most recent wage earning agreement, calculated by the method described in (5)(a)(A).

(iii) For workers employed less than four weeks under a changed wage earning agreement as described in this subsection, insurers must use the intent of the most recent wage earning agreement as confirmed by the employer and the worker.

(iv) For determining benefits under this rule for occupational disease claims, insurers must use the wage at the date of disability, if the worker was working at the time of medical verification of the inability to work, or the wage at the date of last regular employment, if the worker was not working due to the injury at the time of medical verification of the inability to work in place of "the date of injury."

(b) Workers employed through a temporary service provider on a "temporary basis," or a worker-leasing company as defined in OAR 436-050, must have their weekly wage determined by the method provided in subsection (a) of this section. However, each job assignment shall not be considered a new wage earning agreement.

(c) For workers paid salary plus considerations (e.g. rent, utilities, food, etc.) insurers must compute the rate on salary only if the considerations continue during the period the worker is disabled due to the injury. If the considerations do not continue, the insurer must use salary plus a reasonable value of those considerations. Expenses incurred due to the job and reimbursed by the employer (e.g. meals, lodging, per diem, equipment rental) are not considered part of the wage.

(d) Earnings from a second job will be considered for calculating temporary partial disability only to the extent that the post-injury income from the second job exceeds the pre-injury income from the second job (i.e., increased hours or increased wage).

(e) For workers employed where tips are a part of the worker's earnings insurers must use the wages actually paid, plus the amount of tips required to be reported by the employer under section 6053 of the Internal Revenue Code of 1954, as amended, or the amount of actual tips reported by the worker, whichever amount is greater.

(f) Insurers shall consider overtime hours only when the worker worked overtime on a regular basis. Overtime earnings must be included in the computation at the overtime rate. For example, if the worker worked one day of overtime per month, use 40 hours at regular wage and two hours at the overtime wage to compute the weekly rate. If overtime varies in hours worked per day or week, use the averaging method described in subsection (a). One-half day or more will be considered a full day when determining the number of days worked per week.

(g) Bonus pay shall be considered only when provided as part of the written or verbal employment contract as a means to increase the worker's wages. End-of-the-year and other one time bonuses paid at the employer's discretion shall not be included in the calculation of compensation.

(h) Incentive pay shall be considered only when regularly earned. If incentive pay earnings vary, use the averaging method described in subsection (a).

(i) Covered workers with no wage earnings such as volunteers, jail inmates, etc., must have their benefits computed on the same assumed wage as that upon which the employer's premium is based.

(j) For workers paid by commission only or commission plus wages insurers must use the worker's average commission earnings for previous 52 weeks, if available. For workers without 52 weeks of earnings, insurers must use the assumed wage on which premium is based. Any regular wage in addition to commission must be included in the wage from which compensation is computed.

(k) For workers who are sole proprietors, partners, officers of corporations, or limited liability company members including managers, insurers must use the assumed wage on which the employer's premium is based.

(l) For school teachers or workers paid in a like manner, insurers must use the worker's annual salary divided by 52 weeks to arrive at weekly wage. Temporary disability benefits shall extend over the calendar year.

(m) For workers with cyclic schedules, insurers must average the hours of the entire cycle to determine the weekly wage. For purposes of temporary disability payments, the cycle shall be considered to have no scheduled days off. For example: A worker who works ten hours for seven days, has seven scheduled days off, then repeats the cycle, is considered to have a 14 day cycle. The weekly wage and payment schedule would be based on 35 hours a week with no scheduled days off.

(6) When a working shift extends into another calendar day, the date of injury shall be the date used for payroll purposes by the employer.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.210(2), 656.704 & 656.726(4)

Stats. Implemented: ORS 656.210, 656.704, 656.726(4)

Hist.: WCB 12-1970, f. 9-21-70, ef. 10-25-70; 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0212, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90, Renumbered from 436-060-0020 former sections (6), (7), (8), (9) & (10); WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0035

Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) For the purpose of this rule:

(a) "Assigned processing administrator" is the company or business that the director has selected and authorized to process and pay supplemental disability benefits on behalf of the director, when the insurer has elected not to process and pay these benefits.

(b) "Primary job" means the job at which the injury occurred.

(c) "Secondary job" means any other job(s) held by the worker in Oregon subject employment at the time of injury.

(d) "Temporary disability" means wage loss replacement for the primary job.

(e) "Supplemental disability" means wage loss replacement for the secondary job(s) that exceeds the temporary disability, up to, but not exceeding, the maximum established by ORS 656.210.

(f) "Verifiable documentation" means information that provides:

(A) Identification of the Oregon subject employer(s) and the time period that establishes the worker held the secondary job, in addition to the primary job, at the time of injury; and

(B) Adequate information to calculate the average weekly wage in accordance with OAR 436-060-0025.

(g) "Insurer" includes third party administrator.

(2) The insurer shall establish the temporary disability rate by multiplying the weekly wage, determined under OAR 436-060-0025, from the

primary employer by 66 2/3% (.6667). If the result meets or exceeds the maximum temporary disability rate, the worker is not eligible for supplemental disability benefits.

(3) Within five business days of receiving notice or knowledge of employment in addition to the primary job on a claim on which the temporary disability rate for the primary job does not meet or exceed the maximum rate, the insurer must:

(a) Send the worker an initial notice informing the worker what type of information the insurer or the assigned processing administrator must receive to determine the worker's eligibility for supplemental disability. If the insurer has elected not to process and pay these benefits, the insurer must copy the assigned processing administrator with the notice to the worker.

(b) The notice must contain the name, address, and telephone number of the assigned processing administrator, and must also clearly advise the worker that the verifiable documentation must be sent to the assigned processing administrator.

(4) The initial notice in section (3) must also inform the worker that if the verifiable documentation is not received, the insurer will determine the worker's temporary disability rate based only on the job at which the injury occurred. If the insurer later receives the documentation, the insurer must determine the worker's eligibility for supplemental disability benefits and, if the worker is found eligible, re-calculate the temporary disability rate. Additional benefits due, but not yet paid because of the worker's prior failure to provide documentation, must be paid retroactively. Any delay in the payment of a higher disability rate because of the worker's failure to provide verifiable documentation under this paragraph will not result in a penalty under ORS 656.262(11).

(5) Within 14 days of receiving the worker's verifiable documentation, the insurer or the assigned processing administrator must determine the worker's eligibility for supplemental disability and must communicate the decision to the worker and the worker's representative, if any, in writing. The letter must also advise the worker why he/she is not eligible when that is the decision and how to appeal the decision, if the worker disagrees with the decision.

(6) A worker is eligible if:

(a) The worker was employed at the secondary job by an Oregon subject employer at the time of the injury,

(b) The worker provides notification of a secondary job to the insurer within 30 days of the insurer's receipt of the initial claim, and

(c) The worker's temporary disability rate from wages at the primary job does not meet or exceed the maximum rate under section (2) of this rule.

(7) The insurer or the assigned processing administrator must calculate supplemental disability for an eligible worker by adding all earnings the worker received from all subject employment, under ORS 656.210(2)(a)(B). In no case shall an eligible worker receive less compensation than would be paid if based solely on wages from the primary employer.

(8) If the temporary disability rate from the primary employer does not meet or exceed the maximum rate, the insurer or the assigned processing administrator must combine the weekly wages, determined under OAR 436-060-0025, for each employer and multiply by 66 2/3% (.6667) to establish the combined disability rate up to the maximum rate. This is the base amount on which the worker's combined benefits will be calculated.

(9) No three-day waiting period applies to supplemental disability benefits.

(10) The worker's scheduled days off for the job at which the injury occurred shall be used to calculate and pay supplemental disability.

(11) To establish the combined partial disability benefits when the worker has post injury wages from either job, the insurer or the assigned processing administrator must use all post injury wages from both primary and all secondary employers. The insurer or the assigned processing administrator must calculate the amount due the worker based on the combined wages at injury and combined post injury wages using the temporary partial disability calculation in OAR 436-060-0030. The insurer or the assigned processing administrator must then calculate the amount due from the primary job based only on the primary wages at injury and the primary post injury wages. That amount shall be subtracted from the amount due the worker; the remainder is the supplemental disability amount.

(12) If the worker receives post injury wages from the secondary job equal to or greater than the secondary wages at the time of injury, no supplemental disability is due.

(13) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing administrator must process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(14) Supplemental disability may be due on a nondisabling claim even if temporary disability is not due from the primary job. The nondisabling claim will not change to disabling status due to payment of supplemental disability. When supplemental disability payments cease on a nondisabling claim, the insurer or the assigned processing administrator must send the worker written notice advising the worker that their supplemental disability payments have stopped and of the worker's right to appeal that action to the Workers' Compensation Board within 60 days of the notice, if the worker disagrees.

(15) If the insurer has elected to process and pay supplemental disability under ORS 656.210(5)(a), the insurer must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability simultaneously with any temporary disability due. Reimbursement for supplemental disability paid will be made under OAR 436-060-0500.

(16) If the insurer has elected not to process and pay supplemental disability, the assigned processing administrator must determine the worker's on-going entitlement to supplemental disability and must pay the worker supplemental disability due once each 14 days.

(17) A worker who is eligible for supplemental disability under section (5) of this rule has an on-going responsibility to provide information and documentation to the insurer or the assigned processing administrator, even if temporary disability is not due from the primary job.

(18) If the insurer has elected not to process and pay supplemental disability, the insurer must cooperate and communicate with the assigned processing administrator and both must retain documentation of shared information, as necessary, to coordinate benefits due.

(19) Supplemental disability applies to occupational disease claims the same as injury claims. Supplemental disability benefits for an occupational disease shall be based on the worker's combined primary and secondary wages at the time there is medical verification the worker is unable to work because of the disability.

(20) When an insurer elects to pay supplemental disability under ORS 656.210(5)(a) and OAR 436-060-0010(20) and receive reimbursement under OAR 436-060-0500, the insurer must maintain a record of supplemental disability paid to the worker, separate from temporary disability paid as a result of the job at injury.

(21) If a worker disagrees with the insurer's or the assigned processing administrator's decision about the worker's eligibility for supplemental disability or the rate of supplemental disability, the worker may request a hearing before the Hearings Division of the Workers' Compensation Board. If the worker chooses to request a hearing on the insurer's decision concerning the worker's eligibility for supplemental disability, the worker must submit an appeal of the insurer's or the assigned processing administrator's decision within 60 days of the notice in section (5) of this rule. However, the insurer for the primary job is not required to contact the secondary job employer. The worker is responsible to provide any necessary documentation.

(22) An insurer who elects not to process and pay supplemental disability benefits may be sanctioned upon a worker's complaint if the insurer delays sending necessary information to the assigned processing administrator and that delay causes a delay in the worker receiving supplemental disability benefits.

(23) In the event of a third party recovery, previously reimbursed supplemental disability benefits are a portion of the paying agency's lien.

(24) Remittance on recovered benefits shall be made to the department in the quarter following the recovery in amounts determined in accordance with ORS 656.591 and 656.593.

Stat. Auth.: ORS 656.210, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210, 656.325(5), 656.704, 656.726(4)
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2006, f. 6-15-06, cert. ef. 7-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0060
Lump Sum Payment of Permanent Partial Disability Awards

(1) Under ORS 656.230, in all cases where an award for permanent partial disability does not exceed $6,000, the insurer must pay all of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the insurer may approve an application from the worker or worker's representative for lump sum payment of all or part of

the award. The insurer may deny the request for lump sum payment if any of the following apply:

(a) The worker has not waived the right to appeal the adequacy of the award;

(b) The award has not become final by operation of law;

(c) The payment of compensation has been stayed pending a request for hearing or review under ORS 656.313; or

(d) The worker is enrolled and actively engaged in training according to the rules adopted pursuant to ORS 656.340 and 656.726. For dates of injury prior to January 1, 2005, the insurer may not approve a request for lump sum payment of unscheduled permanent disability. For dates of injury on or after January 1, 2005, the insurer may not approve a request for lump sum payment of work disability when the worker:

(A) Has been found eligible for a vocational training program and will start the program within 30 days of the date of the decision on the lump sum request;

(B) Is actively enrolled and engaged in a vocational training program under OAR 436-120; or

(C) Has temporarily withdrawn from such a program.

(2) When an insurer receives a request for a lump sum application from the worker or the worker's representative, the insurer must send the lump sum application, Form 1174, to the requestor within ten business days.

(3) For the purpose of this rule, each opening of the claim is considered a separate claim and any subsequent permanent partial disability award from a claim reopening is a new and separate award. Additional award of permanent partial disability obtained through the appeal process is considered part of the total cumulative award for the open period of that claim.

(4) If the insurer agrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, they must make the lump sum payment within 14 days of receipt of the signed application.

(5) If the insurer disagrees with the worker's request for lump sum payment of a permanent partial disability award in excess of $6,000, the insurer must respond to the requestor within 14 days of receiving the request explaining the reason for denying the lump sum request.

(6) A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement under ORS 656.236 does not require further approval by the insurer .

(7) When a partial payment is approved by the insurer , it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid under ORS 656.216. Denial or partial approval of a request does not prevent another request by the worker for a lump sum payment of all or part of any remainder of the award, provided additional information is submitted.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.230, 656.704, 656.726(4)

Hist.: WCB 6-1966, f. & ef. 6-24-66; WCB 5-1974, f. 2-13-74, ef. 3-11-74; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0250, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0105

Suspension of Compensation for Insanitary or Injurious Practices, Refusal of Treatment or Failure to Participate in Rehabilitation; Reduction of Benefits

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker must have the opportunity to dispute the suspension of compensation prior to issuance of the order. The worker is not entitled to compensation during or for the period of suspension under ORS 656.325(2) when the worker commits insanitary or injurious acts which imperil or retard recovery; refuses to submit to medical or surgical treatment reasonably required to promote recovery; or fails or refuses to participate in a physical rehabilitation program.

(2) The insurer must demand in writing the worker either immediately cease actions which imperil or retard recovery or immediately begin to change the inappropriate behavior and participate in activities needed to help the worker recover from the injury. Such actions include insanitary or injurious practices, refusing essential medical or surgical treatment, or failing to participate in a physical rehabilitation program. Each time the insurer sends such a notice to the worker, the written demand must contain the following information, and a copy shall be sent simultaneously to the worker's attorney and attending physician:

(a) A description of the unacceptable actions;

(b) Why such conduct is inappropriate, including the fact that the conduct is harmful and/or retards the worker's recovery, as appropriate;

(c) The date by which the inappropriate actions must stop, or the date by which compliance is expected, including what the worker must specifically do to comply; and,

(d) The following notice of the consequences should the worker fail to correct the problem, in prominent or bold face type:

"If you continue to do insanitary or injurious acts beyond the date in this letter, or fail to consent to the medical or surgical treatment which is needed to help you recover from your injury, or fail to participate in physical rehabilitation needed to help you recover as much as possible from your injury, then we will request the suspension of your workers' compensation benefits. In addition, you may also have any permanent disability award reduced in accordance with ORS 656.325 and OAR 436-060."

(3) For the purposes of this rule, failure or refusal to accept medical treatment means the worker fails or refuses to remain under a physician's or authorized nurse practitioner's care or abide by a treatment regimen. A treatment regimen includes, but is not limited to a prescribed diet, exercise program, medication or other activity prescribed by the physician or authorized nurse practitioner which is designed to help the worker reach maximum recovery and become medically stationary.

(4) The insurer must verify whether the worker complied with the request for cooperation on the date specified in subsection (2)(c). If the worker initially agrees to comply, or complies and then refuses or fails to continue doing so, the insurer is not required to send further notice before requesting suspension of compensation.

(5) The request for suspension must be sent to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service as for a summons. The request must include the following information:

(a) That the request for suspension is made in accordance with ORS 656.325 and OAR 436-060-0105;

(b) A description of the actions of the worker which prompted the request, including whether such actions continue;

(c) Any reasons offered by the worker to explain the behavior, or a statement that the worker has not provided any reasons, whichever is appropriate;

(d) How, when and with whom the worker's failure or refusal was verified;

(e) A copy of the letter required in section (2);

(f) Any other relevant information including, but not limited to; chart notes, surgical or physical therapy recommendations/prescriptions, and all physician or authorized nurse practitioner recommendations; and

(g) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division authorizes suspension of your compensation and you do not correct your unacceptable actions or show us a good reason why they should be considered acceptable, we will close your claim."

(6) Any delay in obtaining confirmation or in requesting consent for suspension of compensation may result in authorization being denied or the date of authorization being modified by the date of actual confirmation or the date the request is received by the division.

(7) If the division concurs with the request, it shall issue an order suspending compensation from a date established under section (5) until the worker complies with the insurer's request for cooperation. Where the worker is suspended for a pattern of noncooperation, the division may require the worker to demonstrate cooperation before restoring compensation.

(8) The insurer must monitor the claim to determine if and when the worker complies with the insurer's requests. When cooperation resumes, payment of compensation must resume effective the date cooperation was resumed.

(9) The insurer must make all reasonable efforts to assist the worker to restore benefits when the worker demonstrates the willingness to make such efforts.

(10) If the worker makes no effort to reinstate benefits within 60 days of the date of the consent order, the insurer must close the claim under OAR 436-030-0034.

(11) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the insurer's request.

(12) The division may also take the following actions in regard to the suspension of compensation:

(a) Modify or set aside the order of consent before or after filing of a request for hearing.

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error.

(c) Reevaluate the necessity of continuing a suspension.

(13) An order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

(14) The director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits shall be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate. When an insurer submits a request to reduce benefits under this section, the insurer must:

(a) Specify the basis for the request;

(b) Include all supporting documentation;

(c) Send a copy of the request, including the supporting documentation, to the worker and the worker's representative, if any, by certified mail; and

(d) Include the following notice in prominent or bold face type:

"Notice to worker: If you think this request to reduce your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division grants this request, you may lose all or part of your benefits."

(15) The division shall promptly make a decision on a request to reduce benefits and notify the parties of the decision. The insurer's failure to comply with one or more of the requirements addressed in this rule may be grounds for denial of the request to reduce benefits.

Stat. Auth.: ORS 656.325, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.325, 656.704 & 656.726(4)

Hist.: WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94, Renumbered from 436-060-0085(1),(2),(4),(5); WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2000, f. 12-22-00, cert. ef. 1-1-01; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0135

Injured Worker, Worker Representative Responsible to Assist in Investigation; Suspension of Compensation and Notice to Worker

(1) When the worker refuses or fails to cooperate in an investigation of an initial claim for compensation, a claim for a new medical condition, a claim for an omitted medical condition, or an aggravation claim as required by ORS 656.262(13), the division will suspend compensation under ORS 656.262(14) by order under conditions set forth in this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to cooperate with an investigation. The worker must have the opportunity to submit information disputing the insurer's request for suspension of compensation prior to issuance of the order.

(2) A worker must submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques reasonably requested by the insurer. For the purposes of this rule, "personal and telephonic interviews" may be audio or video taped by one or more of the parties if prior written notice is given of the intent to record or tape an interview.

(3) The division will consider requests for suspension of benefits under ORS 656.262(14) only after the insurer has notified the injured worker in writing of the worker's obligation to cooperate as required by section (4) or (5) of this rule and only in claims where there has been no acceptance or denial issued.

(4) For suspension of benefits to be granted under this rule, the insurer must notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements, and must give the worker at least 14 days to cooperate. The notice must be sent to the worker and copied to the worker's attorney, if represented, and must advise the worker of the date, time and place of the interview and/or any other reasonable investigation requirements. If the insurer contracts with a third party, such as an investigation firm, to investigate the claim, the notice shall be on the insurer's stationery and must conform with the requirements of this section. The notice must inform the worker that the interview, deposition, and/or any other investigation requirements are related to the worker's compensation claim. The notice must also contain the following statement in prominent or bold face type:

"The workers' compensation law requires injured workers to cooperate and assist the insurer or self-insured employer in the investigation of claims for compensation. Injured workers are required to submit to and fully cooperate with personal and telephonic interviews and other formal or informal information gathering techniques. If you fail to reasonably cooperate with the investigation of this claim, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

(5) The request for suspension must be sent to the division after the 14 days in section (4) have expired. Any delay in requesting suspension may result in authorization being denied. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information sufficient to show the worker's failure to cooperate:

(a) That the insurer requests suspension of benefits under ORS 656.262(14) and this rule;

(b) Documentation of the specific actions of the worker or worker's representative that prompted the request;

(c) Any reasons given by the worker for failure to comply, or a statement that the worker has not given any reasons, whichever is appropriate;

(d) A copy of the notice required in section (4) of this rule; and

(e) All other pertinent information, including, but not limited to, a copy of the claim for a new or omitted condition when that is what the insurer is investigating.

(6) After receiving the insurer's request as required in section (5) of this rule, the division will promptly notify all parties that the worker's benefits will be suspended in five working days unless the worker or the worker's attorney contacts the division by telephone or mails a letter documenting that the failure to cooperate was reasonable or unless the insurer notifies the division that the worker is now cooperating. The notice of the division will also advise that the insurer's obligation to accept or deny the claim within 60 days is suspended unless the insurer's request is filed with the division after the 60 days to accept or deny the claim has expired.

(7) If the worker cooperates after the insurer has requested suspension, the insurer must notify the division immediately to withdraw the suspension request. The division will notify all the parties. An order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(8) If the worker documents the failure to cooperate was reasonable the division will not suspend payment of compensation. However, an order may be issued identifying the dates during which the insurer's obligation to accept or deny the claim was suspended.

(9) If the worker has not documented that the failure to cooperate was reasonable, the division will issue an order suspending all or part of the payment of compensation to the worker. The suspension will be effective the fifth working day after notice is provided by the division as required by section (6) of this rule. The suspension of compensation shall remain in effect until the worker cooperates with the investigation. The worker and insurer must notify the division immediately when the worker cooperates with the investigation. If the worker makes no effort to reinstate compensation within 30 days of the date of the notice, the insurer may deny the claim under ORS 656.262(14) and OAR 436-060-0140(10).

(10) Under ORS 656.262 (13), an insurer who believes that a worker's attorney's unwillingness or unavailability to participate in an interview is unreasonable may notify the director in writing and the division will consider assessment of a civil penalty against the attorney of not more than $1,000. The worker's attorney must have the opportunity to dispute the allegation prior to the issuance of a penalty. Notice under this section must be sent to the division. A copy of the notice must be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer must contain the following information:

(a) What specific actions of the attorney prompted the request;

(b) Any reasons given by the attorney for failing to participate in the interview; and

(c) A copy of the request for interview sent to the attorney.

(11) Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request.

Stat. Auth.: ORS 656.704 & 656.726(4)

Stats. Implemented: ORS 656.262, 656.704, 656.726(4)

Hist.: WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 17-1996(Temp), f. 8-5-96, cert. ef. 8-12-96; WCD 21-1996, f. 10-18-96, cert. ef. 11-27-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 6-2002(Temp), f. 4-22-02, cert. ef. 5-10-02 thru 11-5-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0137
Vocational Evaluations; and Suspension of Compensation

(1) A worker receiving permanent total disability benefits must attend a vocational evaluation reasonably requested by the insurer or the director. The insurer may request no more than three separate vocational evaluations, except as provided under this rule.

(2) When the insurer has obtained the three vocational evaluations allowed under ORS 656.206 and wishes to require the worker to attend an additional evaluation, the insurer must first request authorization from the director. Insurers that fail to first request authorization from the director may be assessed a civil penalty. The process for requesting authorization is as follows:

(a) The insurer must submit a request for authorization to the director in a form and format as prescribed by the director, which includes but is not limited to: the reasons for an additional vocational evaluation; the conditions to be evaluated; dates, times, places, and purposes of previous evaluations; copies of previous vocational evaluation notification letters to the worker; and any other information requested by the director; and

(b) The insurer must provide a copy of the request to the worker and the worker's attorney.

(3) The director will review the request and determine if additional information is needed. Upon receipt of a request for additional information from the director, the parties will have 14 days to respond. If the parties do not provide the requested information, the director will approve or disapprove the request for authorization based on available information.

(4) The director's decision approving or denying more than three vocational evaluations may be appealed to the Hearings Division of the Workers' Compensation Board within 60 days of the order.

(5) For purposes of determining the number of insurer required vocational evaluations, any evaluations scheduled but not completed are not counted as a statutory vocational evaluation.

(6) The insurer may contract with a third party to schedule vocational evaluations. If the third party notifies the worker of a scheduled evaluation on behalf of the insurer, the third party must send the notice on the insurer's stationery and the notice must conform with the requirements of OAR 436-060-0137(7).

(7) The notice must be sent to the worker at least 10 days prior to the evaluation. The notice sent for each evaluation, including those which have been rescheduled, must contain the following:

(a) The name of the vocational assistance provider or facility;

(b) A statement of the specific purpose for the evaluation;

(c) The date, time and place of the evaluation;

(d) The first and last name of the attending physician or authorized nurse practitioner or a statement that there is no attending physician or authorized nurse practitioner, whichever is appropriate;

(e) If applicable, confirmation that the director has approved the evaluation;

(f) Notice to the worker that the reasonable cost of public transportation or use of a private vehicle will be reimbursed; when necessary, reasonable cost of child care, meals, lodging and other related services will be reimbursed; a request for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request; should an advance of costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely appearance; and

(g) The following notice in prominent or bold face type:

"You must attend this vocational evaluation. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the evaluation. If you fail to attend or fail to cooperate, or do not have a good reason for not attending, your compensation benefits may be suspended in accordance with the workers' compensation law and rules, ORS 656.206 and OAR 436-060. If you have questions about your rights or responsibilities, you may call the Workers' Compensation Division at 1-800-452-0288 or the Ombudsman for Injured Workers at 1-800-927-1271."

(8) The insurer must pay the costs of the vocational evaluation and related services reasonably necessary to allow the worker to attend the evaluation. Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(9) When the worker refuses or fails to attend, or otherwise obstructs, a vocational evaluation reasonably requested by the insurer or the director under ORS 656.206, the division may suspend the worker's compensation.

(10) The insurer must send the request for suspension to the division. A copy of the request, including all attachments, must be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request must include the following information:

(a) That the insurer requests suspension of benefits under ORS 656.206 and OAR 436-060-0137;

(b) What specific actions of the worker prompted the request;

(c) The dates of any prior vocational evaluations the worker has attended and the names of the vocational assistance provider or facilities, or a statement that there have been no prior evaluations, whichever is appropriate;

(d) A copy of any approvals given by the director for more than three vocational evaluations, or a statement that no approval was necessary, whichever is appropriate;

(e) Any reasons given by the worker for failing to attend, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(f) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the vocational evaluation received by the insurer from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(g) A copy of the letter required in section (7) and a copy of any written verification received under subsection (10)(f);

(h) Any other information which supports the request; and

(i) The following notice in prominent or bold face type:

"Notice to worker: If you think this request to suspend your compensation is wrong, you should immediately write to the Workers' Compensation Division, 350 Winter Street NE, PO Box 14480, Salem, Oregon 97309-0405. Your letter must be mailed within 10 days of the date of this request. If the division grants this request, you may lose all or part of your benefits."

(11) If the insurer fails to comply with this rule, the division may deny the request for suspension.

(12) If the division suspends compensation, the suspension will be effective from the date the worker fails to attend a vocational evaluation or such other date the division deems appropriate until the date the worker attends the evaluation. The worker is not entitled to compensation during or for the period of suspension. Any delay in requesting suspension may result in suspension being denied or the date of suspension being modified.

(13) The insurer must assist the worker to meet requirements necessary for the resumption of compensation payments. When the worker has attended the vocational evaluation, the insurer must verify the worker's participation and resume compensation effective the date of the worker's compliance.

(14) The division may also:

(a) Modify or set aside the suspension order before or after filing of a request for hearing;

(b) Order payment of compensation previously suspended where the division finds the suspension to have been made in error; or

(c) Reevaluate the necessity of continuing a suspension.

(15) A suspension order becomes final unless, within 60 days after the date of mailing of the order, a party files a request for hearing on the order with the Hearings Division of the Workers' Compensation Board.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.206
Hist.: WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0147
Worker Requested Medical Examination

(1) The director shall determine the worker's eligibility for a Worker Requested Medical Examination (Exam) under ORS 656.325(1). The worker is eligible for an exam if the worker has made a timely request for a Workers' Compensation Board hearing on a denial of compensability as required by ORS 656.319(1)(a); and the denial was based on one or more Independent Medical Examination reports with which the attending physician or authorized nurse practitioner disagreed.

(2) The worker must submit a request for the exam to the director. A copy of the request must be sent simultaneously to the insurer or self-insured employer. The request must include:

(a) The name, address, and claim identifying information of the injured worker;

(b) A list of physicians, including name(s) and address(es), who have previously provided medical services to the worker on this claim or who have previously provided medical services to the worker related to the claimed condition(s);

(c) The date the worker requested a hearing and a copy of the hearing request;

(d) A copy of the insurer's denial letter; and

(e) Document(s) that demonstrate that the attending physician or authorized nurse practitioner did not concur with the independent medical examination report(s).

(3) The insurer must, upon written notice from the worker, mail to the director no later than the 14th day following the insurer's receipt of the worker's request, the names and addresses of all physicians or nurse practitioners who have:

(a) Acted as attending physician or authorized nurse practitioner;

(b) Provided medical consultations and/or treatment to the worker;

(c) Examined the worker at an independent medical examination; or

(d) Reviewed the worker's medical records on this claim. For the purpose of this rule, "Attending Physician" and "Independent Medical Examination" have the meanings defined in OAR 436-010-0005 and 436-010-0265(1), respectively.

(4) Failure to provide the required documentation described in section (3) in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(5) The director will notify all parties in writing of the physician selected, or will provide the worker or the worker's representative a list of appropriate physicians.

(6) If the director provides a list of physicians, the following applies:

(a) The worker's or the worker's representative's response must be in writing, signed, and received by the director within ten business days of providing the list.

(b) The worker or the worker's representative may eliminate the name of one physician from the list.

(c) If the worker or the worker's representative does not respond as provided in this section, the director will select a physician.

(d) The director will notify the parties in writing of the physician selected.

(7) The worker and/or the worker's legal representative shall schedule the exam with the selected physician and notify the insurer and the Workers' Compensation Board of the scheduled exam date within 14 days of the notification date in (6) of this rule. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(8) The insurer must send the physician the worker's complete medical and diagnostic record on this claim and the original questions asked of the independent medical examination(s) physician(s) no later than 14 days prior to the date of the scheduled exam. If the diagnostic records are not in the insurer's possession, the insurer must request that the medical provider send the diagnostic records to the selected physician at least 14 days prior to the scheduled exam.

(9) The worker or the worker's representative shall communicate questions related to the compensability denial in writing to be answered by the physician at the exam to the physician at least 14 days prior to the scheduled date of the exam. An unrepresented worker may consult with the Injured Worker Ombudsman for assistance.

(10) Upon completion of the exam the physician must address the original independent medical examination(s) questions and the questions from the worker or the worker's representative under section (9) of this rule and send the report to the worker's legal representative, if any, or the worker, and the insurer within 5 working days.

(11) The insurer must pay the physician selected under this rule in accordance with OAR 436-009. Delivery of medical services to injured workers shall be in accordance with OAR 436-010.

(12) If the worker fails to attend the scheduled Worker Requested Medical Exam, the insurer must pay the physician for the missed examination. The insurer is not required to pay for another examination unless the worker did not attend the missed examination for reasons beyond the worker's reasonable control.

(13) The insurer must reimburse the worker for all necessary related services under ORS 656.325(1).

Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented:ORS 656.325(1), 656.704, 656.726(4)
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0150
Timely Payment of Compensation

(1) Benefits are deemed paid when addressed to the last known address of the worker or beneficiary and deposited in the U.S. Mail or deposited in the worker's or beneficiary's account by approved electronic equivalent. Payments falling due on a weekend or legal holiday under ORS 187.010 and 187.020 may be paid on the last working day prior to or the first working day following the weekend or legal holiday. Subsequent payments may revert back to the payment schedule prior to the weekend or legal holiday.

(2) For the purpose of this rule, legal holidays in the State of Oregon are:

(a) Each Sunday;

(b) New Year's Day on January 1;

(c) Martin Luther King, Jr.'s Birthday on the third Monday in January;

(d) Presidents Day, for the purpose of commemorating Presidents Washington and Lincoln, on the third Monday in February;

(e) Memorial Day on the last Monday in May;

(f) Independence Day on July 4;

(g) Labor Day on the first Monday in September;

(h) Veterans Day on November 11;

(i) Thanksgiving Day on the fourth Thursday in November; and

(j) Christmas Day on December 25.

(k) Each time a holiday, other than Sunday, falls on Sunday, the succeeding Monday shall be a legal holiday. Each time a holiday falls on Saturday, the preceding Friday shall be a legal holiday.

(l) Additional legal holidays shall include every day appointed by the Governor as a legal holiday and every day appointed by the President of the United States as a day of mourning, rejoicing or other special observance only when the Governor also appoints that day as a holiday.

(3) First payment of time loss must be timely. An insurer's performance is in compliance when 90 percent of payments are timely. The director may assess a penalty against an insurer falling below these norms during any quarter.

(4) Compensation withheld under ORS 656.268(12) and (13), and ORS 656.596(2), shall not be deemed untimely provided the insurer notifies the worker in writing why benefits are being withheld and the amount that must be offset before any further benefits are payable.

(5) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:

(a) The date of the employer's notice or knowledge of the claim, provided the attending physician or authorized nurse practitioner has authorized temporary disability. Temporary disability accrued prior to the date of the employer's notice or knowledge of the claim shall be due within 14 days of claim acceptance;

(b) The date the attending physician or authorized nurse practitioner authorizes temporary disability, if the authorization is more than 14 days after the date of the employer's notice or knowledge of the claim;

(c) The start of authorized vocational training under ORS 656.268(9), if the claim has previously been closed;

(d) The date the insurer receives medical evidence supported by objective findings that shows the worker is unable to work due to a worsening of the compensable condition under ORS 656.273;

(e) The date of any division order, including, but not limited to, a reconsideration order, which orders payment of temporary disability. If a reconsideration order has been appealed by the insurer, the appeal stays payment of temporary disability benefits except those which accrue from the date of the order, under ORS 656.313;

(f) The date of a notice of claim closure issued by the insurer which finds the worker entitled to temporary disability;

(g) The date a notice of closure is set aside by a reconsideration order;

(h) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order must begin no later than the 14th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the signature date and from the courts, it is the date of the appellate judgment;

(i) The date the division refers a claim to the insurer for processing under ORS 656.029;

(j) The date the division refers a noncomplying employer claim to an assigned claims agent under ORS 656.054; or

(k) The date a claim disposition is disapproved by the Board or Administrative Law Judge, if temporary disability benefits are otherwise due;

(l) The date the division designates a paying agent under ORS 656.307;

(m) The date a claim is reclassified from nondisabling to disabling, if temporary disability is due and payable; and

(n) The date an insurer voluntarily rescinds a denial of a disabling claim.

(6) Temporary disability must be paid to within seven days of the date of payment at least once each 14 days. When making payments as provided in OAR 436-060-0020(1), the employer may make subsequent payments of temporary disability concurrently with the payroll schedule of the employer, rather than at 14-day intervals.

(7) Permanent disability must be paid no later than the 30th day after:

(a) The date of a notice of claim closure issued by the insurer;

(b) The date of any litigation order which orders payment of permanent total disability. Permanent total benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed.

For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the mailing date and from the courts it is the date of the appellate judgment;

(c) The date of any division order, including, but not limited to, a reconsideration order, which orders payment of compensation for permanent disability;

(d) The date any litigation authorizing permanent partial disability becomes final;

(e) The date a claim disposition is disapproved by the Board or Administrative Law Judge, if permanent disability benefits are otherwise due; or

(f) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, under ORS 656.268(9) and OAR 436-060-0040(2).

(8) Fatal benefits must be paid no later than the 30th day after:

(a) The date of a notice of acceptance issued by the insurer; or

(b) The date of any litigation order which orders fatal benefits. Fatal benefits accruing from the date of the order must begin no later than the 30th day after the date the order is filed. For the purpose of this rule, the "date the order is filed" for litigation from the Workers' Compensation Board, is the mailing date and from the courts it is the date of the appellate judgment.

(9) Subsequent payments of permanent disability and fatal benefits are made in monthly sequence. The insurer may adjust monthly payment dates, but must inform the beneficiary prior to making the adjustment. No payment period shall exceed one month without the division approval.

(10)(a) When paying temporary disability benefits the insurer must notify the worker or beneficiary in writing of the specific purpose of the payment and the time period for which the payment covers.

(b) When issuing the initial payment of permanent disability or fatal benefits the insurer must notify the worker or beneficiary in writing of the specific purpose of the payment, the schedule of future payments, and the time period each payment will cover. The insurer is not required to provide an explanation in writing with each subsequent permanent disability or fatal benefit payment.

(c) The insurer must provide an explanation in writing to the worker or beneficiary when the benefit amount, time period covered, or payment schedule changes.

(11) The insurer must maintain records of compensation paid for each claim where benefits are due and payable.

(12) If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer must provide specific reasons for non-payment or reduction of each item.

(13) Payment of a Claim Disposition Agreement must be made no later than the 14th day after the Board or Administrative Law Judge mails notice of its approval of the agreement to the parties, unless otherwise stated in the agreement.

(14) Under ORS 656.126(6), when Oregon compensation is more than the compensation under another law for the same injury or occupational disease, or compensation paid the worker under another law is recovered from the worker for the same injury or occupational disease, the insurer must pay any unpaid compensation to the worker up to the amount required by the claim under Oregon law within 14 days of receipt of written documentation supporting the underpayment of Oregon compensation.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.262(4), 656.268(9), 656.273, 656.278, 656.289, 656.307, 656.313, 656.704, 656.726(4)
Hist.: WCB 9-1966, f. & ef. 11-14-66; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 6-1981(Admin), f. 12-23-81, ef. 1-1-82; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0310, 5-1-85; WCD 8-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 4-1987, f. 12-18-87, ef. 1-1-88; WCD 6-1989, f. 12-22-89, cert. ef. 1-1-90; WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 13-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 2-28-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 10-2007, f. 11-1-07, cert. ef. 1-1-08; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0153
Electronic Payment of Compensation

(1) An insurer may pay benefits through a direct deposit system, automated teller machine card, or other means of electronic transfer if the worker agrees in writing. The worker may discontinue receiving benefits electronically by notifying the insurer in writing.

(2) The instrument of payment must be negotiable and payable to the worker for the full amount of the benefit paid, without cost to the worker. The worker must be able to make an initial withdrawal of the entire amount of the benefit paid without delay or cost to the worker.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.262(4), 84.013
Hist. ; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0155
Penalty to Worker for Untimely Processing

(1) Under ORS 656.262(11), the director may require the insurer to pay an additional amount to the worker as a penalty and an attorney fee to the worker's attorney when the insurer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim.

(2) Requests for penalties and attorney fees under this section must be in writing, stating what benefits have been delayed or remain unpaid, and mailed or delivered to the division within 180 days of the alleged violation. An attorney must submit the following to the director in order to be awarded an attorney fee:

(a) A current, valid retainer agreement;

(b) A statement of hours spent on the issue pertaining to the delayed payment of compensation; and

(c) The amount sought for legal services performed in connection with the delayed compensation issue.

(3) For the purpose of this section, "violation" is either:

(a) A late payment or the nonpayment of any single payment due, in which case a request for penalty must be mailed or delivered to the director within 180 days of the date payment was due; or

(b) A continuous nonpayment or underpayment such as with yearly cost of living increases for temporary disability compensation. In these instances, a request for penalty must be mailed or delivered to the director within 180 days of the date of the last underpayment. All prior underpayments will be considered as one violation, regardless of when the first underpayment occurred.

(4) When notified by the director that additional amounts may be due the worker as a penalty under this rule, the insurer must respond in writing to the division. The response must be mailed or delivered to the division within 21 days of the date of the division's inquiry letter, with copies of the response, including any attachments, sent simultaneously to the worker and the worker's attorney (if represented). If an insurer fails to respond or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), assessment of a civil penalty may occur under OAR 436-060-0200. In addition, failure to provide copies of the response to the worker and/or attorney timely may result in the assessment of a $50.00 civil penalty under OAR 436-060-0200.

(5) When no written reason for delay is provided by the insurer as required in section (4) and no reason for the delay is evident from the worker's or division's records, the delay shall be considered unreasonable, unless the worker has provided insufficient information to assess a penalty. In such cases, a civil penalty may be assessed under OAR 436-060-0200.

(6) The director will only consider a penalty issue where the assessment and payment of additional amounts described in ORS 656.262(11) is the sole issue of any proceeding between the parties. If a proceeding on any other issue is initiated before the Hearings Division of the Workers' Compensation Board between the same parties prior to the director issuing an order under this section, and the director is made aware of the proceeding, jurisdiction over the penalty proceeding before the director shall immediately rest with the Hearings Division and result in referral of the proceedings to the Hearings Division. If the director has not been made aware of the proceeding before the Hearings Division and issues a penalty order which becomes final, the penalty of the director will stand.

(7) The director will use the matrix attached to these rules in Appendix "B" in assessing penalties. When there are no "amounts then due" upon which to assess a penalty, no penalty will be issued under this rule.

(8) Penalties and attorney fees ordered under this rule must be paid to the worker and attorney no later than the 30th day after the date of the order, unless the order is appealed. If the order is appealed and later upheld, the penalty and attorney fee will be due within 14 days of the date the order upholding the penalty becomes final. Failure to pay penalties and attorney fees in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(9) Disputes regarding unreasonable delay or unreasonable refusal to pay compensation, or unreasonable delay in acceptance or denial of a claim may be resolved by the parties. In cases where the parties wish to resolve such disputes and the assessment and payment of additional amounts described in ORS 656.262(11) is the sole issue of a proceeding between the parties, and the violation(s) occurred within the last 180 days in accordance

with section (3), then a stipulation must be submitted to the division for approval. The stipulation must specify:

(a) The benefits delayed and the amounts;

(b) The time period(s) involved;

(c) If applicable, the name of the medical provider(s) and the date(s) of service(s) relating to medical bills;

(d) The amount of the penalty not to exceed 25 percent of the amount of compensation delayed; and

(e) The attorney fees, if applicable.

(10) Payment of the penalty and attorney fee is due within 14 days after the date the division approves the stipulation, unless otherwise stated in the stipulation. Failure to pay penalties or attorney fees in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(11) Any other agreements between the parties to pay a penalty or attorney fee without benefit of a stipulation approved by the division will not be acknowledged as a violation as it applies to the matrix attached to these rules.

[ED. NOTE: Appendices referenced are available from the agency.]
Stat. Auth.: ORS 656.262(11), 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.262(11), 656.704 & 656.726(4)
Hist.: WCD 9-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 29-1990, f. 11-30-90, cert. ef. 12-26-90; WCD 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 7-1994, f. 8-11-94, cert. ef. 8-28-94; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

436-060-0500
Reimbursement of Supplemental Disability for Workers with Multiple Jobs at the Time of Injury

(1) When an insurer elects to pay supplemental disability due a worker with multiple jobs at the time of injury, reimbursement of the supplemental amount shall be made by the director quarterly, after receipt and approval of documentation of compensation paid by the insurer or the third party administrator. The director will reimburse the insurer, in care of a third party administrator, if applicable.

(2) Requests for reimbursement must be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and must include, but may not be limited to:

(a) Identification and address of the insurer responsible for processing the claim;

(b) The worker's name, WCD file number, date of injury, social security number, and the insurer claim number;

(c) Whether the claim is disabling or nondisabling;

(d) The primary and secondary employer's legal names;

(e) The primary and secondary employer's WCD registration numbers;

(f) The weekly wage of all jobs at the time of the injury separated by employer;

(g) The dates for the period(s) of supplemental disability due and payable to the worker. Dates must be inclusive (e.g., 1-16-02 through 1-26-02);

(h) The amount of supplemental disability paid for the periods in (2)(g);

(i) The quarter and year in which the payment was made;

(j) A signed payment certification statement verifying the payments; and

(k) Any other information required by the director.

(3) In addition to the supplemental disability reimbursement, the division shall calculate and the insurer shall be paid an administrative fee based on the annual claim processing administrative cost factor, as published in Bulletin 316.

(4) Periodically the division will audit the physical file of the insurer responsible for processing the claim to validate the amount reimbursed. Reimbursement will be disallowed and repayment will be required if, upon such audit, it is found:

(a) Payments exceeded statutory amounts due, excluding reasonable overpayments, as determined by the division;

(b) Compensation has been paid as a result of untimely or inaccurate claims processing; or

(c) Payments of compensation have not been documented, as required by OAR 436-050.

(5) Supplemental disability benefits due subject workers of an employer who is in a noncomplying status as defined in ORS 656.052 are not eligible for separate reimbursement under this rule, but remain a cost recoverable from the employer as provided by ORS 656.054(2).

(6) Claim Dispositions or Stipulated Settlements, under ORS 656.236 or 656.289 which include amounts for supplemental disability benefits due to multiple jobs, are not eligible to receive reimbursement from the Workers' Benefit Fund unless made with the prior written approval of the director.

(a) Requests for written approval of proposed dispositions must include:

(A) A copy of the proposed disposition or settlement which specifies the amount of the proposed contribution to be made from the Workers' Benefit Fund;

(B) A statement from the insurer indicating how the amount of the contribution was calculated; and

(C) Any other information required by the director.

(b) The director will not approve the disposition for reimbursement if the proposed contribution exceeds a reasonable projection of that claim's future liability to the Workers' Benefit Fund.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.704, 656.726(4)
Stats. Implemented: ORS 656.210, 656.704, 656.726(4)
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; WCD 10-2002, f. 10-2-02 cert. ef. 11-1-02; WCD 9-2003(Temp), f. 8-29-03, cert. ef. 9-2-03 thru 2-28-04; WCD 11-2003(Temp), f. & cert. ef. 9-22-03 thru 2-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04; WCD 9-2004, f. 10-26-04, cert. ef. 1-1-05; WCD 8-2005, f. 12-6-05, cert. ef. 1-1-06; WCD 5-2008, f. 12-15-08, cert. ef. 1-1-09

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Department of Corrections
Chapter 291

Rule Caption: Use of Electronic Immobilizing Devices for Parole and Probation Officers.
Adm. Order No.: DOC 28-2008(Temp)
Filed with Sec. of State: 11-25-2008
Certified to be Effective: 11-25-08 thru 5-22-09
Notice Publication Date:
Rules Adopted: 291-022-0161, 291-022-0162
Rules Amended: 291-022-0115, 291-022-0160
Subject: These temporary rule modifications are necessary to establish policies and procedures for the deployment and use of electronic immobilizing devices in use of force situations for parole and probation officers.
Rules Coordinator: Janet R. Worley—(503) 945-0933

291-022-0115
Definitions

(1) Chemical Agents: Chemical compounds that when deployed are designed to cause sufficient physiological effect to stop, control or temporarily immobilize an individual.

(2) Deadly Physical Force: Physical force that under the circumstances in which it is used is readily capable of causing death or serious physical injury.

(3) Electronic Immobilizing Devices (EID): Security equipment designed to stop, control or temporarily immobilize through the use of high voltage, low amperage electric shock

(4) Level of Force: The type of force employed, the degree of that type of force employed, and the circumstances within which the force is employed.

(5) Local State Director: A person within the Department of Corrections who reports to the Chief of Community Corrections and has responsibility for managing a state community corrections office within a particular county.

(6) Offender: Any person under supervision who is on parole, post prison supervision, transitional leave, local control and/or probation status.

(7) Officer: Any state parole and probation officer certified as such by the Department of Public Safety Standards and Training

(8) Physical Force: The use of hands, other parts of the body, objects, instruments, chemical devices, firearms, or other physical methods, for the purpose of overcoming the resistance to lawful authority.

(9) Physical Injury: Impairment of physical condition or substantial pain.

(10) Planned Use of Force: The use of force in situations where time and circumstances allow for consultation with, and approval by, higher ranking employees, and there is some opportunity to plan the actual use of force.

(11) Reasonable Force: That force which the officer can objectively articulate was reasonable given the active resistance or attempts at evasion by the offender and the facts known at the time by the officer.

(12) Reactive Use of Force: The use of force in situations where time and circumstances do not permit approval by higher ranking employees, or consultation or planning.

(13) Security Equipment: Firearms, ammunition, chemical agents, restraints and similar devices.

(14) Serious Physical Injury: Physical injury which creates a substantial risk of death or which causes serious and protracted disfigurement, protracted impairment of health, or protracted loss or impairment of the function of any bodily organ.

(15) Security Restraints: Handcuffs, temporary cuffs (flexcuffs), and other similar equipment designed to control a person from injuring himself/herself, others, and to prevent escape.

(16) Show of Force: A demonstration of the current ability to use force, such as the massing of parole and probation officers or other officials.

(17) Totality of the Circumstances: All factors considered. With respect to use of force circumstances include, but are not limited to, comparative size; physical, emotional, and mental condition; skill level of combatants; nature of the offense; weapons; and availability of assistance.

(18) Use of Force: Any situation in which an employee uses physical force against an offender or other person, except those situations in which security restraints are used in a standard manner for arrest, escort, or transport.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 6-2005, f. & cert. ef. 5-24-05; DOC 28-2008(Temp), f. & cert. ef. 11-25-08 thru 5-22-09

291-022-0160
Security Equipment

(1) Security Equipment:

(a) All security equipment shall require the approval of the Director or designee before being issued and used as department authorized security equipment.

(b) Only department authorized and/or issued equipment shall be used to apply physical force to individuals.

(c) Security equipment shall not be issued to or used by an employee who has not been trained in the proper use of such devices.

(d) Unless authorized by the local state director or written directive, the carrying or use of personal security equipment is prohibited.

(e) The local state director shall authorize the storage and use of security equipment.

(2) Security Restraints:

(a) The standard routine use of security restraints for arrest, escort or transportation of an offender is not a use of force within the context of this rule.

(b) The use of security restraints is authorized to restrict, immobilize, and control the movement of offenders or for the purpose of officer safety.

(c) An arrestee shall be placed in security restraints with their hands behind their back, before and during transport. Exceptions may exist due to physical and/or medical conditions, at which point alternative methods may be utilized.

(d) Security restraints shall be applied consistent with the training and experience of the officer. Restraints will be checked for tightness and double locked.

(e) Officers shall ensure that unnecessary pressure is not placed on the offender's chest, back or neck while applying restraints. Officers shall maintain close observation of a restrained arrestee in order to detect breathing difficulties and/or loss of consciousness.

(f) The officer shall check at least every 30 minutes and verify the security restraints are not causing injury or an obvious medical problem for an arrestee whom has been placed in restraints as a result of a use of force situation.

(3) Chemical Agents:

(a) Authorization to carry a chemical agent shall be granted by the local state director.

(b) Authorization to carry department issued chemical agents shall be limited to the performance of official duties.

(c) Officers authorized to carry a chemical agent shall carry the chemical agent whenever:

(A) Protective body armor is worn;

(B) A firearm is carried;

(C) An arrest is anticipated or when making an arrest; or

(D) A confrontation with vicious dogs or other dangerous animals is anticipated.

(d) An officer shall only discharge a chemical agent for the following:

(A) To defend the officer or another person from an animal attack;

(B) To defend the officer or another person from imminent danger; or

(C) To enforce a valid order(s) to an offender to submit to the application of restraints.

(e) Those affected by a chemical agent shall be permitted to wash their face, eyes and other exposed skin areas, as soon as safely possible after the chemical agent has been used.

(f) Those affected by a chemical agent in a closed area shall be permitted to move to an uncontaminated area as soon as safely possible after the chemical agent has been used.

(g) An offender receiving an application of a chemical agent shall be under continuous staff observation for the first ten minutes and thereafter every ten minutes for the next 20 minutes after receiving the application of a chemical agent.

(4) Electronic Immobilizing Device (EID):

(a) Authorization to carry an EID may be granted by the local state director in accordance to Department's policy on Electronic Immobilizing Devices (Parole and Probation Officers)(50.1.3)

(b) Authorization to carry an EID shall be limited to the performance of official duties.

(c) Use of the EID will be in accordance with these rules.

(5) Mandatory Use: Officers shall carry a chemical agent or an EID or another approved less than lethal force option whenever:

(a) Protective body armor is worn;

(b) A firearm is carried;

(c) An arrest is anticipated or when making an arrest; or

(d) A confrontation with vicious dogs or other dangerous animals is anticipated.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 6-2005, f. & cert. ef. 5-24-05; DOC 28-2008(Temp), f. & cert. ef. 11-25-08 thru 5-22-09

291-022-0161
Electronic Immobilizing Device Deployment

(1) The EID may be deployed:

(a) To control a dangerous or violent offender when deadly force does not appear to be justified.

(b) To control an offender when other conventional tactics have been, or will likely be ineffective and when control is needed for the protection of the officer or others.

(c) On animals, as a deterrent to aggressive behavior, when the officer believes such aggression may cause injury to the officer or another person whom is present.

(2) When feasible, the officer shall provide a verbal warning to the offender prior to deploying the EID.

(3) The officer will use only the amount of force which reasonably appears necessary, given the facts and circumstances perceived by the officer at the time of the event, to effectively bring an incident under control.

(4) Once the offender is incapacitated or restrained, continued use of the EID is prohibited, unless the officer reasonably believes the offender is a continuing threat.

Stat Auth: ORS 179.040, 423.020, 423.030 & 423.075
Stat Impl: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 28-2008(Temp), f. & cert. ef. 11-25-08 thru 5-22-09

291-022-0162
Treatment of Affected Persons

(1) Immediately after deploying the EID on an offender, the officer shall be alert to any indication that the individual needs medical care. This includes being aware of any secondary injuries that may have occurred during the incident.

(2) Probes may be removed by the officer unless embedded in a soft tissue site (face, throat, groin, female breasts). A probe embedded in soft tissue should only be removed by medical personnel.

(3) Monitoring the offender for medical problems shall continue for the time the officer has custody of the offender. Medical assistance shall be summoned as soon as a medical problem is observed.

(4) When custody or care of the offender is transferred, the officer shall inform jail staff or medical personnel of the approximate time the offender was immobilized, the puncture sites of the probes, and the probe size.

(5) Photographs shall be taken of the offender's injuries as soon as practical and retained as part of the documentation of the incident.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: DOC 28-2008(Temp), f. & cert. ef. 11-25-08 thru 5-22-09

Department of Energy
Chapter 330

Rule Caption: Amend State Home Oil Weatherization (SHOW) program rules.
Adm. Order No.: DOE 8-2008
Filed with Sec. of State: 12-4-2008
Certified to be Effective: 12-5-08
Notice Publication Date: 11-1-2008
Rules Amended: 330-061-0005, 330-061-0025, 330-061-0030
Subject: The proposed rules would:

Increase the rebate for installing qualifying energy conservation measures from $1,000 to $2,000 not to exceed 50 percent of the costs for projects completed by Community Action Agency or other agency serving low-income households.

Clarify rebate amounts for blower door tests, duct leakage tests.

Clarify energy conservation measures eligible for rebate.

Make editorial and housekeeping changes to OAR 330-061-005 to OAR 330-06-0050.

Rules Coordinator: Michael Grainey—(503) 378-4128

330-061-0005
Purpose

(1) OAR 330-061-0005 through 330-061-0050 prescribe how the Oregon Department of Energy shall run a program providing energy conservation measure rebates. This program shall be known as the energy conservation measure rebate, a part of the State Home Oil Weatherization Program, run by the Oregon Department of Energy. Operation of the oil energy conservation measure rebate depends on availability of funds.

(2) These rules are effective December 5, 2008 or upon filing with the Secretary of State, whichever is later and shall apply to energy conservation measure rebate applications postmarked on or after the effective date of these rules.

Stat. Auth.: ORS 469.040 & 469.165
Stats. Implemented: ORS 469
Hist.: DOE 5-1983, f. & ef. 12-2-83; DOE 8-1984, f. & ef. 12-19-84; DOE 1-1987, f. & ef. 2-19-87; DOE 3-1987, f. & ef. 12-18-87; DOE 4-1993, f. & cert. ef. 10-22-93; DOE 2-2003, f. 9-24-03, cert. ef. 10-1-03; DOE 5-2004, f. 10-14-04, cert. ef. 11-1-04; DOE 2-2007, f. 8-29-07, cert. ef. 9-1-07; DOE 8-2008, f. 12-4-08, cert. ef. 12-5-08

330-061-0025
Amount of Rebate

(1) The Oregon Department of Energy shall annually allocate available rebate funding based on the following income categories and in the following dollar and percentage amounts:

(a) Households at or below eligibility levels for the U.S. Department of Energy's Low Income Weatherization Program can receive weatherization and energy conservation measure services from a Community Action Agency or other agency serving low-income households. The agency may apply for the rebate program for installing qualifying energy conservation measures. The rebate for installing qualifying energy conservation measures shall not exceed 50 percent of the costs or $2,500, whichever is less.

(b) Any household may receive a cash rebate for installing qualifying energy conservation measures, subject to the following limitations:

(A) A rebate for a fuel oil furnace or burner may not exceed 25 percent of the costs or $150, whichever is less.

(B) A rebate for installation of a qualifying above-ground oil tank may not exceed 25 percent of the costs or $150, whichever is less.

(C) A rebate for storm windows, storm doors, double pane windows, or double pane sliding doors may not exceed 25 percent of the costs or $150, whichever is less.

(D) A rebate for insulated doors may not exceed 25 percent of the costs or $150, whichever is less.

(E) A rebate for a blower-door test to assess the potential energy efficiency and other benefits from whole house air sealing may not exceed 100 percent of the costs or $100, whichever is less.

(F) A rebate for a duct leakage test performed by a contractor listed by the Oregon Department of Energy to assess potential energy efficiency and other benefits from duct sealing may not exceed 100 percent of the costs or $100, whichever is less.

(G) A rebate for insulation, weatherstripping and caulking may not exceed 25 percent of the costs or $500, whichever is less.

(H) A rebate for blower door guided whole house air sealing may not exceed 25 percent of the costs or $500, whichever is less.

(I) A rebate for duct sealing performed by a contractor listed by the Oregon Department of Energy may not exceed 25 percent of the costs or $500, whichever is less.

(J) The rebate for all other energy conservation measures may not exceed 25 percent of the costs or $500, whichever is less.

(K) The total rebate received by a household for energy conservation measures subject to these rules may not exceed $500.

(2) Notwithstanding OAR 330-061-0025(1), The Director may:

(a) Reduce incentive amounts or limit the number of qualifying energy conservation measures if the Director determines that rebate applications are likely to exceed the funding allocated. This action will apply to any applications received no sooner than 30 calendar days after that determination.

(b) Allocate additional funding for financial incentives through pilot programs that the Oregon Department of Energy determines may encourage installation of cost-effective energy efficiency measures.

(3) In some cases, a landlord may not wish to install energy conservation measures in all units within a building. To determine the building type, all dwelling units in the building must be counted. The rebate is only available for those units where energy conservation measures have been installed. All dwelling units sharing a common space conditioning system shall be considered part of the same residential building.

Stat. Auth.: ORS 469.040 & 469.165
Stats. Implemented: ORS 469
Hist.: DOE 5-1983, f. & ef. 12-2-83; DOE 8-1984, f. & ef. 12-19-84; DOE 1-1987, f. & ef. 2-19-87; DOE 3-1987, f. & ef. 12-18-87; DOE 2-1991, f. & cert. ef. 10-14-91; DOE 4-1993, f. & cert. ef. 10-22-93; DOE 1-2000, f. 3-30-00, cert. ef. 4-1-00; DOE 2-2003, f. 9-24-03, cert. ef. 10-1-03; DOE 5-2004, f. 10-14-04, cert. ef. 11-1-04; DOE 2-2007, f. 8-29-07, cert. ef. 9-1-07; DOE 8-2008, f. 12-4-08, cert. ef. 12-5-08

330-061-0030
Application Procedure

(1) Energy audit required prior to rebate payment:

(a) An applicant for a rebate must submit to the Oregon Department of Energy a copy of an energy audit for the building or dwelling unit for which a rebate is requested before the rebate is provided;

(b) A rebate will only be provided for energy conservation measures listed in OAR 330-061-0010(10), subject to the limitations of 330-061-0015 and 330-061-0025.

(2) Applicant certification. The applicant shall certify to the Oregon Department of Energy that the applicant heats with fuel oil or wood, the application is for costs of qualifying energy conservation measures, the applicant will grant permission for an inspection of the installed measures within a reasonable time if requested by the Oregon Department of Energy, and the applicant understands that the installed measures must comply with the program's energy conservation measure specifications and if the measures do not comply that the installation must be remedied or the rebate repaid.

(3) A tenant must get prior written consent from the owner of the building or dwelling unit to be eligible to apply for a rebate for the installation of energy conservation measures.

(4) A third party applying for assistance on behalf of any owner or tenant who would be eligible to receive a rebate must get written consent from the owner or tenant before receiving a rebate on the owner's or tenant's behalf.

(5) Contractor requirements:

(a) All contractors who install energy conservation measures receiving a rebate must be registered with the Oregon Construction Contractors Board. This requirement may not apply to community action agencies acting as contractors;

(b) Contractors shall certify if requested by the Oregon Department of Energy that neither they nor their suppliers (if any) are on the Consolidated List of debarred, suspended, and ineligible contractors prepared by the General Services Administration pursuant to the temporary rule published at 47 FR 43692 and any successor rule;

(c) Contractors shall certify that a new flame retention burner or fuel oil furnace for which a rebate is requested meets or exceeds the required steady state efficiency;

(d) Warranties:

(A) Basic Requirement:

(i) The contractor for the installation of energy conservation measures shall, in connection with such measures, warrant in writing that the recipient shall (for those measures found within one year from the date of installation to be defective due to materials, manufacture, design or installation) at a minimum be entitled to obtain, within a reasonable period of time and at no charge, appropriate replacement parts, materials or installation;

(ii) Any replacement parts or materials must be provided at the site of installation without charge for transportation and must be installed without charge by the contractor.

(B) Other law. This section may not relieve a warrantor under this section from full compliance with federal and state laws applicable to warranties, except to the extent that such law is inconsistent with the requirements of this section.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 469.040 & 469.165
Stats. Implemented: ORS 469
Hist.: DOE 5-1983, f. & ef. 12-2-83; DOE 8-1984, f. & ef. 12-19-84; DOE 1-1987, f. & ef. 2-19-87; DOE 3-1987, f. & ef. 12-18-87; DOE 2-1991, f. & cert. ef. 10-14-91; DOE 1-2000, f. 3-30-00, cert. ef. 4-1-00; DOE 2-2003, f. 9-24-03, cert. ef. 10-1-03; DOE 5-2004, f. 10-14-04, cert. ef. 11-1-04; DOE 2-2007, f. 8-29-07, cert. ef. 9-1-07; DOE 8-2008, f. 12-4-08, cert. ef. 12-5-08

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Department of Fish and Wildlife
Chapter 635

Rule Caption: Amended rules related to Oregon Commercial Fishing Regulations.
Adm. Order No.: DFW 142-2008
Filed with Sec. of State: 11-21-2008
Certified to be Effective: 11-21-08
Notice Publication Date: 10-1-2008
Rules Amended: 635-004-0014, 635-004-0020, 635-004-0035, 635-004-0048, 635-004-0050, 635-004-0060, 635-004-0135, 635-004-0170, 635-005-0001, 635-005-0005, 635-005-0016, 635-005-0045, 635-005-0047, 635-005-0048, 635-005-0055, 635-005-0065, 635-005-0084, 635-005-0090, 635-005-0095, 635-005-0100, 635-005-0135, 635-005-0140, 635-005-0145, 635-005-0180, 635-006-0001, 635-006-0132, 635-006-0133, 635-006-0145, 635-006-0150, 635-006-0165, 635-006-0200, 635-006-0205, 635-006-0207, 635-006-0210, 635-006-0211, 635-006-0213, 635-006-0215, 635-006-0225, 635-006-0230, 635-006-0235, 635-006-0412, 635-006-0425, 635-006-0810, 635-006-1035, 635-006-1075, 635-041-0005, 635-041-0010, 635-041-0030, 635-041-0040, 635-041-0045, 635-041-0060, 635-041-0061, 635-041-0063, 635-041-0065, 635-041-0510, 635-041-0520, 635-041-0600, 635-042-0001, 635-042-0007, 635-042-0022, 635-042-0110
Subject: Amended rules adopt changes to: (1) rules for commercial sale of steelhead trout and walleye purchased outside Oregon; (2) rules allowing use of a dock ticket in lieu of a fish receiving ticket at the time of landing; and (3) housekeeping and technical corrections were made to ensure rule consistency within commercial fishing regulations contained in chapter 635, divisions 4, 5, 6, 41 and 42.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-004-0014
No Directed Reduction Fishery Allowed

(1) No more than ten percent of a sardine landing may be used for the purposes of conversion into fish flour, fish meal, fish scrap, fertilizer, fish oil, other fishery products or by-products for purposes other than human consumption or fishing bait.

(2) Exceptions to the limit in section (1) of this rule may be granted due to unforeseen circumstances with written authorization by the Director to avoid wastage of fish.

Stat. Auth.: ORS 506.119
Stats. Implemented: ORS 506.109 & 506.129
Hist.: DFW 139-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0020
Definitions

As used in Division 004 regulations, unless the context requires otherwise:

(1) "At-sea processing" means processing that takes place on a vessel or other platform that floats and is capable of being moved from one location to another whether shoreside or on the water.

(2) "Commission" means the Oregon Fish and Wildlife Commission.

(3) "Department" means the Oregon Department of Fish and Wildlife.

(4) "Director" means the Director of the Oregon Department of Fish and Wildlife.

(5) "DTS complex" includes Dover sole (*Microstomus pacificus*), thornyhead (*Sebastolobus* spp.), and trawl-caught sablefish (blackcod, *Anoplopoma fimbria*).

(6) "Exclusive economic zone" means the zone between 3 200 nautical miles offshore of the United States.

(7) "Fishing gear" includes:

(a) "Beam trawl" means a trawl which is held open by a fixed beam frame;

(b) "Bobbin trawl" means the same as roller trawl, and is a type of bottom trawl;

(c) "Bottom trawl" means a trawl in which the otter boards or the footrope of the net contact the seabed, and includes Danish and Scottish seine gear. It also includes pair trawls fished on the bottom. Any trawl not meeting the requirements for pelagic trawls described in OAR 635-004-0040(5) is a bottom trawl;

(d) "Chafing gear" means webbing or other material attached to the codend of a trawl net to protect the codend from wear;

(e) "Codend" shall be defined as the last 50 mesh length constituting the terminal, closed end of a trawl. The meshes shall be counted forward of the pursing tackle which terminates the codend;

(f) "Double-ply mesh" or "Double-bar mesh" means two lengths of twine tied into a single knot;

(g) "Double-walled codend" means a codend constructed of two walls of webbing;

(h) "Fixed gear" means longline, trap or pot, setnet, and stationary hook-and-line gears;

(i) "Gillnet" has the meaning as set forth in OAR 635-042-0010;

(j) "Hook-and-line" means one or more hooks attached to one or more lines;

(k) "Large footrope trawl gear" is a bottom trawl net with a footrope diameter larger than 8 inches (20 cm) (including rollers, bobbins or other material encircling or tied along the length of the footrope).

(l) "Longline" means a stationary buoyed, and anchored groundline with hooks attached;

(m) "Mesh size" means the opening between opposing knots. Minimum mesh size means the smallest distance allowed between the inside of one knot to the inside of the opposing knot regardless of twine size;

(n) "Nontrawl gear" means all legal commercial groundfish gear other than trawl gear;

(o) "Pelagic trawl" (midwater or off-bottom) means a trawl in which the otter boards may be in contact with the seabed but the footrope of the net remains above the seabed. It includes pair trawls if fished in midwater. A pelagic trawl has no rollers or bobbins on the net;

(p) "Pot or trap" means a portable, enclosed device with one or more gates or entrances and one or more lines attached to surface floats;

(q) "Roller trawl" or "bobbin trawl" are identical, and mean a trawl net with footropes equipped with rollers or bobbins made of wood, steel, rubber, plastic, or other hard material which protects the net and footrope during fishing on the seabed. A roller trawl is a type of bottom trawl;

(r) "Seine" means any nonfixed net other than a trawl net or gillnet;

(s) "Selective flatfish trawl gear" is a type of small footrope trawl gear. The selective flatfish trawl net must be a two-seamed net with no more than two riblines, excluding the codend. The breastline may not be longer than 3 ft (0.92 meters) in length. There may be no floats along the center third of the headrope or attached to the top panel except on the riblines. The footrope must be shorter than 105 ft (32.26 meters) in length. The headrope must be at least 30% longer in length than the footrope. An explanatory diagram of a selective flatfish trawl net is provided as Figure 1 of Part 660, Subpart G in Title 50 Code of Federal Regulations.

(t) "Set net" means a stationary, buoyed and anchored gillnet or trammel net;

(u) "Single-walled codend" means a codend constructed of a single wall of webbing knitted with single or double-ply mesh;

(v) "Small footrope trawl gear" is a bottom trawl net with a footrope diameter of 8 inches (20 cm) or smaller (including rollers, bobbins or other material encircling or tied along the length of the footrope). Other lines or ropes that run parallel to the footrope must not be augmented with material encircling or tied along their length such that they have a diameter larger than 8 inches (20 cm). For enforcement purposes, the footrope will be measured in a straight line from the outside edge to the opposite outside edge at the widest part on any individual part, including any individual disk, roller, bobbin, or any other device.

(w) "Trammel net" means a gillnet made with two or more walls joined to a common float line;

(x) "Trawl net" means a cone or funnel-shaped net which is towed or drawn through the water by one or two vessels. Trawl nets are used both on bottom and off bottom. They may be fished with or without trawl doors.

They may employ warps or cables to herd fish. Trawl nets are restricted to beam trawl, bobbin or roller trawl, bottom trawl and pelagic trawl;

(y) "Trawl riblines" means heavy rope or lines that run down the sides, top, or underside of a trawl net from the mouth of the net to the terminal end of the codend to strengthen the net during fishing;

(z) "Troll" means fishing gear that consists of 1 or more lines that drag hooks with bait or lures behind a moving fishing vessel. Additional troll fishing gear defined in the Code of Federal Regulations, Title 50, Part 660 H;

(aa) "Vertical hook and line (Portuguese longline)" means a line attached to the vessel or to a surface buoy vertically suspended to the bottom by a weight or anchor, with hooks attached between its surface and bottom end.

(8) "Groundfish" means all species of ocean food fish defined as groundfish in the Pacific Coast Groundfish Fishery Management Plan and in the Federal Groundfish Regulations, Title 50, Parts 660 and 663.

(9) "Inland waters" means all waters of the state except the Pacific Ocean.

(10) "Land, landed, or landing" means to begin transfer of fish from a fishing vessel. Once transfer begins, all fish aboard the vessel are counted as part of the landing.

(11) "Length, total" is measured from the tip of the snout (mouth closed) to the tip of the tail (pinched together) without mutilation of the fish or the use of additional force to extend the length.

(12) Management lines include:

(a) "Cape Arago" means a line extending due west at 43 degrees 20 minutes 50 seconds north latitude;

(b) "Cape Blanco" means a line extending due west at 42 degrees 50 minutes 00 seconds north latitude;

(c) "Cape Falcon" means a line extending due west at 45 degrees 46 minutes 00 seconds north latitude;

(d) "Cape Lookout" means a line extending due west at 45 degrees 20 minutes 15 seconds north latitude;

(e) "Cascade Head" means a line extending due west at 45 degrees 03 minutes 50 seconds north latitude;

(f) "Heceta Head" means a line extending due west at 44 degrees 08 minutes 18 seconds north latitude;

(g) "Humbug Mountain" means a line extending due west at 42 degrees 40 minutes 30 seconds north latitude;

(h) "Mack Arch" means a line extending due west at 42 degrees 13 minutes 40 seconds north latitude.

(13) "Ocean food fish" includes all saltwater species of food fish except salmon, halibut, and shellfish whether found in fresh or salt water.

(14) "Pacific Ocean" means all water seaward of the end of the jetty or jetties of any river, bay, or tidal area, except in the Columbia River the Pacific Ocean has the definition prescribed in OAR 635-003-0005, or all water seaward of the extension of the shoreline high watermark across the river, bay, or tidal area where no jetties exist.

(15) "Rockfish" includes:

(a) Aurora rockfish, *Sebastes aurora*;
(b) Bank rockfish, *S. rufus*;
(c) Black rockfish, *S. melanops*;
(d) Black and yellow rockfish, *S. chrysomelas*;
(e) Blackgill rockfish, *S. melanostomus*;
(f) Blue rockfish, *S. mystinus*;
(g) Bocaccio, *S. paucispinis*;
(h) Bronzespotted rockfish, *S. gilli*;
(i) Brown rockfish, *S. auriculatus*;
(j) Calico rockfish, *S. dalli*;
(k) California scorpionfish, *Scorpaena quttata*;
(l) Canary rockfish, *Sebastes pinniger*;
(m) Chilipepper, *S. goodei*;
(n) China rockfish, *S. nebulosus*;
(o) Copper rockfish, *S. caurinus*;
(p) Cowcod, *S. levis*;
(q) Darkblotched rockfish, *S. crameri*;
(r) Dusty rockfish, *S. ciliatus*;
(s) Flag rockfish, *S. rubrivinctus*;
(t) Gopher rockfish, *S. carnatus*;
(u) Grass rockfish, *S. rastrelliger*;
(v) Greenblotched rockfish, *S. rosenblatti*;
(w) Greenspotted rockfish, *S. chlorostictus*;
(x) Greenstriped rockfish, *S. elongatus*;
(y) Harlequin rockfish, *S. variegatus*;
(z) Honeycomb rockfish, *S. umbrosus*;
(aa) Kelp rockfish, *S. atrovirens*;
(bb) Longspine thornyhead, *Sebastolobus altivelis*;
(cc) Mexican rockfish, *Sebastes macdonaldi*;
(dd) Olive rockfish, *S. serranoides*;
(ee) Pacific ocean perch, *S. alutus*;
(ff) Pink rockfish, *S. eos*;
(gg) Quillback rockfish, *S. maliger*;
(hh) Redbanded rockfish, *S. babcocki*;
(ii) Redstripe rockfish, *S. proriger*;
(jj) Rosethorn rockfish, *S. helvomaculatus*;
(kk) Rosy rockfish, *S. rosaceus*;
(ll) Rougheye rockfish, *S. aleutianus*;
(mm) Sharpchin rockfish, *S. zacentrus*;
(nn) Shortbelly rockfish, *S. jordani*;
(oo) Shortraker rockfish, *S. borealis*;
(pp) Shortspine thornyhead, *Sebastolobus alascanus*;
(qq) Silvergray rockfish, *Sebastes brevispinis*;
(rr) Speckled rockfish, *S. ovalis*;
(ss) Splitnose rockfish, *S. diploproa*;
(tt) Squarespot rockfish, *S. hopkinsi*;
(uu) Starry rockfish, *S. constellatus*;
(vv) Stripetail rockfish, *S. saxicola*;
(ww) Tiger rockfish, *S. nigrocinctus*;
(xx) Treefish, *S. serriceps*;
(yy) Vermilion rockfish, *S. miniatus*;
(zz) Widow rockfish, *S. entomelas*;
(aaa) Yelloweye rockfish, *S. ruberrimus*;
(bbb) Yellowmouth rockfish, *S. reedi*.

(16) "*Sebastes* complex" means all rockfish managed by the **Pacific Coast Groundfish Fishery Management Plan** except Pacific ocean perch (*Sebastes alutus*), widow rockfish (*S. entomelas*), shortbelly rockfish (*S. jordani*), and thornyhead (*Sebastolobus* spp.). The *Sebastes* complex includes yellowtail rockfish (*Sebastes flavidus*).

(17) "Shore-based (shoreside) processors" means any facility where fish will be processed which is fixed permanently to land.

(18) "Tender" means any vessel that buys or obtains fish directly from a catching vessel and transports it to a port of landing or fish dealer.

(19) "Trip limit" means the total allowable amount of a groundfish species or species complex, by weight, or by percentage of fish on board, that may be taken and retained, possessed, or landed per vessel from a single fishing trip. A vessel which has landed its cumulative or daily limit may continue to fish on the limit for the next legal period as long as the fish are not landed until the next period:

(a) "Daily trip limit" means the maximum amount that may be taken and retained, possessed, or landed per vessel in 24 consecutive hours, starting at 0001 hours local time. Only one landing of groundfish may be made in that 24 hour period;

(b) "Cumulative trip limit" means the maximum amount that may be taken and retained, possessed, or landed per vessel in a specified period of time, without a limit on the number of landings or trips. Cumulative trip limits apply to calendar months.

Stat. Auth.: ORS 496.138 & 506.119
Stats. Implemented: ORS 496.162 & 506.129
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FWC 37, f. & ef. 1-23-76, Renumbered from 625-010-0545; FWC 49-1979, f. & ef. 11-1-79, Renumbered from 635-036-0270; FWC 10-1983, f. & ef. 3-1-83; FWC 1-1985(Temp), f. & ef. 1-4-85; FWC 5-1985, f. & ef. 2-19-85; FWC 17-1987(Temp), f. & ef. 5-7-87; FWC 103-1988, f. 12-29-88, cert. ef. 1-1-89; FWC 28-1989(Temp), f. 4-25-89, cert. ef. 4-26-89; FWC 130-1990, f. 12-31-90, cert. ef. 1-1-91; FWC 67-1991, f. 6-25-91, cert. ef. 7-1-91; FWC 21-1992(Temp), f. 4-7-92, cert. ef. 5-1-92; FWC 141-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 21-1992(Temp), f. 4-7-92, cert. ef. 5-1-92; FWC 36-1992, f. 5-26-92, cert. ef. 5-27-92; FWC 6-1993, f. 1-28-93, cert. ef. 2-1-93; FWC 95-1994, f. 12-28-94, cert. ef. 1-1-95; FWC 45-1995, f. & cert. ef. 6-1-95; FWC 71-1996, f. 12-31-96, cert. ef. 1-1-97; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 32-2005(Temp), f. 4-29-05, cert. ef. 5-1-05 thru 10-27-05; DFW 70-2005, f. & cert. ef. 7-8-05; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0035
Fishing Gear

(1) It is *unlawful* to possess, deploy, haul, or carry on board a fishing vessel a set net, trap or pot, longline, or commercial vertical hook-and-line that is not in compliance with the gear restrictions listed in sections (2) and (3) of this rule, unless such gear is the gear of another vessel that has been retrieved at sea and made inoperable or stowed in a manner not capable of being fished. The disposal at sea of such gear is prohibited by **Annex V** of the **International Convention for the Prevention of Pollution From Ships, 1973** (**Annex V of MARPOL 73/78**).

(2) It is *unlawful* to take ocean food fish for commercial purposes by any means except:

(a) Handline, pole-and-line, or pole-reel-and-line;

(b) Longlines and vertical hook and lines are permitted in the ocean;

(c) Pots or traps;

(d) Dipnets of hoop or A-frame design;

(e) Troll gear is permitted in the ocean from May 1 of any year through April 14 of the following year;

(f) Seines are permitted in the ocean for ocean food fish other than groundfish and for the taking of herring, sardine, smelt, and anchovy from the following inland waters:

(A) Columbia River westerly of the U.S. Highway 101 Astoria Bridge across the Columbia River;

(B) Tillamook Bay;

(C) Yaquina Bay;

(D) Alsea Bay;

(E) Winchester Bay;

(F) Coos Bay.

(g) Trawl nets (bottom and pelagic) are permitted in the ocean;

(h) Set nets (trammel nets and anchored gillnets) are permitted outside state waters for groundfish south of latitude 38 degrees N. (Pt. Reyes, CA). The use of set nets is prohibited in all areas of the Pacific Ocean north of latitude 38 degrees N. except when permitted by an experimental gear permit (OAR 635-006-0020) or except when permitted under the Developmental Fisheries Program (635-006-0800 through 635-006-0950); or

(i) Spear.

(3) Longline, vertical hook-and-line and pot gear which is fixed or anchored to the bottom or drifting unattached to the vessel have the following restrictions:

(a) Gear shall not be left unattended for more than seven days;

(b) Longline and pot gear shall be marked at each terminal surface end with a pole, flag, light, radar reflector, and a buoy showing clear identification of the owner or operator;

(c) Vertical hook-and-line gear that is closely tended may be marked only with a single buoy of sufficient size to float the gear. "Closely tended" means that a vessel is within visual sighting distance or within 1/4 nautical mile as determined by electronic navigational equipment, of its vertical hook-and-line gear;

(d) Pot gear used for other than Dungeness crab and hagfish shall have biodegradable escape panels constructed with #21 or smaller, untreated cotton twine in such manner that an opening at least eight inches in diameter will result when the twine deteriorates;

(e) Pot gear used for hagfish shall include a biodegradable escape exit of at least three inches in diameter constructed with 120 thread size or smaller, untreated cotton twine or mild steel not to exceed 1/4-inch (six mm) in diameter or other materials approved by the Director. All other species of finfish and shellfish caught in hagfish pots authorized under this rule must be returned immediately to the water.

(4) A buoy used to mark fixed gear under section (3)(b) of this rule must be marked with a number clearly identifying the owner or operator of the vessel. The number may be either:

(a) If required by applicable state law, the vessel's number, the commercial fishing license number, or buoy brand number; or

(b) The vessel documentation number issued by the U.S. Coast Guard, or, for an undocumented vessel, the vessel registration number issued by the state.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 506.119

Stats. Implemented: ORS 506.129

Hist.: FC 246, f. 5-5-72, ef. 5-15-72, Renumbered from 625-010-0555; FWC 166, f. & ef. 12-23-77; FWC 34-1979, f. & ef. 8-22-79, Renumbered from 635-036-0280; FWC 10-1983, f. & ef. 3-1-83; FWC 103-1988, f. 12-29-88, cert. ef. 1-1-89; FWC 123-1989, f. 12-19-89, cert. ef. 1-1-90; FWC 112-1990, f. 10-3-90, cert. ef. 10-5-90; FWC 141-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 45-1995, f. & cert. ef. 6-1-95; FWC 51-1995, f. 6-16-95, cert. ef. 6-19-95; FWC 71-1996, f. 12-31-96, cert. ef. 1-1-97; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0048

Maintaining Records of Cumulative Catch

Vessels landing groundfish under a cumulative catch limit shall keep copies of fish landing receipts on board for inspection by authorized enforcement officials for a minimum of 90 days from date of delivery. Receipts shall be signed and dated by both the dealer representative and vessel captain. Fish landing receipts may be in the form of Department Fish Receiving Tickets; fish dealer "dock tickets" identified with official dealer logo's or other identifying letterhead; or official Fish Receiving Tickets from other states.

Stat. Auth.: ORS 496.138, 496.162, 506.109, 506.119 & 506.129

Stats. Implemented: ORS 506.129

Hist.: FWC 141-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 36-1992, f. 5-26-92, cert. ef. 5-27-92; FWC 95-1994, f. 12-28-94, cert. ef. 1-1-95; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0050

Logbook Required

(1) The Department will provide a logbook to each licensed commercial fishing boat from which ocean food fish other than Dungeness crab are taken by means of a trawl net (including a shrimp trawl net), longline, hook-and-line, or pot. In addition, a logbook shall be provided to each licensed commercial fishing boat taking squid regardless of gear. The skipper of such boat shall be responsible for maintaining the logbook in an accurate and truthful manner in accordance with the instructions contained therein.

(2) Logbooks shall be completed for a fishing trip within one week of landing.

(3) The skipper of the licensed commercial fishing boat shall, upon request of an authorized representative of the Department, permit examination and transcription of information from such logbook. Information so received by the Department shall be considered as confidential.

(4) The agency copy of the logbook shall be surrendered upon request of Department personnel.

Stat. Auth.: ORS 506.119

Stats. Implemented: ORS 506.129

Hist.: FC 246, f. 5-5-72, ef. 5-15-72, Renumbered from 625-010-0570; FWC 34-1979, f. & ef. 8-22-79, Renumbered from 635-036-0295; FWC 15-1984, f. & ef. 4-5-84; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 135-2002, f. 12-23-02, cert. ef. 1-1-03; DFW 120-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0060

Fishing Gear

(1) It is *unlawful* to take shad for commercial purposes by any means other than:

(a) Gillnets or set nets of a mesh size not less than five inches nor more than 6 1/2 inches in the Coos, Coquille, and Siuslaw Rivers, except that in Coos Bay, the use of any set net downstream of a straight line from the red blinking light on the south bank at the east end of the Marshfield Channel to the green blinking light at the east end of the Marshfield Channel just off the northwesterly end of Bull Island, and a straight line from the same green blinking light across the northernmost tip of Bull Island to the east bank of Cooston Channel is prohibited;

(b) Gillnets having a mesh size of not less than six inches nor more than 6 3/4 inches in the Umpqua River;

(c) Gillnets or set nets of a mesh size not less than six inches nor more than 6 3/4 inches in the Smith River, a tributary of the Umpqua.

(2) "Gillnet" includes drift net or floater net and means a mesh net which takes fish commonly by gilling, having cork and lead lines and which is in a position to drift with the tide or current at all times in the waters in which it is being fished.

(3) It is *unlawful* for a gillnet in whole or in part to be anchored, tied, staked, fixed, or attached to the bottom, shore, or a beached boat; left unattended at any time it is in operation; attended by more than one boat while being fished; or for more than one gillnet to be fished from a licensed commercial fishing boat at any one time.

(4) There shall be sufficient buoyancy in the corks and/or floats on the cork line of any gillnet so that said net shall be free to drift with the current. None of the lines used thereon shall be of metal or of any metallic substance or material. The lead or weight on the lead line of any gillnet shall not exceed two pounds in total weight on any one fathom, measurement to be taken along the cork line of said net. However, should extra or additional weight appear necessary or make practical the operation of any such net, permission to use in excess of two pounds-weight per fathom of net may be granted by the Commission to any duly licensed gillnet fisher upon written application which includes an adequate justification for the additional leads or weights of any kind attached to any part of such net except as herein provided.

(5) "Set net" means a net which takes fish commonly by gilling and which in operation is set or anchored in a fixed position to a specific location and is not free to move or drift with the current or tide.

(6) Before a fisher may fish a set net at any one location, the fisher must first register the site by providing a written description of the site location to the Department of Fish and Wildlife, Southwest Regional Office, 4192 N. Umpqua Highway, Roseburg, OR 97470.

(7) It is *unlawful* for a:

(a) Set net or gillnet which is constructed of material having a breaking strength greater than 24 pounds pull on any single mesh to be used during the 1977 coastal rivers shad season;

(b) Set net or gillnet which is constructed of material having a breaking strength greater than ten pounds pull on any single mesh to be used beginning with the 1978 coastal rivers shad season;

(c) Set net to be used which exceeds 300 feet in length;

(d) Set net or any part or portion thereof to be set or operated within a distance of 150 feet from any other set net or any part or portion thereof including the monument or marker to which attached;

(e) Set net to be set or operated in such a manner that the portion of the set net at right angles to the thread of the bay or river is at any time longer than one-third the measured distance across the bay or river. This distance to be measured from bank to bank at mean low water;

(f) Commercial fisher to register and operate more than six set net sites at any one time;

(g) Commercial fisher to fish a set net at a site which the fisher has not registered with the Department;

(h) Commercial fisher to fish a set net at a site which is not clearly marked with his or her commercial fishing license number on a substantial post or monument created for that purpose on the bank of the river or upon a buoy securely anchored on the site location.

(8) The size of mesh of any gillnet or set net is determined by placing any three meshes of such net, while wet from soaking in water for not less than an hour, under ten pounds vertical tension and then measuring while under such tension the distance between the inside of the knot of the middle mesh to the outside of the opposite vertical knot of the middle mesh.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 241, f. 4-5-72, ef. 4-15-72; FC 272(74-4), f. 3-20-74, ef. 4-11-74; FC 287(74-22), f. 11-27-74, ef. 12-25-74; FWC 91, f. 2-23-77, ef. 3-1-77, Renumbered from 625-010-0620, Renumbered from 635-036-0305; FWC 27-1980, f. & ef. 6-23-80; FWC 77-1984, f. 11-28-84, ef. 12-1-84; FWC 8-1985 (Temp), f. & ef. 2-19-85; FWC 50-1989, f. 7-28-89, cert. ef. 7-31-89; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0135
Declaration

(1) The vessel operator of any vessel participating in the far offshore fishery intending to land fish or fish products in Oregon shall notify the Department of any such fishing trip at least 48 hours prior to leaving port by writing to the Oregon Department of Fish and Wildlife, Building #3, Marine Science Drive, Newport, OR 97365, or by calling 541-867-4741 during regular business hours Monday through Friday. Such declaration shall include the area to be fished and the intended port of landing, including the identification of the processor to whom delivery will be made.

(2) In addition, 24 hours or more prior to landing, the vessel operator shall notify the Department, at the telephone number listed above, during regular business hours, or the Oregon State Police at other times, telephone number 1-800-452-7888, of the following:

(a) Vessel name and documentation number;

(b) Estimated time of arrival;

(c) Port of landing;

(d) Processor's location; and

(e) Estimated weight of fish on board.

Stat. Auth.: ORS 496.138, 496.162, 506.119 & 506.129
Stats. Implemented: ORS 496.138, 496.162, 506.119 & 506.129
Hist.: FWC 109-1991(Temp), f. & cert. ef. 9-27-91; FWC 10-1992, f. 2-26-92, cert. ef. 2-27-92; DFW 142-2008, f. & cert. ef. 11-21-08

635-004-0170
Incidental Catch in Other Fisheries

A person may operate a vessel in the black rockfish / blue rockfish / nearshore fishery without a permit required by OAR 635-006-1015(1)(j) if the person:

(1) For only one landing per day, lands no more than 15 pounds of black rockfish, blue rockfish, nearshore fish, as defined in ORS 506.011, or a combination of black rockfish, blue rockfish or nearshore fish and if the black rockfish, blue rockfish and nearshore fish:

(a) Make up 25 percent or less of the total poundage of the landing; and

(b) Are landed with fishing gear that is legal to use in the fishery in which the black rockfish, blue rockfish or nearshore fish are landed;

(2) Operates a vessel in the ocean troll salmon fishery pursuant to ORS 508.801 to 508.825 and the person lands black rockfish, blue rockfish or a combination of black rockfish and blue rockfish in the same landing in which the person lands a salmon under the permit required by 508.801 to 508.825. The black rockfish or blue rockfish landed under this subsection must be landed dead. A person who lands black rockfish and blue rockfish under this subsection may land up 100 pounds of black rockfish, blue rockfish or a combination of black rockfish and blue rockfish per landing.

(3) Lands no more than 15 pounds per vessel of black rockfish, blue rockfish, or a combination of black rockfish and blue rockfish per trip, after the total amount of black rockfish and blue rockfish combined landed in the salmon troll fishery reaches 3000 pounds in any calendar year, except as provided in subsection (4).

(4) Operates a vessel in the west coast groundfish trawl fishery pursuant to federal regulations and lands no more than 1,000 pounds of black rockfish, blue rockfish or a combination of black rockfish and blue rockfish per calendar year and if the black rockfish and blue rockfish:

(a) Make up 25 percent or less of the total poundage of each landing; and

(b) Are landed dead; or

(5) Is a nonprofit aquarium or has contracted with a nonprofit aquarium to land black rockfish, blue rockfish or nearshore fish for the purpose of displaying or conducting research on the black rockfish, blue rockfish or nearshore fish.

(6) Does not exceed daily, weekly, or period limits as established in OAR 635-004-0033.

Stat. Auth.: ORS 506.109 & 506.119
Stats. Implemented: ORS 506.129 & 506.450 - 506.465
Hist.: DFW 112-2003, f. & cert. ef. 11-14-03; DFW 138-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 123-2007(Temp), f. 11-26-07, cert. ef. 11-28-07 thru 12-31-07; DFW 128-2007, f. 12-13-07, cert. ef. 1-1-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0001
Clams and Mussels for Bait

(1) As used in Division 005 regulations:

(a) "Bait" means clams or mussels not harvested for human consumption;

(b) "Biotoxin" means naturally occurring shellfish toxins monitored by the Oregon Department of Agriculture;

(c) "Commission" means the Oregon Fish and Wildlife Commission.

(d) "Department" means the Oregon Department of Fish and Wildlife.

(e) "Director" means the Director of the Oregon Department of Fish and Wildlife.

(f) "Health closure area" means an area closed to the public due to health risks of consuming shellfish from the area;

(g) "Live boxed" means any type of container used to hold or store clams/mussels in the water;

(h) "Open area" means an area approved by the Oregon Department of Agriculture for the harvest of clams or mussels for human consumption;

(i) "Restricted area" means an area closed or prohibited to commercial harvest of shellfish by the Oregon Department of Agriculture for the harvest of clams or mussels for human consumption by commercial shellfish harvesters.

(j) "Shellfish sanitation certificate" means a license required by Oregon Department of Agriculture to engage in business of harvesting shellfish for human consumption;

(2) It is *unlawful* to take clams or mussels for any commercial purpose from a health closure area closed for biotoxins.

(3) It is *unlawful* for any person to sell shellfish for human consumption:

(a) Taken from an area designated as restricted by the Oregon Department of Agriculture; or

(b) Taken without a shellfish sanitation certificate from the Oregon Department of Agriculture.

(4) Clams and mussels taken as bait must be visibly dyed with a Department of Fish and Wildlife-approved dye;

(a) Dyeing must occur before leaving the harvest area, before being transported by vehicle, or before the time of docking of the vessel used in harvesting;

(b) Clams and mussels taken for bait may not be possessed aboard a vessel while clams and mussels for human consumption are on board. Upon leaving the vessel or the harvest area, clams and mussels taken as bait may not be mixed with clams and mussels taken for human consumption.

(c) Prior to sale, clams or mussels taken from restricted areas and live boxed must be stored in a restricted area pending sale.

(d) Clams or mussels taken for human consumption and later sold as bait must be dyed at the time of sale to a bait dealer.

Stat. Auth.: ORS 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 137-1991(Temp), f. 12-20-91, cert. ef. 12-23-91; FWC 39-1992(Temp), f. & cert. ef. 6-19-92; DFW 61-2002, f. & cert. ef. 6-14-02; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0005
Abalone Fishery Prohibited

It is unlawful to take abalone for commercial purposes except for the following:

(1) Under OAR 635-006-0800 or;

(2) A commercial aquaculture facility may take abalone for use as broodstock under the terms and conditions specified in a permit issued by the Department. Application for such a permit shall be in writing and shall

include a description of the commercial aquaculture facility, the methods for collecting and returning broodstock abalone to and from the wild, the methods for checking abalone and imported kelp food for pathogens or exotic fauna, the procedures for isolating and culturing abalone to prevent contamination of wild abalone stock and such other information as the Department may require. Permit applications shall be mailed to: Marine Resources Program Office, Department of Fish and Wildlife, 2040 SE Marine Science Drive, Newport, OR, 97365.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 241, f. 4-5-72, ef. 4-15-72; Renumbered from 625-010-0320, 1975; Renumbered from 635-036-0190, 1979; FWC 24-1995, f. 3-29-95, cert. ef. 4-1-95; DFW 4-2008, f. & cert. ef. 1-23-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0016
Permit and Logbook Required

(1) It is *unlawful*:

(a) To take clams for commercial purposes without first obtaining a permit from the Department;

(b) To take clams except under the terms and conditions specified in the permit. Permits may be issued to mechanically harvest clams in subtidal areas by means of water jet or other hand or handpowered tool. Application for such a permit must be written and include a description of the specific areas where mechanical taking is proposed and such other information as the Director shall require.

(2) Applications should be mailed to: Marine Resources Program Office, Department of Fish and Wildlife, 2040 SE Marine Science Drive, Newport, OR 97365.

Stat. Auth.: ORS 506.109 & 506.119
Stats. Implemented: ORS 506.129
Hist.: FWC 30-1985, f. 6-27-85, ef. 7-1-85; DFW 61-2002, f. & cert. ef. 6-14-02; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0045
Closed Season in Pacific Ocean and Columbia River

(1) In addition to any closures described in Section 3, it is unlawful to take, land or possess Dungeness crab for commercial purposes from the Pacific Ocean or Columbia River from August 15 through November 30.

(2) It is *unlawful* prior to January 1 to land or to receive, or to buy, Dungeness crab from a vessel that has not been certified by officials of the State of Oregon, Washington, or California to have been free of Dungeness crab on November 30, except as provided in section (3)(b) of this rule.

(3) Delay of Season Openings:

(a) The Northern Zone is bounded on the north by Gray's Harbor (at Oyehut) and on the south by Cascade Head, Oregon: Upon a determination by the Department that preseason sampling indicates the consistent presence of more than 50 percent Grade II and III (softshell) crab in the samples, the Director, in consultation with the Washington Department of Fish and Wildlife, may adopt a temporary rule delaying the opening date of the commercial crab season in all or part of the Northern Zone area until additional sampling indicates meat recovery is 23 percent or is projected to be 23 percent by the opening date.

(b) The Southern Zone is bounded on the north by Cascade Head and on the south by Point Arena: Upon a determination by the Department that preseason sampling indicates meat recovery is projected to be less than 25 percent by December 1 in the Oregon portion of the Southern Zone, the Director shall delay the opening date of the commercial crab fishery in all or part of the Oregon portion of the zone for 15 days and re-open December 16.

(4) In the event the season in the Northern Zone or Southern Zone is delayed, the following applies:

(a) The Director shall adopt rules identifying the boundary between, or within, the Northern and Southern zones. The boundary between or within the zones shall take into account the existence of traditional fishing patterns;

(b) If the opening date for a season is delayed for either zone, or part of a zone, fishers electing to fish in a zone or part of a zone with a December 1 opening date may not fish in an area with the delayed opening date within the first 30 days of the delayed opening date;

(c) For the first 30 days of a fishing zone season, vessels electing to fish a zone shall be certified by officials of the State of Oregon, Washington or California to have been free of Dungeness crab on the day immediately prior to the opening day of the selected fishing zone. At the time of vessel inspection, the vessel operator shall certify the vessel has not been used to take crab in the selected fishing zone.

(4) Upon a determination by the Department that catch in Oregon's Pacific Ocean Dungeness crab fishery after May 31 is greater than ten percent of the catch in the previous December 1 through May 31 period, the Director shall adopt a temporary rule closing the commercial season until the following December 1.

Stat. Auth.: ORS 506.119
Stats. Implemented: ORS 506.129
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 285(74-20), f. 11-27-74, ef. 12-25-74; FC 293(75-6), f. 6-23-75, ef. 7-11-75; FWC 30, f. & ef. 11-28-75; FWC 132, f. & ef. 8-4-77; FWC 30-1985, f. 6-27-1985, ef. 7-1-85, Renumbered from 625-010-0155, Renumbered from 635-036-0125; FWC 56-1982, f. & ef. 8-27-82; FWC 13-1983, f. & ef. 3-24-83; FWC 39-1983(Temp), f. & ef. 8-31-83; FWC 11-1984, f. 3-30-84, ef. 9-16-84, except section (1) per FWC 45-1984, f. & ef. 8-30-84; FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 78-1986(Temp), f. & ef. 12-1-86; FWC 36-1987, f. & ef. 7-1-87; FWC 97-1987(Temp), f. & ef. 11-17-87; FWC 102-1988, f. 11-29-88, cert. ef. 12-29-88; FWC 119-1989(Temp), f. 11-29-89, cert. ef. 12-1-89; FWC 135-1991(Temp), f. 12-10-91, cert. ef. 12-11-91; FWC 136-1991(Temp), f. & cert. ef. 12-19-91; FWC 112-1992, f. 10-26-92, cert. ef. 11-1-92; FWC 70-1993, f. 11-9-93, cert. ef. 11-11-93; FWC 88-1994(Temp), f. 11-30-94, cert. ef. 12-1-94; FWC 89-1994(Temp), f. & cert. ef. 12-1-94; FWC 89-1995(Temp), f. 11-28-95, cert. ef. 12-1-95; FWC 1-1996(Temp), f. 1-11-96, cert. ef. 1-13-96; DFW 51-1998(Temp), f. 6-29-98, cert. ef. 7-1-98 thru 9-15-98; DFW 54-1998(Temp), f. & cert. ef. 7-24-98 thru 9-15-98; DFW 40-1999, f. & cert. ef. 5-26-99; DFW 70-2000, f. & cert. ef. 10-23-00; DFW 77-2000(Temp), f. 11-27-00, cert. ef. 12-1-00 thru 12-14-00; DFW 39-2002, f. & cert. ef. 4-26-02; DFW 128-2002(Temp), f. & cert. ef. 11-15-02 thru 1-31-03; DFW 129-2002(Temp), f. & cert. ef. 11-20-02 thru 1-31-03; DFW 132-2002(Temp), f. & cert. ef. 11-25-02 thru 1-31-03 (Suspended by DFW 133-2002(Temp)); DFW 133-2002(Temp), f. & cert. ef. 12-6-02 thru 1-31-03; DFW 117-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 2-29-04; Administrative correction 10-26-04; DFW 113-2004(Temp), f. 11-23-04, cert. ef. 12-1-04 thru 3-1-05; DFW 116-2004(Temp), f. & cert. ef. 12-8-04 thru 3-1-05; DFW 126-2004(Temp), f. & cert. ef. 12-21-04 thru 3-1-05; DFW 132-2004(Temp), f. & cert ef. 12-30-04 thru 3-1-05; Administrative correction, 3-18-05; DFW 129-2005(Temp), f. & cert. ef. 11-29-05 thru 12-31-05; DFW 140-2005(Temp), f. 12-12-05, cert. ef. 12-30-05 thru 5-31-06; Administrative correction 7-20-06; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0047
Possession and Landing Limits

(1) It is *unlawful*, from the second Monday in June through August 14, for any permitted ocean Dungeness crab vessel to take, land or possess more than 1200 pounds of Dungeness crab per week from the Pacific Ocean and Columbia River.

(2) Landing Dungeness crab legally taken from the Pacific Ocean and Columbia River is allowed in Oregon with a valid Oregon Dungeness crab permit.

(3) Commercial fishers must retain copies of fish landing receipts for a minimum of 90 days on board vessels landing Dungeness crab under the cumulative catch limit described in section (1) of this rule. The receipts must be available for inspection by authorized enforcement officials and by employees of the Department. Legal landing receipts are defined in section (4).

(4) For purposes of this rule, the following definitions apply:

(a) "Landing" and "Land" means to begin transfer of Dungeness crab from a fishing vessel. Once transfer begins, all Dungeness crab aboard the vessel are counted as part of the landing;

(b) "Landing receipt" means either a Department issued Fish Receiving Ticket or a fish dealer dock ticket identified with a fish dealer's logo or letterhead and that must include the following:

(A) Fish dealer's name and dealer license number;

(B) Date of landing of the Dungeness crab;

(C) Name of fisher from whom the Dungeness crab were purchased;

(D) Vessel name, vessel license number, and the federal document or State Marine Board number of the vessel from which catch was made;

(E) Port name of first landing;

(F) Fishing gear used by the fisher;

(G) Gross pounds of Dungeness crab received and price paid per pound; and

(H) Signature of both the fisher making the landing and the individual preparing the landing receipt.

(c) "Week" means the period beginning 12:01 a.m. local time Monday through 12 midnight Sunday.

Stat. Auth.: ORS 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: DFW 40-1999, f. & cert. ef. 5-26-99; DFW 117-2005, f. 10-7-05, cert. ef. 12-1-05; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0048
Reporting Requirements

All commercial fishers landing Dungeness crab must report the area of primary catch to the dealer at the time of landing.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: DFW 117-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 2-29-04; DFW 10-2004, f. & cert. ef. 2-13-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0055
Fishing Gear

It is *unlawful* for commercial purposes to:

(1) Take crab by any means other than crab rings or crab pots (ORS 509.415); a crab ring is any fishing device that allows crab unrestricted entry or exit while fishing.

(2) Possess on a vessel, use, control, or operate any crab pot which is greater than thirteen cubic feet in volume, calculated using external dimensions.

(3) Possess on a vessel, use, control, or operate any crab pot which does not include a minimum of two circular escape ports of at least 4-1/4 inches inside diameter located on the top or side of the pot. If escape ports are placed on the side of the pot, they shall be located in the upper half of the pot.

(4) Possess on a vessel, use, control, or operate any crab pot which does not have a release mechanism. Acceptable release mechanisms are:

(a) Iron lid strap hooks constructed of iron or "mild" steel rod (not stainless steel) not to exceed 1/4-inch (6 mm) in diameter;

(b) A single loop of untreated cotton or other natural fiber twine, or other twine approved by the Department not heavier than 120 thread size between pot lid tiedown hooks and the tiedown straps; or

(c) Any modification of the wire mesh on the top or side of the pot, secured with a single strand of 120 thread size untreated cotton, natural fiber, or other twine approved by the Department which, when removed, will create an opening of at least five inches in diameter.

(5) Place, operate, or leave crab rings or pots in the Pacific Ocean and Columbia River or in any bay or estuary during the closed season, except that in only the Pacific Ocean and Columbia River, rings or pots may be placed no more than 64 hours immediately prior to the date the Dungeness crab season opens. In addition, unbaited crab rings or pots with open release mechanisms may be left in the Pacific Ocean (not including the Columbia River) for a period not to exceed 14 days following the closure of the Dungeness crab season.

(6) Have Dungeness crab gear deployed in the Pacific Ocean or Columbia River more than 14 days without making a landing of Dungeness crab.

(7) Use commercial crab pots in the Columbia River or Pacific Ocean unless the pots are individually marked with a surface buoy bearing, in a visible, legible and permanent manner, the brand of the owner and the Department buoy tag, provided that:

(a) The brand is a number registered with and approved by the Department;

(b) Only one unique buoy brand shall be registered to any one permitted vessel;

(c) All crab pots fished by a permitted vessel must use only the Oregon buoy brand number registered to that vessel in the area off of Oregon;

(d) The Department shall issue crab buoy tags to the owner of each commercial crab permit in the amount determined by OAR 635-006-1015(1)(g)(E);

(e) All buoy tags eligible to a permit holder must be purchased from the Department at cost and attached to the gear prior to setting gear; and

(f) Buoys attached to a crab pot must have the buoy tag securely attached to the first buoy on the crab pot line (the buoy closest to the crab pot) at the end away from the crab pot line;

(g) Additional buoy tags to replace lost tags will be issued by the Department as follows:

(A) As of the first business day after 30 days following the season opening in the area fished, up to ten percent of the tags initially issued for that season; or

(B) For a catastrophic loss, defined as direct loss of non-deployed gear in the event of a vessel being destroyed due to fire, capsizing, or sinking. Documentation of a catastrophic loss may include any information the Department considers appropriate, such as fire department or US Coast Guard reports; or

(C) If the Director finds that the loss of the crab pot buoy tags was:

(i) Due to an extraordinary event; and

(ii) The loss was minimized with the exercise of reasonable diligence; and

(iii) Reasonable efforts were taken to recover lost buoy tags and associated fishing gear.

(D) Upon receipt of the declaration of loss required by subsection (E) of this rule, and a request for replacement tags under subsection (C) of this rule, the Director or the Director's designee may provide an opportunity for the permit holder requesting the replacement tags to describe why the buoy tag loss meets the criteria for replacement under subsection (C). The Director or the Director's designee shall provide the Director's order to the permit holder and to the Department's License Services. The permit holder may appeal the Director's findings to the Fishery Permit Review Board under OAR 635-006-1065(1)(g).

(E) Permit holders (or their alternative designated on the buoy tag order form) must obtain, complete, and sign a declaration of loss under penalty of perjury in the presence of an authorized Department employee. The declaration shall state the number of buoy tags lost, the location and date where lost gear or tags were last observed, and the presumed cause of the loss.

(8) Remove, damage, or otherwise tamper with crab buoy or pot tags except when lawfully applying or removing tags on the vessel's buoys and pots.

(9) Possess on a vessel, use, control, or operate any crab pot which does not have a pot tag identifying the pot as that vessel's, a surface buoy bearing the Department buoy brand registered to that vessel and a Department buoy tag issued by the Department to that vessel, except:

(a) To set gear as allowed under OAR 635-006-1015; or

(b) Under a waiver granted by the Department to allow one time retrieval of permitted crab gear to shore by another crab permitted vessel provided that:

(A) Vessel is incapacitated due to major mechanical failure or destroyed due to fire, capsizing, or sinking;

(B) Circumstances beyond the control of the permit holder created undue hardship as defined by OAR 635-006-1095(7)(d);

(C) A Request must be in writing and a waiver approved and issued prior to retrieval.

(D) A copy of the waiver must be on board the vessel making the retrieval. (Contact Oregon Department of Fish and Wildlife License Services, Salem for guidelines.)

(c) A vessel may transit through the Columbia River and the Pacific Ocean adjacent to Oregon while possessing crab pots not bearing Oregon buoy tags or Oregon buoy branded surface buoys, provided that the vessel is authorized to participate in the Dungeness crab fishery of an adjacent state.

(10) Attach one crab pot to another crab pot or ring net by a common groundline or any other means that connects crab pots together,

(11) Take crabs for commercial purposes by crab pots from any bay or estuary except the Columbia River.

(12) Operate more than 15 crab rings from any one fishing vessel in bays or estuaries, except the Columbia River.

(13) Take or fish for Dungeness crab for commercial purposes in the Columbia River or Pacific Ocean adjacent to the state of Oregon unless a crab pot allocation has been issued to the permit required under OAR 635-006-1015(1)(g).

(14) Deploy or fish more crab pots than the number of pots assigned by the crab pot allocation certificate or to use any vessel other than the vessel designated on the crab pot allocation, except to set gear as allowed under OAR 635-006-1015.

Stat. Auth.: ORS 506.119

Stats. Implemented: ORS 506.109 & 506.129

Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 285(74-20), f. 11-27-74, ef. 12-25-74, Renumbered from 625-010-0160; FWC 49-1978, f. & ef. 9-27-78, Renumbered from 635-036-0130; FWC 56-1982, f. & ef. 8-27-82; FWC 81-1982, f. & ef. 11-4-82; FWC 82-1982(Temp), f. & ef. 11-9-82; FWC 13-1983, f. & ef. 3-24-83; FWC 11-1984, f. 3-30-84, ef. 9-16-84, except section (5) per FWC 45-1984, f. & ef. 8-30-84; FWC 72-1984, f. & ef. 10-22-84; FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 78-1986 (Temp), f. & ef. 12-1-86; FWC 97-1987(Temp), f. & ef. 11-17-87; FWC 102-1988, f. 11-29-88, cert. ef. 12-29-88; FWC 107-1990, f. & cert. ef. 10-1-90; FWC 70-1993, f. 11-9-93, cert. ef. 11-11-93; FWC 84-1994, f. 10-31-94, cert. ef. 12-1-94; FWC 68-1996(Temp), f. & cert. ef. 12-5-96; FWC 2-1997, f. 1-27-97, cert. ef. 2-1-97; DFW 45-2006, f. 6-20-06, cert. ef. 12-1-06; DWF 96-2006(Temp), f. & cert. ef. 9-8-06 thru 3-6-07; DFW 97-2006(Temp), f. 9-8-06, cert. ef. 9-9-06 thru 3-7-07;DFW 123-2006(Temp), f. 11-28-06, cert. ef. 12-1-06 thru 3-7-06; DFW 135-2006(Temp), f. & cert. ef.12-26-06 thru 6-15-07; DFW 11-2007, f. & cert. ef. 2-14-07; DFW 41-2007, f. & cert. ef. 6-8-07; DFW 82-2007(Temp), f. 8-31-07, cert .ef. 9-1-07 thru 10-31-07; DFW 113-2007, f. & cert. ef. 10-25-07; DFW 127-2007(Temp), f. & cert. ef. 12-11-07 thru 6-7-08; DFW 129-2007(Temp), f. & cert. ef. 12-14-07 thru 6-7-08; DFW 29-2008(Temp), f. & cert. ef. 3-25-08 thru 8-31-08; DFW 59-2008(Temp), f.& cert. ef. 6-11-08 thru 8-28-08; DFW 98-2008(Temp), f. 8-19-08, cert. ef. 8-29-08 thru 10-31-08; Administrative correction 11-18-08; DFW 145-2008(Temp), f. 11-24-08, cert. ef. 12-1-08 thru 5-29-09; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0065
Fishing Gear

(1) Except as provided in OAR 635-005-0063, it is unlawful to take, Tanner, Oregon hair, and scarlet king crab for commercial purposes except by crab rings, crab pots, and crab pot longline gear. Crab rings are defined as any fishing device that allows crab unrestricted entry or exit while fishing. Crab pots and crab pot longline gear must comply with the provisions contained in 635-004-0035.

(2) Except as provided in OAR 635-005-0063, it is unlawful to take red rock and box crab for commercial purposes except by crab rings and

crab pots. Crab rings and crab pots must comply with the provisions contained in 635-005-0055.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 84-1994, f. 10-31-94, cert. ef. 12-1-94; DFW 4-2008, f. & cert. ef. 1-23-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0084
Identification of Gear

All boats, traps, buoys, liveboxes, holding pens, boxes, bags, or other containers used to take, hold, or transport crayfish must be labeled with an identification number issued by the Department.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FWC 22-1988, f. 3-21-88, cert. ef. 4-1-88; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0090
Closed Season

(1) It is *unlawful* to take intertidal animals and mussels for commercial purposes without first obtaining a permit issued by the Department.

(2) Commercial permits will not be issued to other than licensed commercial or bait fishers.

(3) Application for a permit may be submitted by letter or on the appropriate Department form. Letter applications must include the following:

(a) Name and address of applicant;
(b) Commercial or bait fishing license number of applicant;
(c) Species to be collected;
(d) Collecting period;
(e) Collecting areas.

(4) Applications should be mailed to: Marine Resources Program Office, Oregon Department of Fish and Wildlife, 2040 SE Marine Science Drive, Newport, Oregon 97365.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 241, f. 4-5-72, ef. 4-15-72, Renumbered from 625-010-0650, Renumbered from 635-036-0315; FWC 20-1980, f. 4-25-80, ef. 4-28-80; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0095
Collection Report

(1) A collection report form will be provided with each commercial intertidal animal permit issued by the Department. The collection report must be completed and returned to the Department by the permittee immediately upon expiration of the collection permit.

(2) No subsequent collection permit shall be issued to an individual who has not submitted a collection report for any prior collection permit.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 241, f. 4-5-72, ef. 4-15-72, Renumbered from 625-010-0655, Renumbered from 635-036-0320; FWC 20-1980, f. 4-25-80, ef. 4-28-80; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0100
Permit Areas

It is *unlawful* to take subtidal or intertidal marine invertebrates and shellfish (including mussels) for commercial purposes, other than as set forth in a collection permit issued by the Department, in the following areas described in OAR 635-039-0090 and the "Oregon Sport Fishing Regulations:"

(1) Boiler Bay.
(2) Depoe Bay.
(3) Harris Beach.
(4) Haystack Rock.
(5) Neptune State Park.
(6) Sunset Bay — Cape Arago.
(7) Yaquina Head.
(8) Pirate Cove Research Reserve.
(9) Gregory Point Research Reserve.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.119 & 506.129
Hist.: FC 241, f. 4-5-72, ef. 4-15-72, Renumbered from 625-010-0660, Renumbered from 635-036-0325; FWC 20-1980, f. 4-25-80, ef. 4-28-80; FWC 25-1995, f. 3-29-95, cert. ef. 4-1-95; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0135
Oyster Importation Prohibited Except by Permit

It is *unlawful* for any person to import oysters into this state for the purpose of planting or to plant the same in the waters of this state without first having obtained a permit to do so from the Director.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 140, f. 3-4-66, Renumbered from 625-010-0280, Renumbered from 635-036-0170; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0140
Oyster Import Applications and Permit

(1) Any person before importing into this state any oysters for the purpose of planting shall first apply in writing to the Director for a permit to import the oysters. Such application shall be in the form of a letter and shall include the following information: maximum quantity to be imported, name of exporter, the approximate time the shipment will be made, and the name of the person or agency that will inspect the seed including a notarized certification from such person or agency at the time the oysters are inspected, declaring them to the best of his knowledge free from disease, infestation pests, and other substances which might endanger shellfish in the waters of this state.

(2) The Director shall issue a permit to import oysters for planting in the waters of this state when it has been established to his satisfaction that a qualified person or agency will inspect the oysters and certify them as being free of disease, infestation pests, and other substances which might endanger shellfish in the waters of this state.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 140, f. 3-4-66; FWC 30-1985, f. 6-27-85, ef. 7-1-85, Renumbered from 625-010-0285, Renumbered from 635-036-0175; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0145
Prohibited Activities in Restricted Shellfish Area

(1) Netarts Bay and all waters, tidelands, and oyster handling facilities operated in conjunction with said water and tidelands of Netarts Bay are defined as a restricted shellfish area.

(2) It shall be *unlawful* for any person to move or transfer from a restricted shellfish area any oysters, any marine organisms adversely affecting oysters, or other material whatsoever without first obtaining written permission from the Director.

Stat. Auth.: ORS 506.119 & 506.129
Stats. Implemented: ORS 506.129
Hist.: FC 140, f. 3-4-66, Renumbered from 625-010-0290, Renumbered from 635-036-0180; FWC 30-1985, f. 6-27-85, ef. 7-1-85; DFW 142-2008, f. & cert. ef. 11-21-08

635-005-0180
Sea Urchin Fishery

(1) It is *unlawful* for commercial purposes to take, land, or possess sea urchins:

(a) Without first obtaining a permit issued by the Department;

(b) Which have been taken in water depths less than ten feet below mean lower low water;

(c) Where more than two divers were in the water off any one boat at the same time;

(d) Where more than two persons without permits, excluding persons authorized by the Department for the performance of official duties, were on board any boat while harvesting, possessing, or transporting sea urchins;

(e) Within the following areas:

(A) From Orford Reef described as the area encompassed by parallels of Latitude 42°46'N and 42°49'N from May 1 through October 31;

(B) Within 1,000 feet of Pyramid Rock on Rogue Reef described by the area encompassed by parallels of Latitude 42°26.4'N and 42°26.9'N and by meridians of Longitude 124°28.4'W and 124°27.8'W, or within the rectangle marked by corner buoys from May 1 through August 31.

(f) Unless the vessel displays the vessel's federal document or Marine Board numbers on a weather deck so as to be visible from above. The number shall contrast with the background and be in block arabic numerals at least 18 inches high for vessels over 65 feet in length and at least ten inches high for vessels 65 feet or less. The operator of the vessel shall keep the identifying markings clearly legible and in good repair, and shall ensure that no part of the vessel, its rigging, or its fishing gear obstructs the view of the vessel number from an enforcement vessel or aircraft;

(g) More than 50 per permit holder per day per trip between two and three and one-half inches in diameter (shell diameter — not including spines), except as provided in section (2) of this rule for purple sea urchins. There is no limit on the number of sea urchins less than two inches or greater than three and one-half inches in diameter.

(2) Placement, maintenance and removal of the buoys referred to in section (1)(e)(B) of this rule may be carried out cooperatively by the Department and volunteers from the sea urchin industry according to specifications set forth by memorandum of agreement with industry representatives or other interested parties.

(3) A holder of a current sea urchin permit may take more than 50 purple sea urchins between two inches and three and one-half inches in diameter, provided the permit holder obtains a special commercial sea urchin permit from the Department. Applications for a special commercial sea urchin permit shall be submitted on forms provided by the Department. The Department may attach terms and conditions to any special commercial permit including, but not limited to, on-board observers, area or time limits, and preharvest dive surveys of urchin beds.

(4) For each trip, any permit holder shall clearly identify and keep separate until processed all sea urchin taken by that permit holder.

(5) Notwithstanding any other provision in these regulations, no person other than the holder of a current sea urchin permit issued by the Department is allowed to dive in the water to take or attempt to take sea urchins or to otherwise assist, while submerged, in the harvest of sea urchins.

Stat. Auth.: ORS 506.119, 506.129 & 508.760
Stats. Implemented: ORS 506.129
Hist.: FWC 85-1987, f. 10-6-87, ef. 1-1-88; FWC 117-1989, f. 11-22-89, cert. ef. 12-1-89; FWC 50-1990, f. 6-15-90, cert. ef. 6-18-90; FWC 118-1990, f. 10-24-90, cert. ef. 10-22-90; FWC 12-1991, f. & cert. ef. 2-20-91; FWC 26-1992, f. 4-21-92, cert. ef. 4-22-92; FWC 96-1994, f. 12-28-94, cert. ef. 1-1-95; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0001
Definitions

For the purposes of OAR 635-006-0001 through 635-006-1210:

(1) "Commercial fishing license" means the commercial fishing licenses required by ORS 508.235 and, for purposes of the Limited Fish Seller Permit, includes an Albacore Tuna Landing License.

(2) "Commission" means the Oregon Fish and Wildlife Commission.

(3) "Department" means the Oregon Department of Fish and Wildlife.

(4) "Director" means the Director of the Oregon Department of Fish and Wildlife.

(5) "Fair market value" shall be based on the market price of food fish or shellfish at the same time and place that the fish are landed, or the price established in OAR 635-006-0232 when the market price cannot be determined. For species not listed in 635-006-0232, fair market value shall be based on the average price per pound paid to law enforcement officials for any fish or shellfish confiscated from persons landing legal overages, or the average ex-vessel price per pound paid for that species in that port during the month in which the overage occurred, whichever is greater. Unless otherwise noted, the fair market value is the price per pound and is based on round weight.

(6) "Fish buyer" means an individual employed by a wholesale fish dealer or food fish canner to purchase or receive food fish or shellfish from commercial fishers at locations other than the licensed premises of the wholesale fish dealer or food fish canner.

(7) "Fish-buying station" means a location other than the licensed premises of a wholesale fish dealer or food fish canner at which such wholesale fish dealer or food fish canner purchases or receives food fish or shellfish from commercial fishers.

(8) "Food fish canner" means a wholesale fish dealer who cans food fish including shellfish in hermetically sealed containers whereby no further preservation, artificial or otherwise, is required.

(9) "Harvester" means any person legally authorized to take food fish for commercial purposes.

(10) "Import" means to transport into Oregon from outside the State of Oregon.

(11) "Land" or "landing" means to begin transfer of fish from a fishing vessel. Once transfer begins, all fish aboard the vessel are counted as part of the landing.

(12) "Landing fees" means all fees due to the Department based on the pounds of fish or value of fish landed.

(13) "Limited fish seller" means any person who holds a valid Oregon commercial fishing license and who has obtained an annual Limited Fish Seller Permit which enables the fisher to sell any species of food fish, taken in lawful activity directly from his or her boat, pursuant to ORS 508.550.

(14) "Limited fish seller — nontreaty Columbia River Gillnet Salmon Vessel Permit fishery" means a person who holds a valid Oregon commercial fishing license, a Columbia River Gillnet Salmon Vessel Permit, and who has obtained an annual limited fish seller permit which enables the fisher to sell any species of food fish, taken in lawful activity directly from his or her boat or at locations away from the boat.

(15) "Nonreporting fish dealer" means a wholesale fish dealer or fish bait dealer who buys food fish exclusively from other wholesale fish dealers or bait dealers.

(16) "Overage" means any landing or portion of a landing that exceeds groundfish trip limits. Groundfish trip limits are approved by Pacific Fisheries Management Council and implemented by the National Marine Fisheries Service.

(17) "Possession" means holding any food fish, shellfish or parts thereof in a person's custody or control.

(18) "Processing" means smoking, reducing, loining, steaking, pickling, filleting, or fresh packaging requiring freezing of food fish, or any part thereof. (Does not include cooking crab.)

(19) "Processor" means a person who buys fresh food fish from a licensed commercial fisher or a wholesale fish dealer and processes food fish for sale through retail outlets or for sale to the ultimate consumer.

(20) "Purchase" means to obtain by paying money or its equivalent, trade, or barter.

(21) "Receive" or "Receiving" means to take or come into possession of.

(22) "Retail fish bait dealer" means a person who buys fresh food fish or shellfish from a wholesale fish dealer or wholesale fish bait dealer, and sells to the ultimate consumer for use as bait.

(23) "Retail fish dealer" means a person who buys fresh food fish or shellfish from wholesale fish dealers, undertakes limited processing activity (limited to loining of tuna, filleting, smoking, steaking, or pickling food fish or shellfish), and sells only to the ultimate consumer.

(24) "Retain" means to keep in possession or use.

(25) "Shellfish canner" means a wholesale fish dealer who cans only shellfish in hermetically sealed containers whereby no further preservation, artificial or otherwise, is required.

(26) "Transport" means, for purposes of OAR 635-006-0165, to move the food fish after landing.

(27) "Ultimate consumer" means the party that utilizes the product as food, including restaurants.

(28) "Value" means the monetary value of the food fish, or parts thereof, including eggs and other by-products, at the point of landing as usually determined by the first exchange between the harvester and the first purchaser. In addition:

(a) Value is typically the amount of money which the first purchaser pays at the time and place that the fish are off-loaded from a vessel, or brought to shore if there is no vessel involved in harvesting, before any reductions or deductions in the amount of money as a result of the dealer furnishing ice, fuel, food or other commodities; and

(b) Value includes bonuses and other payments based directly on the quantity or quality of food fish exchanged, regardless of the time of payment of such bonuses or other payments; and

(c) Value includes any payments based on the proportion or percentage of processed products recovered from the food fish landed in the round or other form; and

(d) Value for food fish not sold by the harvester is the value received for comparable fish sold to a wholesale fish dealer at the same time and place that the fish are landed; and

(e) Value for food fish purchased from a harvester, by the harvester when acting as a wholesale fish dealer, is the price that is or would be paid to any other harvester for the same fish; and

(f) Value for food fish sold by a limited fish seller is the retail price received by the harvester from the first purchaser; and

(g) Value for food fish imported from out of state but not previously taxed out of state is the price paid for the fish by the first Oregon purchaser.

(29) "Wholesale fish bait dealer" means a person who buys food fish or shellfish, or parts thereof, from a licensed commercial fisher, licensed commercial bait fisher, or licensed angler, and sells or uses such food fish or shellfish for bait, scientific or educational purposes, or live public display.

(30) "Wholesale fish dealer" means a person who:

(a) Buys food fish or shellfish from a commercial fisher; or

(b) Processes food fish or shellfish or any part thereof; or

(c) Sells food fish or shellfish to retail dealers or other wholesale fish dealers.

Stat. Auth.: ORS 506.119 & 513.020
Stats. Implemented: ORS 506.129, 508.025, 508.040 & 508.550
Hist.: FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0132
Limited Fish Sellers Permit

(1) The permit referred to in ORS 508.550 shall be available to commercial fishers who hold a valid commercial fishing license, including Albacore Tuna Landing License, and who sell the catch off his or her own vessel, or a vessel operated by the fisher.

(2) It is *unlawful* under this permit to sell any food fish or shellfish from a vessel which were not taken by that vessel.

(3) Prior to selling food fish from their vessel, the holder of a Limited Fish Seller Permit must notify the Department of the estimated number of food fish on board the vessel and the location where sales are to take place. Completion of a fish ticket prior to selling with the estimated number of fish on board and completion of the Limited Fish Seller Permit application which identifies location from which the sales occur constitutes the required notice. Change in location of sales from that reported in the Limited Fish Seller Permit application must be reported to the Department.

(4) Dressed fish must have an established dressed to round weight conversion factor.

(5) After the sale of and reporting of whole or dressed food fish, a limited fish seller may conduct or allow limited processing on his/her boat (limited to loining or filleting) of food fish or any part thereof for the ultimate consumer.

Stat. Auth.: ORS 506.119 & 513.020
Stats. Implemented: ORS 506.129, 508.025, 508.040 & 508.550
Hist.: FWC 1-1986, f. & ef. 1-10-86; FWC 99-1987, f. & ef. 11-17-87; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 84-1999, f. & cert. ef. 11-1-99; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0133
Limited Fish Seller Permit-Non-Treaty Columbia River Gillnet Salmon Vessel Permit Fishery Pilot Program

(1) The permit referred to in ORS 508.550 and as authorized by HB3094 (2003) shall be available to commercial fishers who hold a valid commercial fishing license and a Columbia River Gillnet Salmon Vessel Permit (Columbia River Gillnet Permit) and who sell the catch off his or her own vessel, or a vessel operated by the fisher or at locations away from the vessel.

(2) It is *unlawful* under this permit to sell any food fish or shellfish from a vessel or at locations away from the vessel which were not taken by the licensed vessel.

(3) Prior to selling food fish away from their vessel, the holder of a Limited Fish Seller Permit and a Columbia River Gillnet Permit must complete and forward a Fish Receiving Ticket at the time of landing in accordance with OAR 635-006-0210 and 635-006-0212 and must notify the Department of the location where sales are to take place. Compliance with these rules prior to selling and completion of the Limited Fish Seller Permit application which identifies location from which the sales occur and port of landing constitutes the required notice. Change in location of sales from that reported on the Limited Fish Seller Permit application must be reported to the Department.

(4) The permittee may designate other persons to sell fish at locations away from the vessel that were taken by the licensed vessel. The designees must carry a copy of the permit during sales. A copy of the fish receiving ticket or a signed statement pursuant to ORS 509.110 must accompany the permittee and designees while transporting and selling fish. The permittee will also designate on the fish ticket or sworn statement the location the fish are to be sold.

(5) After the sale of and reporting of whole or dressed food fish, a limited fish seller may conduct or allow limited processing (limited to loining or filleting) of food fish or any part thereof for the ultimate consumer.

(6) Activities conducted pursuant to this permit must be in accordance with the state Department of Agriculture licensing and food safety regulations.

(7) This authority expires January 2, 2008.

Stat. Auth.: ORS 506.119 & 513.020
Stats. Implemented: ORS 506.129, 508.025, 508.040, 508.550 & HB 3094 (2003)
Hist.: DFW 63-2003, f. & cert. ef. 7-17-03; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0145
Commercial Fishing License

(1) A commercial fishing license is issued in accordance with ORS 508.035 and 508.235 of the commercial fishing laws and is required for each individual who for commercial purposes:

(a) Takes or assists in the taking of any food fish or shellfish from the waters or land of this state;

(b) Operates or assists in the operation of any boat or fishing gear for the taking of food fish in the waters of this state; or

(c) Lands food fish from the waters of the Pacific Ocean at any point in this state.

(2) A commercial fishing license shall be in the possession of the licensee when engaged in the taking or landing of food fish or shellfish when taken for commercial purposes.

(3) It is *unlawful* for a licensed commercial fisher to keep any food fish or shellfish taken under such license for personal use.

Stat. Auth.: ORS 506.109, 506.119 & 506.129
Stats. Implemented: ORS 506.109, 506.119 & 506.129
Hist.: FC 246, f. 5-5-72, ef. 5-15-72, Renumbered from 625-040-0065, Renumbered from 635-036-0545; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0150
Single Delivery License

(1) The Single Delivery License is issued in accordance with ORS 508.035 for a one-time landing of food fish and is in lieu of the commercial fishing and boat license described in OAR 635-006-014 0 and 635-006-0145. Where "commercial fishing license" is used in ORS 508.235 and "boat license" is used in 508.260, this license may be substituted.

(2) In the absence of a commercial fishing and boat license, it is *unlawful* to engage in the taking or landing of food fish in waters of this state without a single delivery license.

(3) No food fish shall be removed from a boat requiring a Single Delivery License until the fee for such license is received and such license has been issued by an authorized agent of the Department. The license shall be on board the boat and available for inspection by the Oregon State Police or a representative of the Department whenever food fish are being unloaded.

(4) Single delivery licenses shall be forfeited upon landing to the wholesale fish dealer, who shall attach the license document to the appropriate Fish Receiving Ticket. Vessels taking fish outside of state waters may substitute the license fee at the time of landing for the license document.

(5) Vessels operating under a Single Delivery License must comply with OAR 635-006-0140(7), when requested by the Department.

Stat. Auth.: ORS 506.119, 506.129, 508.235 & 508.260
Stats. Implemented: ORS 508
Hist.: FC 246, f. 5-5-72, ef. 5-15-72, Renumbered from 625-040-0085, Renumbered from 635-036-0550; FWC 81-1985, f. 12-16-85, ef. 1-1-86; DFW 128-2003, f. 12-15-03, cert. ef. 1-1-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0165
Commercial Fisher Transportation Report

(1) It is *unlawful* for any commercial fisher or any other person to transport food fish or shellfish in this state without first preparing and having in possession a written transportation report, invoice, or memorandum. The transportation report, invoice, or memorandum shall include the following:

(a) Date;

(b) Name and address of person from whom food fish or shellfish were received. If being transported by a commercial fisher or received from a commercial fisher, include his or her commercial fishing license number;

(c) Name and address of the Oregon licensed Wholesale Fish Dealer or Oregon licensed Fish Bait Dealer where the food fish or shellfish are being delivered;

(d) The number of each species of food fish or shellfish, their weight or estimated weight in pounds.

(2) The food fish or shellfish shall be transported within 48 hours to an Oregon licensed Wholesale Fish Dealer or Oregon licensed Fish Bait Dealer and reported on a Fish Receiving Ticket within 48 hours of arriving in port.

(3) The transportation report, invoice, or memorandum shall be prepared prior to any food fish or shellfish being removed from the boat of original taking or prior to transporting away from the point of initial landing. For clams, the report shall be prepared prior to leaving the beach or clam digging area. For food fish or shellfish transported into Oregon from another state, the report shall be prepared prior to entering the State of Oregon. A bill of lading or freight bill required for common carriers is acceptable in lieu of a transportation report.

(4) The transportation report, invoice, or memorandum shall be retained by the commercial fisher or person transporting the food fish including shellfish for a period of six months and is subject to inspection by the Director, the Director's authorized agent, or by the Oregon State Police at any time during that period.

(5) This section does not apply to retail fish dealers, retail bait fish dealers, wholesale fish dealers, food fish canners, shellfish canners, and wholesale fish bait dealers when required to keep records in accordance with OAR 635-006-0205 and ORS 508.535.

Stat. Auth.: ORS 506.119
Stats. Implemented: ORS 506.129
Hist.: FC 246, f. 5-5-72, ef. 5-15-72, Renumbered from 625-040-0100, Renumbered from 635-036-0565; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0200
Required Records

(1) All retail fish dealers, retail and wholesale fish bait dealers, wholesale fish dealers, buyers, food fish canners and shellfish canners shall keep a record of all food fish and shellfish received whether from a fisher or from other fish dealers. This record shall include the quantity in pounds of each species of food fish or shellfish received, the date received, price paid per pound, and the name and address of the person from whom such food fish or shellfish were received. If received from a fisher, his or her commercial fishing license number shall be used in lieu of an address and the fishing gear used in taking shall also be required. If received from a treaty Indian, his or her tribal affiliation and enrollment number as shown on official identification card issued by the U.S. Department of Interior, Bureau of Indian Affairs, or tribal government shall be used in lieu of an address or commercial fishing license.

(2) This record is:

(a) Subject to inspection by the Director, the Director's authorized agent, or the Oregon State Police;

(b) To be prepared and available at the time food fish or shellfish are received at the premises of the fish dealer regardless of whether purchased or not;

(c) To be retained for a period not less than three years, at a location within Oregon where the record is to be available for inspection as designated in section (2)(a) of this rule. Notice of the physical location is to be provided to the Department.

Stat. Auth.: ORS 506.109, 506.119, 506.129, 508.406, 508.530 & 508.535
Stats. Implemented: ORS 506.109, 506.119, 506.129, 508.406, 508.530 & 508.535
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FWC 28, f. 11-28-75, ef. 1-1-76, Renumbered from 625-040-0125, Renumbered from 635-036-0570; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 68-1994, f. 9-28-94, cert. ef. 10-1-94; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0205
Required Reports

(1) Every licensed wholesale fish dealer, wholesale fish bait dealer, food fish canner, and shellfish canner shall report all food fish or shellfish received from commercial fishers or commercial bait fishers authorized to land his or her catch in Oregon or received from a fish dealer from another state in which no tax or fee is levied and collected on the food fish or shellfish.

(2) As used in these regulations, any licensed wholesale fish dealer, fish buying station, fish buyer, bait dealer or canner whose licensed premises includes a receiving or docking facility for unloading the catch from a commercial fishing vessel shall be considered as the receiver and purchaser and shall have the responsibility for weighing the catch, reporting, and paying landing fees on such catch. The aforementioned premises shall only be licensed by one wholesale dealer, fish buying station, fish buyer, bait dealer or canner at one given time, except as provided in section (3) of this rule.

(3) Notwithstanding section (2) of this rule, upon receipt and approval by the Department of a Memorandum of Understanding in a form provided by the Department and signed by both parties, a licensed wholesale fish dealer or canner (identified as primary dealer) whose licensed premises includes a receiving or docking facility for unloading the catch from a commercial fishing vessel may act as an agent for another licensed wholesale fish dealer or canner (identified as secondary dealer).

(a) Through the Memorandum of Understanding the primary dealer agrees:

(A) To unload fish or shellfish products at their licensed receiving or buying dock from fishing vessels who are providing catch to the secondary dealer as per prior agreement and arrangement with the secondary dealer;

(B) To confirm that the landing is legal and the species are legal;

(C) To accurately report on Fish Receiving Tickets, assigned to the secondary dealer by the Department, all landing information in accordance with OAR 635-006-0210, with the exception of price;

(D) To obtain fisher signature on the Fish Receiving Ticket reporting such catch or if necessary, a dock ticket for net-caught groundfish in accordance with OAR 635-006-0211;

(E) To, upon transfer of the landed product from the primary dealer to the secondary dealer, provide the Fish Receiving Ticket record of the landing to the secondary dealer; and

(F) To retain a record of the required landing information of such catches.

(b) In addition through the Memorandum of Understanding, the secondary dealer agrees:

(A) To obtain the appropriate buyer's license;

(B) To complete the Fish Receiving Ticket that reports the transferred product landed at the receiving or buying dock of the primary dealer, by adding the species ex-vessel price;

(C) To submit copies to the Department in accordance with OAR 635-006-0210(2); and

(D) To submit to the Department a monthly remittance report and accompanying landing fees in accordance with OAR 635-006-0215.

(c) The Department may withdraw its approval of any Memorandum of Understanding effective seven calendar days from postmark of written notice, based on the failure to abide by any of the terms of the Memorandum of Understanding or violation of any provision of this rule. If the Department withdraws its approval, then section (2) of this rule shall be applicable.

(4) Two basic reports required for reporting the commercial catch of food fish and shellfish and the payment of landing fees due on such catch are:

(a) The State of Oregon Fish Receiving Ticket; and

(b) The Fish Dealer Monthly Remittance Report. These reports shall be submitted on forms supplied or approved by the Department and completed in accordance with OAR 635-006-0210 and 635-006-0215.

(5)(a) All pink shrimp unloaded at a receiving or docking facility of a wholesale fish dealer or shellfish canner shall be weighed and the net weight (pounds of raw shrimp landed) recorded on a Fish Receiving Ticket before being removed from the receiving facility and prior to processing;

(b) Notwithstanding subsection (5)(a) of this rule, a minimum sampling method or equivalent method may be used to estimate the net weight provided such method is approved and authorized in writing by the Department;

(c) Those wholesale fish dealers or canners authorized to use the sampling procedure in subsection (5)(b) of this rule are subject to inspection for accuracy by the Department or by the Oregon State Police, at any time. Authorization for use of a sampling procedure may be withdrawn if, in the judgment of the Department, the procedure employed is likely to be inaccurate.

Stat. Auth.: ORS 506.119 & 508.530
Stats. Implemented: ORS 506.129 & 508.535
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 274(74-6), f. 3-20-74, ef. 4-11-74; FWC 28, f. 11-28-75, ef. 1-1-76, Renumbered from 625-040-0130, Renumbered from 635-036-0575; FWC 15-1981, f. 4-24-81, ef. 5-1-81; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 78-1993, f. & cert. ef. 12-6-93; FWC 23-1996, f. & cert. ef. 5-10-96; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0207
Limited Fish Seller Required Reports

(1) Every licensed Limited Fish Seller shall report all food fish or shellfish sold directly to consumers. Prior to making any sales of food fish or shellfish, Limited Fish Sellers shall notify the Department, by such means as the Department prescribes, the estimated number of food fish on board the boat and the location where the sale is to take place.

(2) Two reports required for reporting the commercial sale and the payment of landing fees due on such catch are:

(a) The State of Oregon Fish Receiving Ticket; and

(b) The Fish Dealer Monthly Remittance Report. These reports shall be submitted on forms supplied or approved by the Department and completed in accordance with OAR 635-006-0210 and 635-006-0215. In addition, a sequentially numbered receipt for each individual sale shall be issued to the purchaser at time of purchase, and to the fisher if fish are to be kept for personal use. This receipt shall include the date, species, weight in pounds, price, number of fish or shellfish, and vessel name. A copy shall be retained on the vessel for a period of six months and available for three years and is subject to inspection by the Oregon State Police or authorized Department employee.

Stat. Auth.: ORS 506.109, 506.119, 506.129 & 802
Stats. Implemented: ORS 506.109, 506.119, 506.129 & 802
Hist.: FWC 1-1986, f. & ef. 1-10-86; FWC 99-1987, f. & ef. 11-17-87; FWC 142-1991, f. 12-31-92, cert. ef. 1-1-92; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0210
Fish Receiving Ticket — All Fish

(1) Except as provided in OAR 635-006-0211, for each purchase of food fish or shellfish by a licensed wholesale fish dealer, wholesale fish bait dealer, food fish canner, or shellfish canner from a commercial fisher or commercial bait fisher, the dealer or canner shall prepare at the time of landing a Fish Receiving Ticket, or a separate document in lieu of a Fish Receiving Ticket provided the original dock ticket is attached to the completed dealer copy of the Fish Receiving Ticket subsequently submitted to ODFW. Fish Receiving Tickets are prenumbered in books of 50 tickets. Fish dealers shall be required to account for all Fish Receiving Tickets

received from the Department. Fish Receiving Tickets shall be issued in numerical sequence. The Fish Receiving Ticket shall include the following:

(a) Fish dealer's name and license number, including the buying station and location if the food fish or shellfish were received at any location other than the licensed premises of the fish dealer;

(b) Date of landing;

(c) His or her name from whom purchase is made. If not landed from a vessel, then his or her commercial license number shall be added. If received from a Columbia River treaty Indian, his or her tribal affiliation and enrollment number as shown on the official identification card issued by the U.S. Department of Interior, Bureau of Indian Affairs, or tribal government, shall be used in lieu of an address or commercial fishing license;

(d) Boat name, boat license number, and federal document or State Marine Board number from which catch made;

(e) Port of first landing;

(f) Fishing gear used by the fisher;

(g) For salmon and Dungeness crab, zone or area of primary catch;

(h) Species of food fish or shellfish received;

(i) Pounds of each species received:

(A) Pounds may be determined using any one of the following methods:

(i) Actual round weights based on certified scale measurements;

(ii) Actual round weights measured using a hopper scale;

(iii) Weights converted to round weight by multiplying the appropriate conversion weight listed in OAR 635-006-0215.

(B) Pounds shall include "weighbacks" by species. "Weighbacks" are those fish or shellfish with no commercial value.

(j) For Columbia River sturgeon the exact number of fish received and the actual round weight of that number of fish;

(k) Price paid per pound for each species received;

(l) Signature of the individual preparing the Fish Receiving Ticket;

(m) Signature of the fisher making the landing;

(n) Species name, pounds and value of fish retained by fisher for personal use.

(2) Except as provided in OAR 635-006-0212 and 0213, the original of each Fish Receiving Ticket covering food fish and shellfish received shall be forwarded within five working days of the date of landing to the Oregon Department of Fish and Wildlife, 3406 Cherry Avenue, NE, Salem, OR 97303.

(3) Wholesale fish bait dealers landing small quantities of food fish or shellfish may request authorization to combine multiple landings on one Fish Receiving Ticket and to deviate from the time in which Fish Receiving Tickets are due to the Department. Such request shall be in writing, and written authorization from the Department shall be received by the wholesale fish bait dealer before any such deviations may occur.

Stat. Auth.: ORS 496.138, 496.146, 496.162, 506.119, 506.129, 508.530 & 508.535
Stats. Implemented: ORS 506.129, 508.025, 508.040 & 508.550
Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 274(74-6), f. 3-20-74, ef. 4-11-74; FWC 28, f. 11-28-75, ef. 1-1-76, Renumbered from 625-040-0135, Renumbered from 635-036-0580; FWC 1-1986, f. & ef. 1-10-86; FWC 99-1987, f. & ef. 11-17-87; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 22-1992(Temp), f. 4-10-92, cert. ef. 4-13-91; FWC 53-1992, f. 7-17-92, cert. ef. 7-20-92; FWC 16-1995(Temp), f. & cert. ef. 2-16-95; FWC 23-1995, f. 3-29-95, cert. ef. 4-1-95; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 117-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 2-29-04; DFW 10-2004, f. & cert. ef. 2-13-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0211
Fish Receiving Ticket — Net Caught Groundfish

For net-caught groundfish, at time of landing the following information may be recorded on a separate document in lieu of a Fish Receiving Ticket provided this original document (dock ticket) is attached to the completed dealer copy of the Fish Receiving Ticket subsequently submitted to ODFW:

(1) Date of landing.

(2) Boat name and federal document or State Marine Board number from which catch was made.

(3) Port of first landing.

(4) Pounds of fish by species:

(a) Pounds may be determined using any one of the following methods:

(A) Actual round weights based on certified scale measurements;

(B) Actual round weights measured using a hopper scale;

(C) Weights converted to round weight by multiplying the appropriate conversion weight listed in OAR 635-006-0215.

(b) Pounds shall include "weighbacks" by species. "Weighbacks" are those fish or shellfish with no commercial value.

(5) Signature of the fisher delivering the catch.

Stat. Auth.: ORS 506.119, 506.129, 508.530 & 508.535
Stats. Implemented: ORS 506.129, 508.025, 508.040 & 508.550
Hist.: FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 22-1992(Temp), f. 4-10-92, cert. ef. 4-13-92; FWC 53-1992, f. 7-17-92, cert. ef. 7-20-92; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0213
Fish Receiving Ticket — Limited Fish Seller Permit

(1) For food fish or shellfish sold under a Limited Fish Seller Permit, the Limited Fish Seller shall complete daily entries of fish sold on a Fish Receiving Ticket. Fish Receiving Tickets are prenumbered in books of 50 tickets. Limited Fish Sellers shall account for all Fish Receiving Tickets received from the Department. Fish Receiving Tickets shall be issued in numerical sequence. The Fish Receiving Ticket shall include, for each day's sales:

(a) Limited Fish Seller's name and license number;

(b) Date of sales;

(c) Boat name and federal document or State Marine Board number from which catch made;

(d) Port of first landing;

(e) Fishing gear used;

(f) Species of fish or shellfish sold;

(g) Quantity in pounds;

(h) Price received per pound;

(i) Signature of the individual preparing the fish ticket;

(j) Name of wholesale fish dealer to whom other food fish or shellfish were sold from the same fishing trip.

(k) For troll-caught salmon, Fish Receiving Ticket shall show the number of days fished during the trip in which the salmon were caught.

(2) The original of each Fish Receiving Ticket covering fish and shellfish sold per trip shall be forwarded within ten working days following the landing to the Department.

Stat. Auth.: ORS 506.119, 506.129, 508.530, 508.535 & 508.550
Stats. Implemented: ORS 506.129, 508.025, 508.040 & 508.550
Hist.: FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; DFW 63-2003, f. & cert. ef. 7-17-03; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0215
Monthly Remittance Report

(1) A monthly report is required of all licensed:

(a) Wholesale fish dealers, wholesale fish bait dealers, food fish canners, or shellfish canners receiving food fish or shellfish from licensed commercial fishers or bait fishers;

(b) Limited (F)ish Sellers selling food fish or shellfish.

(2) Except as provided in OAR 635-006-0220, the report is required even though no food fish or shellfish are received or sold during the calendar month covered by the report.

(3) The following information shall be included on the report:

(a) Fish dealer's name, license number, and address;

(b) Calendar month of the report;

(c) Serial numbers of all Fish Receiving Tickets issued during the month;

(d) Total pounds of all salmon and steelhead received or sold during the calendar month on which poundage fees are due. Salmon and steelhead may be reported as round weight, dressed head on or dressed head off;

(e) Total value of salmon and steelhead received or sold during the calendar month including fish eggs and parts;

(f) Total value of all other food fish and shellfish including eggs and parts;

(g) Total pounds in the round of all other species of food fish or shellfish received or sold during the calendar month on which taxes are due. The following listed species may be converted to round weight for the purposes of completing monthly reports, by multiplying the below-listed factor by the dressed weight of that species:

(A) Troll salmon:

(i) Gilled and gutted — 1.15

(ii) Gilled, gutted, and headed — 1.30

(B) Halibut:

(i) Gilled and gutted — 1.15

(ii) Gilled, gutted, and headed — 1.35

(C) Sablefish, gutted and headed — 1.60

(D) Pacific whiting:

(i) Fillet — 2.86

(ii) Headed and gutted — 1.56

(iii) Surimi — 6.25

(E) Razor Clams, shelled and cleaned — 2.0

(F) Scallops, shelled and cleaned — 12.2

(G) Thresher shark — 2.0

(H) Skates — 2.6

(I) Lingcod:

(i) Gilled and gutted — 1.1

(ii) Gilled, gutted and headed — 1.5

(J) Spot prawn, tails — 2.24

(h) Total value of food fish landed in another state but not taxed by that state;

(i) Total pounds in the round of all food fish landed in another state but not taxed by that state;

(j) Total fees due — in accordance with ORS 508.505 the fees are the value of the food fish at the point of landing multiplied by the following rates:

(A) All salmon and steelhead, 3.15 percent;

(B) Effective January 1, 2005, all black rockfish, blue rockfish and nearshore fish (as defined by ORS 506.011), 5 percent.

(C) All other food fish and shellfish, 1.09 percent until the first Emergency Board hearing of 1993 and 1.25 percent, thereafter.

(k) Signature of the individual completing the report.

(4) The monthly report and all landing fees due shall be sent to the Department on or before the 20th of each month for the preceding calendar month. Landing fees are delinquent if not received or postmarked within 20 days after the end of the calendar month. A penalty charge of $5 or five percent of the landing fees due, whichever is larger, shall be assessed along with a one percent per month interest charge on any delinquent landing fee payments.

Stat. Auth.: ORS 506.119 & 508.530

Stats. Implemented: ORS 506.129, 508.535 & 508.550

Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 274(74-6), f. 3-20-74, ef. 4-11-74; FWC 28, f. 11-28-75, ef. 1-1-76, Renumbered from 625-040-0140; FWC 48-1978, f. & ef. 9-27-78, Renumbered from 635-036-0585; FWC 17-1981(Temp), f. & ef. 5-22-81; FWC 25-1981(Temp), f. 7-8-81, ef. 7-15-81; FWC 27-1981, f. & ef. 8-14-81; FWC 1-1986, f. & ef. 1-10-86; FWC 4-1987, f. & ef. 2-6-87; FWC 99-1987, f. & ef. 11-17-87; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 22-1992(Temp), f. 4-10-92, cert. ef. 4-13-92, FWC 53-1992, f. 7-17-92, cert. ef. 7-20-92; FWC 5-1993, f. 1-22-93, cert. ef. 1-25-93; DFW 38-1999, f. & cert. ef. 5-24-99; DFW 112-2003, f. & cert. ef. 11-14-03; DFW 31-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 118-2005(Temp), f. & cert. ef. 10-10-05 thru 12-31-05; DFW 139-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 79-2008(Temp) f. & cert. ef. 7-10-08 thru 12-31-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0225

Purchase, Record, Report, and Sale of Steelhead Trout and Walleye from Treaty Indian Fisheries

(1) Steelhead trout and walleye lawfully taken by treaty Indians during commercial fishing seasons may be purchased by licensed wholesale fish dealers, canners, or buyers pursuant to restrictions set forth in sections (2) through (5) of this rule. In addition, steelhead trout and walleye taken lawfully by treaty Indians during commercial fishing seasons may be purchased and/or possessed by any individual pursuant to restrictions set forth in section (6) of this rule.

(2) The wholesale fish dealer, canner, or buyer, shall at the time of purchase, enter the purchase of steelhead trout and walleye on a Department Columbia River Fish Receiving Ticket. Information required to be entered on the Fish Receiving Ticket shall be the same as required by OAR 635-006-0210 and 635-006-0212 for each purchase of food fish.

(3) The record keeping and reporting requirements for food fish as set forth in OAR 635-006-0200 through 635-006-0215 shall apply to all steelhead trout and walleye purchases.

(4) In addition to the records required in connection with the purchase of steelhead trout, and walleye, a record of all sales of steelhead trout and walleye shall be maintained by licensed wholesale fish dealers, canners, or buyers for a period of three years and shall be subject to inspection by the Department, the Director's authorized agent or the Oregon State Police. Such record of sales shall include as a minimum:

(a) Name and address of each person to whom either steelhead or walleye are sold;

(b) Quantity in pounds of each sale identified as whole or round weight or dressed weight;

(c) Date of each delivery.

(5) It is *unlawful* for any wholesale fish dealer, canner, or buyer in possession of legally purchased steelhead trout or walleye from treaty Indians to sell or distribute such fish in Oregon except to another wholesale fish dealer, canner, or buyer.

(6) Steelhead trout and walleye taken lawfully by treaty Indians during commercial fishing seasons may be purchased from a treaty Indian and/or possessed by any individual so long as said fish are accompanied by a written document listing treaty Indian taker's name, tribal enrollment number, number of fish, approximate weight of each fish, date and location where taken, date of sale, and purchaser's name. It is *unlawful* for any individual other than a treaty Indian to sell steelhead trout or walleye. The provisions in this section (6) apply to individuals other than licensed wholesale fish dealers, canners and buyers.

Stat. Auth.: ORS 506.119, 508.530 & 509.031

Stats. Implemented: ORS 498.022, 506.129, 508.535 & 508.550

Hist.: FWC 39, f. & ef. 1-23-76, Renumbered from 625-040-0150, Renumbered from 635-036-0595; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 41-1995, f. 5-23-95, cert. ef. 5-24-95; FWC 51-1997(Temp), f. & cert. ef. 8-27-97; DFW 73-1998, f. & cert. ef. 8-28-98; DFW 32-2008(Temp), f. & cert. ef. 4-1-08 thru 9-27-08; DFW 79-2008(Temp) f. & cert. ef. 7-10-08 thru 12-31-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0230

When Possession of Steelhead or Walleye *Unlawful*

Except as otherwise provided by law or rule, it is unlawful for any person to have in possession either steelhead trout or walleye taken by any means other than by angling. Notwithstanding OAR 635-006-0225, it is lawful for any wholesale fish dealer, canner, buyer or retailer to possess and sell, in Oregon, legally purchased steelhead trout or walleye taken from outside the Columbia River Basin, consistent with reporting requirements contained within 635-006-0200.

Stat. Auth.: ORS 496.138 & 509.031

Stats. Implemented: ORS 496.138 & 509.031

Hist.: FWC 41, f. & ef. 1-23-76, Renumbered from 625-040-0155, Renumbered from 635-036-0600; FWC 142-1991, f. 12-31-91, cert. ef. 1-1-92; FWC 41-1995, f. 5-23-95, cert.e f. 5-24-95; DFW 32-2008(Temp), f. & cert. ef. 4-1-08 thru 9-27-08; Administrative correction 10-21-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0235

Revocation of and Refusal to Issue Commercial Fishing and Fish Dealer Licenses

(1) Except as provided in section (2) of this rule in accordance with ORS 508.485 and 508.490, upon the third conviction or third forfeiture of bail within three years for violation of any of the Commercial Fishing Laws of the State of Oregon or for conviction in the State of Washington of an offense which was a violation of Columbia River Commercial fishing rules adopted pursuant to the Columbia River Compact, by any person, the Commission shall initiate contested case proceedings in accordance with the Administrative Procedures Act (ORS Chapter 183) to revoke, or refuse to issue, licenses issued under the Commercial Fishing Laws (Chapters 506–513).

(2) Convictions or forfeiture of bail for exceeding trip limits in the groundfish trawl fishery, where the trip limit has not been exceeded by more than 15%, shall not be considered as a conviction or forfeiture of bail for purposes of section (1) of this rule.

(3) The Commission shall appoint a hearings officer to conduct the contested case hearing prescribed in section (1) of this rule.

(4)(a) In addition to the hearings officer, the Commission may appoint a three-member License Revocation Board to be present at the hearing and to make advisory recommendations to the Commission concerning revocation or refusal to issue a license to that person. License revocation boards shall consist of members representing the following fishing industries:

(A) Troll salmon;

(B) Gillnet salmon;

(C) Groundfish and shrimp;

(D) Crab;

(E) All other commercial fisheries.

(b) Only members from the appropriate License Revocation Board shall participate in hearings related to their subject area. The hearings officer shall notify the appropriate License Revocation Board of the date, time and place of the hearing, and shall provide any other public notice required by ORS Chapter 183;

(c) At the hearing, the board may request the hearings officer call additional witnesses or seek additional evidence;

(d) At the conclusion of the hearing, the board shall prepare written recommendations concerning the disposition of the case, which the License Revocation Board shall serve on all parties and forward to the Commission.

(5) A proposed order in the form prescribed by OAR 137-003-0070, including findings of fact and conclusions of law, shall be prepared by the hearings officer, served on all parties, and shall be forwarded to the Commission.

(6) In accordance with ORS Chapter 183, the Commission shall provide an opportunity to all parties to respond in writing within a period set by the Commission to the proposed order of the hearings officer and to the written recommendations submitted by the License Revocation Board.

(7) In deciding whether to revoke or refuse to issue a license, the Commission shall consider:

(a) The recommendation of the License Revocation Board;

(b) The gravity of the most recent offense, including whether the offense was a felony and whether the offense involved a closed season, closed area, or *unlawful* gear;

(c) The gravity of the other commercial fishing offenses of which the person has been convicted or forfeited bail;

(d) The impact of the offense on the fisheries resources of the state or, where relevant, on the State of Washington, including consideration of the species involved;

(e) Whether the person also has been convicted of or forfeited bail for violations of the Wildlife laws of the State of Oregon.

Stat. Auth.: ORS 183, 508.485 & 508.490
Stats. Implemented: ORS 508.485 & 508.490
Hist.: FWC 160, f. & ef. 11-25-77; FWC 18-1978, f. & ef. 4-7-78, Renumbered from 635-036-0605; FWC 33-1982, f. & ef. 6-2-82; FWC 9-1988, f. & cert. ef. 3-3-88; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0412
Death of Eligible Permit Holder

(1) In the event that an eligible permit holder dies subsequent to January 29, 1982, his or her permit may then be purchased from the personal representative or executor administering the estate of the permit holder.

(2) In the event that the permit holder's estate referred to in section (1) of this rule is closed:

(a) The permit may be purchased from the permit holder's spouse;

(b) In the event that the permit holder is not survived by a spouse, the permit may be purchased from the permit holder's children.

Stat. Auth.: ORS 506.241
Stats. Implemented: ORS 506.241
Hist.: FWC 22-1983(Temp), f. & ef. 6-13-83; FWC 68-1983, f. & ef. 12-16-83; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0425
Purchase of Permits

Permits shall first be purchased from Category A. Permits shall be purchased from Category B only after purchases approved by the Commission from Category A are selected.

(1) Permits shall be purchased beginning with the lowest offer price.

(2) Each subsequent permit purchase shall be made at the lowest remaining offer price.

(3) In case of ties in otherwise qualified permit holders' offer prices, the Department will first purchase the permit of the permit holder with the greatest total pounds of salmon lawfully landed in Oregon from the Columbia River gillnet salmon fishery for the period 1978 through 1985.

(4) Any offer over $1,000 shall be referred to the Commission for approval.

(5)(a) Permits which are purchased shall be retired by the Department;

(b) The transfer of the offered permit is effective upon written acceptance by the Department.

(6) The Department shall purchase no more than one permit from each applicant.

(7) The Department shall indicate on all application forms a deadline date after which no more program applications and offers to sell permits shall be accepted.

(8) Any offer to sell a permit at the offer price selected by the applicant shall constitute a formal offer to sell the permit to the Department and may not be withdrawn until 120 days after the deadline date specified on the application form provided by the Department.

(9) In determining the total salmon landings of an applicant, the Department may consider as evidence:

(a) Department records;

(b) Such information as the Department considers reliable evidence of the landings;

(c) An affidavit submitted by the permit holder concerning the quantity of salmon lawfully landed.

(10) In determining program eligibility the Department may consider as evidence:

(a) Department records;

(b) Such information as the Department considers reliable evidence of eligibility;

(c) An affidavit submitted by the permit holder concerning his or her eligibility.

Stat. Auth.: ORS 506.241
Stats. Implemented: ORS 506.241
Hist.: FWC 7-1982, f. & ef. 1-29-82; FWC 77-1982, f. & ef. 10-29-82; FWC 1-1984, f. & ef. 1-10-84; FWC 68-1983, f. & ef. 12-16-83; FWC 63-1984, f. & ef. 9-21-84; FWC 56-1986(Temp), f. & ef. 9-11-86; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-0810
Definitions

(1) For the purposes of OAR 635-006-0820 through 635-006-1210 the following definitions shall apply:

(2) "Actively managed" means a fishery under a limited entry system according to the provision of a federal fishery management plan.

(3) "Bay clams" means cockle clams (*Clinocardium nuttallii*), butter clams (*Saxidonus giganteus*), gaper clams (*Tresus capas, nuttallii*), native littleneck clams (*Protothaca stamines*), and softshell clams (*Mya arenaria*).

(4) "Board" means the Developmental Fisheries Board appointed by the Commission.

(5) "Developed fishery" means a fishery where the level of participation, catch, and effort indicate the fishery has approached optimum sustained yield and/or there is sufficient biological information, information on harvest methods, gear types, and markets to develop a long-term management plan for the species.

(6) "Developmental fisheries species" means food fish species adopted by the Commission to be managed under the Developmental Fisheries Program.

(7) "Domestic partner" means an individual who, together with a permit holder has formed a partnership in which both:

(a) Are at least 18 years of age;

(b) Share a close personal relationship and are responsible for each other's welfare;

(c) Are each other's sole domestic partner;

(d) Are not married to anyone and neither has had another domestic partner or a spouse within in the previous six months;

(e) Are not related by blood closer than would bar marriage under ORS 106.020;

(f) Have shared a household for at least six months; and

(g) Are jointly financially responsible for basic living expenses, including expenses for food, shelter, and maintaining a household.

(8) "Immediate family" means a permit holder's spouse, domestic partner, children, father, mother, brother, sister, stepchildren, and grandchildren.

(9) "Maximum sustainable yield" (MSY) means an estimate of the largest average annual catch or yield that can be taken over a significant period of time from each stock under prevailing ecological and environmental conditions.

(10) "Underutilized species" means a food fish species or group of species that is not presently harvested in significant quantities due to poor markets or inadequate gear development or may be caught but not utilized due to poor markets.

(11) "Optimum sustained yield" (OSY) means the desired catch level of a fishery that will provide the greatest overall benefit to the state taking into account economic, social, and ecological considerations that will maintain a level of population that insures the long-term productivity of the stock and does not impair its ability to sustain itself into the future.

(12) "Overfishing" means a level or rate of fishing mortality that jeopardizes the long-term capacity of a stock or stock complex to produce MSY.

Stat. Auth.: ORS 506.109, 506.119, 506.450, 506.455 & 506.465
Stats. Implemented: ORS 596.129
Hist.: FWC 85-1994, f. 10-31-94, cert. ef. 11-1-94; DFW 85-1999, f. & cert. ef. 11-1-99; DFW 119-2001, f. & cert. ef. 12-24-01; DFW 117-2002, f. & cert. ef. 10-21-02; DFW 137-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-1035
Eligibility Requirements for a Permit

Eligibility for a limited entry permit is as follows:

(1) Gillnet salmon — see ORS 508.784.

(2) Troll salmon — see ORS 508.810.

(3) Shrimp — see ORS 508.886 and 508.895.

(4) Scallop — see ORS 508.852.

(5) Roe-herring — The ODFW shall issue a permit as per ORS 508.765:

(a) By renewal of previous year's permit;

(b) Through the lottery if a lottery is held in accordance with OAR 635-006-1085.

(6) Sea Urchin — An individual licensed as a commercial fisher under ORS 508.235 is eligible to obtain the permit required by OAR 635-006-1015:

(a) By renewal of previous year's permit; or

(b) Through the lottery if a lottery is held in accordance with OAR 635-006-1085; or

(c) Through a duly authorized medical transfer of an existing permit in accordance with OAR 635-006-1095;

(d) By combining three currently renewed permits into one new permit as provided in OAR 635-006-1095.

(7) Ocean Dungeness crab:

(a) See ORS 508.931;

(b) For the purposes of eligibility for the Ocean Dungeness Crab Fishery Permit, a boat which received a license waiver issued pursuant to ORS 508.808 shall be considered as having possessed a boat license for that year;

(c) ORS 508.931 and 508.941 require that the vessel be previously licensed in accordance with 508.260 for the purposes of initial eligibility for an ocean Dungeness Crab Fishery Permit. A Single Delivery License may not be substituted for a boat license for this purpose.

(8) Black rockfish/blue rockfish/nearshore fishery — see ORS 508.947.

(9) Brine Shrimp — A commercial fisher licensed under ORS 508.235 is eligible to obtain the permit required by OAR 635-006-1015:

(a) By renewal of previous year's permit; or

(b) If issued a Brine Shrimp Permit under the Developmental Fisheries Program prior to 2004.

(10) Bay clam dive fishery — An individual licensed as a commercial harvester under ORS 508.235 or a vessel is eligible to obtain the permit required by OAR 635-006-1015:

(a) For a South Coast Bay Clam Dive Permit for the year 2006, if a South Coast Bay Clam Dive Permit was issued to the individual or vessel under the Developmental Fisheries Program (OAR 635-006-0900) in 2005 and lawfully made five landings consisting of at least 100 pounds each landing or an annual total of 2,500 pounds of bay clams, using dive gear in Oregon in 2005; or

(b) For a Coast Wide Bay Clam Dive Permit for the year 2006, if a Coast Wide Bay Clam Dive Permit was issued to the individual or vessel under the Developmental Fisheries Program (OAR 635-006-0900) in 2005 and lawfully made five landings consisting of at least 100 pounds each landing or an annual total of 2,500 pounds of bay clams, using dive gear in Oregon in 2005.

(c) After 2006, by renewal of the previous years' permit and satisfaction of the requirements in OAR 635-006-1075(1)(j).

(11) Sardine fishery:

(a) An individual or entity is eligible to obtain the vessel permit required by OAR 635-006-1015:

(A) If issued a Sardine Permit under the Developmental Fisheries Program (OAR 635-006-0900) in 2005; and

(B) Lawfully made landings of sardines into Oregon in 2003 and 2004; and

(C) Lawfully landed:

(i) At least 1,500 metric tons or 35 deliveries in any one year from 2000 through 2004; or

(ii) A total of 100 deliveries of sardines into Oregon in 2000 through 2004.

(b) If the number of permits issued under section (11)(a) of this rule is less than 20, enough permits to reach a total of 20 may be issued under section (11)(c) of this rule to vessels in order of highest total number of deliveries during 2000–2004.

(c) An individual or entity is eligible to obtain the vessel permit under section (11)(b) of this rule if the vessel for which applications is made:

(A) Was not issued a permit under section (11)(a) of this rule; and

(B) Lawfully made landings of sardines into Oregon in 2003 and 2004; and

(C) Lawfully landed:

(i) At least 1,500 metric tons or 35 deliveries in any one year from 2000 through 2004; or

(ii) A total of 100 deliveries of sardines into Oregon in 2000 through 2004

(d) In addition to those Sardine Fishery Permits previously issued by the Department in calendar year 2006, the Department shall issue a Sardine Fishery Permit to any individual or entity, if that individual or entity held a legally qualified Oregon Developmental Fisheries Permit for Sardines on August 1, 2005, provided that neither the individual or entity has been previously issued an Oregon Sardine Fishery Permit in 2006.

Stat. Auth.: ORS 506.119

Stats. Implemented: ORS 506.109

Hist.: FWC 3-1996, f. 1-31-96, cert. ef. 2-1-96; FWC 64-1996, f. 11-13-96, cert. ef. 11-15-96; DFW 11-2003(Temp), f. & cert. ef. 2-10-03 thru 6-30-03; DFW 112-2003, f. & cert. ef. 11-14-03; DFW 137-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 139-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 74-2006, f. & cert. ef. 8-7-06; DFW 2-2007, f. & cert. ef. 1-12-07; DFW 142-2008, f. & cert. ef. 11-21-08

635-006-1075

Renewal of Permit

(1) An individual who obtained a limited entry permit may renew the permit as follows:

(a) Gillnet salmon — see ORS 508.781;

(b) Troll salmon — see ORS 508.807;

(c) Shrimp — see ORS 508.892;

(d) Scallop — see ORS 508.849;

(e) Roe-herring permit — Permits may be renewed by submission to the Department of a $75 fee and a complete application;

(f) Sea Urchin permit:

(A) Permits may be renewed by submission to the Department of a $75 fee and a complete application date-stamped or postmarked by January 31 of the year for which renewal is sought; and

(B) The permittee shall have annually lawfully landed 5,000 pounds of sea urchins in Oregon. If a permittee obtained a permit later than January of the prior year (because the permit was obtained through the lottery, or as a result of the Commercial Fishery Permit Board actions or surrender of a permit by a permit holder), the permittee shall not be required to make the 5,000 pound landing requirement by the following January. Instead, at the next renewal thereafter, the permittee shall be required to demonstrate that the 5,000 pound landing requirement was fulfilled during the first full year (twelve-month period) in which the permit was held.

(g) Ocean Dungeness crab permit — see ORS 508.941. A permit which is not renewed by December 31 lapses, and may not be renewed for subsequent years.

(h) Black rockfish/blue rockfish/nearshore fishery — see ORS 508.947.

(i) Brine Shrimp permit:

(A) Permits may be renewed by submission to the Department of a $75 fee and a complete application date-stamped or postmarked by January 31 of the year for which renewal is sought; and

(B) The permittee shall have lawfully landed 5,000 pounds of brine shrimp in Oregon in the prior year.

(j) Bay clam dive fishery:

(A) Permits may be renewed by submitting to the Department a complete application date-stamped or postmarked by January 31 of the year for which renewal is sought and;

(B) The permittee shall have lawfully made five landings consisting of at least 100 pounds each landing or an annual total of 2,500 pounds of bay clams, using dive gear in Oregon in the prior calendar year;

(C) Logbooks required under OAR 635-006-1110 must be turned into an ODFW office by the application deadline for renewal of a permit.

(D) If a permit is transferred under OAR 635-006-1095(10)(d), annual renewal requirements are waived in the year the transfer occurred.

(k) Sardine fishery:

(A) Permits may be renewed for the following year:

(i) by submitting a complete application to the Department date-stamped or postmarked by December 31 of the year the permit is sought for renewal and;

(ii) submitting the logbooks required under OAR 635-006-1110; and

(iii) the permitted vessel must have lawfully landed into Oregon, during the year preceding the calendar year for which the permit is sought for renewal, either (I) a minimum of 10 landings of sardines of a least 5 metric tons each, or (II) landings of sardines having an aggregate ex-vessel price of at least $40,000.

(B) The Commercial Fishery Permit Board may waive the landing requirements of section (A)(iii) of this rule if it finds that the failure to meet these requirements is due to the permit holder's illness or injury, or to circumstances beyond the control of the permit holder. Final Orders shall be issued by the Commercial Fishery Permit Board and may be appealed as provided in ORS 183.480 through 183.550.

(C) The Commission may, at its discretion, waive the landing requirements of section (A)(iii) of this rule for all Limited Entry Eardine Permit holders due to unusual market conditions.

(2) An application for renewal in any limited entry fishery shall be considered complete if it is legible, has all information requested in the form, and is accompanied by the required fee in full. Any application which is not complete shall be returned, and unless it is thereafter resubmitted and deemed complete by December 31 of the permit year sought, the individual shall not be considered to have applied for renewal in a timely manner.

(3) It is the responsibility of the permittee to ensure that an application is complete and is filed in a timely manner. Failure of the Department to return an application for incompleteness or of an individual to receive a

returned application shall not be grounds for treating the application as having been filed in a timely and complete manner.

Stat. Auth.: ORS 506.119
Stats. Implemented: ORS 506.109, 506.129 & 508.921 - 508.941
Hist.: FWC 3-1996, f. 1-31-96, cert. ef. 2-1-96; FWC 64-1996, f. 11-13-96, cert. ef. 11-15-96; DFW 92-1998, f. & cert. ef. 11-25-98; DFW 112-2003, f. & cert. ef. 11-14-03; DFW 137-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 139-2005, f. 12-7-05, cert. ef. 1-1-06; DFW 23-2006, f. & cert, ef, 4-21-06; DFW 2-2007, f. & cert. ef. 1-12-07; DFW 86-2007(Temp), f. & cert. ef. 9-10-07 thru 9-17-07; Administrative correction 10-16-07; DFW 3-2008, f. & cert. ef. 1-15-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0005
Applicability of Regulations

(1) The right to fish in accordance with OAR 635-041-0005 through 635-041-0085 is restricted to those individuals possessing Indian treaty fishing rights pursuant to the Yakima Treaty (12 Stat. 951), the Warm Springs Treaty (12 Stat. 963), the Umatilla Treaty (12 Stat. 945), or the Nez Perce Treaty (12 Stat. 957).

(2) The fishing activities authorized by the aforementioned treaties for the Columbia River and its tributaries above Bonneville Dam are hereinafter referred to as the Treaty Indian Fishery.

(3) Nothing in these regulations shall prevent any individual having Indian treaty fishing rights from participating equally with other citizens in any other commercial fishery in Oregon so long as such individual complies with the commercial fishing laws and rules of the Commission applicable to such fishery.

(4) The taking of fish from the Columbia River or its tributaries above Bonneville Dam for commercial purposes is prohibited except by the persons, during the times, with the fishing gear, and in the areas specified in OAR 635-041-0005 through 635-041-0085.

(5) It is *unlawful* for any individual to take fish pursuant to the authority of any of the aforementioned treaties and OAR 635-041-0005 through 635-041-0085 who does not have in his or her possession an Indian tribal identification card which identifies him or her as a duly enrolled member of the Yakima, Warm Springs, Umatilla, or Nez Perce Tribe.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79; FWC 13-1979(Temp), f. & ef. 3-30-79, Renumbered from 635-035-0005; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 4-1984, f. & ef. 1-31-84; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0010
Definitions

In addition to the definitions provided in the commercial fishing laws and other rules of the Department, the following definitions shall apply to the Treaty Indian Fishery:

(1) "Commission" means the Oregon Fish and Wildlife Commission.

(2) "Department" means the Oregon Department of Fish and Wildlife.

(3) "Director" means the Director of the Oregon Department of Fish and Wildlife.

(4) "Fishway" means any structure or facility made to facilitate or provide passage for fish over a natural or artificial barrier or obstruction.

(5) "Subsistence fishing" means taking fish for Indians' personal use, including the sale or exchange with other treaty Indians, but not sale or trade with non-Indians.

Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0010; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 4-1984, f. & ef. 1-31-84; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0030
Subsistence Fishing Activities

(1) It is *unlawful* to utilize any fish taken by subsistence fishing for other than subsistence purposes as defined in OAR 635-041-0010 with the exception of shad which may be sold commercially, and with the exception of dipnet caught fish from main stem Columbia and Klickitat River subsistence areas taken during open commercial fishing seasons.

(2) Only sturgeon between 48–60" in overall length from between The Dalles and McNary dams and between 45–60" in overall length from between the Bonneville dam and The Dalles dam may be taken for subsistence purposes.

Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0030; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 4-1984, f. & ef. 1-31-84; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 12-1997(Temp), f. 2-27-97, cert. ef. 3-1-97; DFW 26-2000(Temp), f. 5-4-00, cert. ef. 5-6-00 thru 5-28-00; DFW(Temp), 37-2000, f. 6-30-00, cert. ef. 7-1-00 thru 7-10-00; DFW 22-2003(Temp), f. & cert. ef. 3-25-03 thru 9-20-03; DFW 3-2005(Temp), f. & cert. ef 1-20-05 thru 2-28-05; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0040
Ceremonial Fishing and Notice Requirement

(1) It is *unlawful* for any Indian or group of Indians to conduct ceremonial fishing on the Columbia River or in Oregon Columbia River tributaries outside an Indian reservation without first providing at least two working days advanced written notification to the Director or the Director's designee.

(2) All notices must contain the following information:

(a) Name, place, and time of ceremony for which fish will be used;

(b) Name of individuals and helpers who will be fishing and transporting fish. Only these individuals will be allowed to fish on the occasion covered by the notice;

(c) Exact location(s) of fishing and the amount of gear to be used at each location;

(d) Exact beginning and ending dates of ceremonial fishing;

(e) The type of gear to be used in ceremonial fishing;

(f) Estimated number of fish needed for ceremony;

(g) If fish are to be stored prior to a ceremony, the location of storage must be identified. If they are not to be stored, it must be so indicated;

(h) The signature of the designated tribal official certified to the Department in advance.

(3) It is *unlawful* to:

(a) Fish for ceremonial purposes with commercial fishing gear except in those areas where such fishing gear is authorized for commercial fishing;

(b) Engage in ceremonial fishing during any portion of a week within a commercial fishing season which is closed to commercial fishing;

(c) Sell or barter, offer for sale or barter, buy, or for a commercially licensed fish buyer or wholesale fish dealer to have in his possession fish taken for ceremonial purposes;

(d) Engage in ceremonial fishing unless done in compliance with all provisions contained in the advance notice to the states.

(4) Any individual engaged in ceremonial fishing must have in his possession a signed copy or duplicate copy of the written tribal notification to the Director that such fishing was to be conducted.

(5) Set nets and other commercial fishing gear shall be marked and identified at all times while fishing for ceremonial or other fishing purposes.

(6) A record of the numbers of fish taken for ceremonial purposes will be made available to the Department by the designated tribal official who authorized ceremonial fishing. The report must be sent promptly upon conclusion of each ceremonial fishing activity.

Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0040; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 4-1984, f. & ef. 1-31-84; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 10-1988, f. & cert. ef. 3-4-88; DFW 33-2003(Temp), f. 4-23-03, cert. ef. 4-24-03 thru 10-1-03; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0045
Closed Commercial Fishing Areas

Unless otherwise specified in this rule and OAR 635-041-0063, the following waters are closed to commercial fishing:

(1) All Oregon tributaries of the Columbia River.

(2) The Columbia River westerly and downstream of the Bridge of the Gods.

(3) The Columbia River easterly and upstream of a line extending at a right angle across the thread of the river from a deadline marker one mile downstream of McNary Dam.

(4) The Columbia River between a line extending at a right angle across the thread of the river from a deadline marker at the west end of 3-Mile Rapids located approximately 1.8 miles below The Dalles Dam, upstream to a line from a deadline marker on the Oregon shore located approximately 3/4 mile above The Dalles Dam east fishway exit, thence at a right angle to the thread of the river to a point in midriver, thence downstream to Light "1" on the Washington shore; except that dip nets, bag nets, and hoop nets are permitted during commercial salmon and shad fishing seasons at the Lone Pine Indian fishing site located immediately above The Dalles Interstate Bridge.

(5) The Columbia River between a line extending at a right angle across the thread of the river from a deadline marker at Preachers Eddy

light below the John Day Dam and a line approximately 4.3 miles upstream extending from a marker on the Oregon shore approximately one-half mile above the upper easterly bank of the mouth of the John Day River, Oregon, extending at a right angle across the thread of the river to a point in midriver, thence turning downstream to a marker located on the Washington shore approximately opposite the mouth of the John Day River.

(6) The Columbia River within areas at and adjacent to the mouths of the Deschutes River and the Umatilla River. The closed areas are along the Oregon side of the Columbia River and extend out to the midstream from a point one-half mile above the intersection of the upper bank of the tributary with the Columbia River to a point one mile downstream from the intersection of the lower bank of the tributary with the Columbia River. All such points are posted with deadline markers.

(7) The Columbia River within an area and adjacent to the mouth of the Big White Salmon River. The closed area is along the Washington side of the Columbia River and extends out to midstream at right angles to the thread of the Columbia River between a marker located 1/2 mile downstream from the west bank upstream to Light "35".

(8) The Columbia River within an area at and adjacent to the mouth of Drano Lake (Little White Salmon River). The closed area is along the Washington side of the Columbia River and extends out to midstream at right angles to the thread of the Columbia River between Light "27" upstream to a marker located approximately 1/2 mile upriver of the outlet of Drano Lake.

(9) The Columbia River within an area and adjacent to the mouth of the Wind River. The closed area is along the Washington side of the Columbia River and extends to midstream at right angles to the thread of the Columbia River between markers located 1 1/4 miles downstream from the west bank and 1/2 mile upstream from the east bank.

(10) The Columbia River within areas at and adjacent to the mouth of Hood River. The closed area is along the Oregon side of the Columbia River and extends to midstream at right angles to the thread of the Columbia River between markers located approximately 0.85 miles downriver from the west bank at end of the breakwall at the west end of the Port of Hood River and 1/2 mile upriver from the east bank.

(11) The Columbia River within a radius of 150 feet of the Spring Creek Hatchery fishway, except that during the period of August 25–September 20 inclusive the closed area is along the Washington side of the Columbia River and extends to midstream at right angles to the thread of the Columbia River between a marker located 1-1/2 miles downriver of the Spring Creek Hatchery fishway up to the downstream marker of the Big White Salmon sanctuary located approximately 1/2 mile upriver of the Spring Creek Hatchery fishway.

(12) Herman Creek upstream from a line between deadline markers near the mouth. One marker is located on the east bank piling and the other is located on the west bank to the north of the boat ramp.

(13) The Columbia River within an area and adjacent to the mouth of the Klickitat River. The closed area is along the Washington side of the Columbia River and extends to midstream at right angles to the thread of the Columbia River between the downstream margin of Lyle Landing downstream to a marker located near the railroad tunnel approximately 1-1/8 miles downstream from the west bank.

Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 133, f. & ef. 8-4-77; FWC 149(Temp), f. & ef. 9-21-77 thru 1-18-78; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0045; FWC 6-1980, f. & ef. 1-28-80; FWC 44-1980(Temp), f. & ef. 8-22-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 49-1983(Temp), f. & ef. 9-26-83; FWC 4-1984, f. & ef. 1-31-84; FWC 55-1985(Temp), f. & ef. 9-6-85; FWC 4-1986 (Temp), f. & ef. 1-28-86; FWC 25-1986(Temp), f. & ef. 6-25-86; FWC 42-1986, f. & ef. 8-15-86; FWC 2-1987, f. & ef. 1-23-87; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 54-1989 (Temp), f. & cert. ef. 8-7-89; FWC 90-1989, f. & cert. ef. 9-6-89; FWC 80-1990(Temp), f. 8-7-90, cert. ef. 8-8-90; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0060
Sturgeon Season

(1) Sturgeon may be taken for commercial purposes during commercial salmon, steelhead, sturgeon, or shad fishing seasons with the commercial fishing gear authorized for the taking of salmon, steelhead, sturgeon, or shad.

(2) Sturgeon must be delivered to wholesale fish dealers, canners, or fish buyers undressed (in the round).

(3) It is *unlawful* to:

(a) Take sturgeon from any setline with the intent of depriving the rightful owner of such sturgeon;

(b) Steal or otherwise molest or disturb any lawful fishing gear;

(c) Remove the head or tail of any sturgeon taken for commercial purposes prior to being received at the premises of a wholesale fish dealer or canner;

(d) Remove the head or tail of any sturgeon while in transit;

(e) Remove eggs from the body cavity of sturgeon until the fish is sold;

(f) Purchase from commercial fishers sturgeon eggs which have been removed from the body cavity prior to sale.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0060; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 20-1982(Temp), f. & ef. 3-25-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 4-1984, f. & ef. 1-31-84; FWC 79- 1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 48-1988, f. & cert. ef. 6-21-88; FWC 95-1988(Temp), f. 9-27-88, cert. ef. 9-28-88; FWC 9-1994, f. 2-14-94, cert. ef. 2-15-94; FWC 15-1995, f. & cert. ef. 2-15-95; DFW 108-2001(Temp) f. & cert. ef. 11-14-01 thru 11-20-01; DFW 109-2001(Temp), f. 11-21-01, cert. ef. 11-23-01 thru 12-31-01; DFW 115-2003(Temp), f. 11-20-03, cert. ef. 12-1-03 thru 12-31-03; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0061
Sturgeon Size

(1) White sturgeon may be taken for commercial purposes by treaty Indian fishers during commercial fishing seasons in which sales of sturgeon are authorized.

(2) Sales are limited to white sturgeon between 48–60" in overall length taken from between The Dalles and McNary dams and between 45–60" in overall length from between the Bonneville Dam and The Dalles Dam.

(3) It is *unlawful* to mutilate or disfigure a sturgeon in any manner which extends or shortens its length to the legal limit, or to possess such sturgeon.

Stat. Auth.: ORS 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 2-1985, f. & ef. 1-30-85; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 15-1995, f. & cert. ef. 2-15-95; FWC 12-1997(Temp), f. 2-27-97, cert. ef. 3-1-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 130-2004(Temp), f. 12-23-04, cert. ef. 1-1-05 thru 4-1-05; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0063
Sturgeon Setline Fishery

(1) White sturgeon may be taken by setline for commercial purposes from 12 Noon January 1 through 12 Noon January 31 in all of Zone 6.

(a) In The Dalles and John Day pools white sturgeon taken must be between 48–60 inches in length.

(b) In the Bonneville Pool white sturgeon taken must be between 45–60 inches in length.

(c) White sturgeon taken as described in subsections (1)(a) and (1)(b) of this rule may be sold or kept for subsistence use.

(2) Closed areas are set forth under OAR 635-041-0045.

(3) During the white sturgeon setline season it shall be *unlawful* to:

(a) Operate any fishing gear other than setlines except as provided in OAR 635-041-0060;

(b) Operate any setline having more than 100 hooks;

(c) Use other than single hooks size 9/0 or larger;

(d) Operate any setline on which the buoy or marker does not have the tribal identification number of the individual operating the line clearly marked on it and which is attached in a manner that will not allow it to float visibly on the surface at all times.

(4) Notwithstanding OAR 635-041-0045(6)–(11), it is lawful during the open season to fish for white sturgeon by means of set lines in the Columbia River within areas at and adjacent to the mouths of rivers.

Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0063; FWC 6-1980, f. & ef. 1-28-80; FWC 12-1980, f. & ef. 2-29-80; FWC 64-1980(Temp), f. & ef. 11-7-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 9-1983(Temp), f. & ef. 3-1-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. 1-30-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 48-1988, f. & cert. ef. 6-21-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 12-1989(Temp), f. & cert. ef. 3-21-89; FWC 54-1989(Temp), f. & cert. ef. 8-7-89; FWC 9-1991, f. & cert. ef. 1-31-91; FWC 37-1991(Temp), f. & cert. ef. 4-3-91; FWC 4-1992, f. 1-30-92, cert. ef. 2-1-92; FWC 13-1992(Temp), f. & cert. ef. 3-5-92; FWC 41-1992(Temp), f. 6-30-92, cert. ef. 7-1-92; FWC 107-1992(Temp), f. & cert. ef. 10-9-92; FWC 7-1993, f. & cert. ef. 2-1-93; FWC 15-1996(Temp), f. & cert. ef. 4-1-96; FWC 25-1996(Temp), f. 5-14-96, cert. ef. 5-15-96; FWC 23-1997(Temp), f. 4-4-97, cert. ef. 4-7-97; FWC 35-1997(Temp), f. & cert. ef. 6-13-97; FWC 40-1997(Temp), f. 6-20-97, cert. ef. 6-23-97; DFW 23-1998(Temp), f. & cert. ef. 3-20-98 thru 6-30-98; DFW 50-1998(Temp), f. 6-25-98, cert. ef. 6-26-98 thru 7-24-98; DFW 57-1998(Temp), f. & cert. ef. 7-24-98 thru 12-31-98; DFW 22-1999(Temp), f. & cert. ef. 4-1-99 thru 4-23-99; DFW 28-1999(Temp) , f. & cert. ef. 4-23-99 thru 7-31-99; DFW 41-1999(Temp), f. & cert. ef. 6-7-99 thru 7-31-99; DFW 79-1999(Temp), f. 10-8-99, cert. ef. 10-

11-99 thru 12-31-99; DFW 14-2000(Temp), f. 3-17-00, cert. ef. 3-20-00 thru 7-31-00; DFW 31-2000(Temp), f. 6-9-00, cert. ef. 6-10-00 thru 7-31-00; DMV 43-2000(Temp), f. 8-7-00, cert. ef. 8-8-00 thru 8-20-00; DFW 66-2000(Temp), f. 9-29-00, cert. ef. 10-2-00 thru 12-31-00; DFW 43-2001(Temp), f. 5-23-01, cert. ef. 5-24-01 thru 11-20-01; DFW 65-2001(Temp), f. & cert. ef. 7-24-01 thru 12-31-01; DFW 94-2001(Temp), f. 9-26-01, cert. ef. 9-27-01 thru 12-31-01; DFW 114-2001(Temp), f. & cert. ef. 12-13-01 thru 12-31-01; DFW 51-2002(Temp), f. & cert. ef. 5-22-02 thru 9-1-02; DFW 104-2002(Temp), f. & cert. ef. 9-19-02 thru 12-31-02; DFW 121-2002(Temp), f. 10-24-02, cert. ef. 10-27-02 thru 12-31-02; DFW 49-2003(Temp), f. & cert. ef. 6-5-03 thru 9-1-03; DFW 58-2003(Temp), f. & cert. ef. 7-9-03 thru 12-31-03; DFW 67-2003(Temp), f. 7-18-03, cert. ef. 7-21-03 thru 12-31-03; DFW 104-2003(Temp), f. 10-10-03, cert. ef. 10-11-03 thru 12-31-03; DFW 120-2005(Temp), f. & cert. ef. 10-11-05 thru 12-31-05; Administrative correction 1-19-06; DFW 69-2006(Temp), f. 7-28-06, cert. ef. 7-31-06 thru 12-31-06; DFW 131-2006(Temp), f. 12-20-06, cert. ef. 1-1-07 thru 6-29-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 60-2007(Temp), f. 7-30-07, cert. ef. 8-1-07 thru 12-31-07; Administrative Correction 1-24-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0065
Winter Salmon Season

(1) Salmon, steelhead, shad, white sturgeon, walleye and carp may be taken for commercial purposes from the Columbia River Treaty Indian Fishery, from 12 noon February 1 to 6:00 p.m. March 21.

(2) There are no mesh size restrictions.

(3) Closed areas as set forth in OAR 635-041-0045 remain in effect with the exception of Spring Creek Hatchery sanctuary.

(4) White sturgeon between 48–60 inches in length in The Dalles and John Day pools and white sturgeon between 45–60 inches in the Bonneville Pool may be sold or kept for subsistence use.

(5) Sale of platform and hook-and-line caught fish is allowed during open commercial fishing seasons.

Stat. Auth.: ORS 183.325 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 89, f. & ef. 1-28-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 2-1979, f. & ef. 1-25-79; FWC 13-1979(Temp), f. & ef. 3-30-1979, Renumbered from 635-035-0065; FWC 6-1980, f. & ef. 1-28-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. l-30-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 3-1988(Temp), f. & cert. ef. 1-29-88; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 13-1989(Temp), f. & cert. ef. 3-21-89; FWC 15-1990(Temp), f. 2-8-90, cert. ef. 2-9-90; FWC 20-1990, f. 3-6-90, cert. ef. 3-15-90; FWC 13-1992(Temp), f. & cert. ef. 3-5-92; FWC 7-1993, f. & cert. ef. 2-1-93; FWC 12-1993(Temp), f. & cert. ef. 2-22-93; FWC 18-1993(Temp), f. & cert. ef. 3-2-93; FWC 7-1994, f. & cert. ef. 2-1-94; FWC 11-1994(Temp), f. & cert. ef. 2-28-94; FWC 9-1995, f. & cert. ef. 2-1-95; FWC 19-1995(Temp), f. & cert. ef. 3-3-95; FWC 5-1996, f. & cert. ef. 2-7-96; FWC 4-1997, f. & cert. ef. 1-30-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 20-1998(Temp), f. & cert. ef. 3-13-98 thru 3-20-98; DFW 23-1998(Temp), f. & cert. ef. 3-20-98 thru 6-30-98; DFW 2-1999(Temp), f. & cert. ef. 2-1-99 through 2-19-99; DFW 9-1999, f. & cert. ef. 2-26-99; DFW 14-1999(Temp), f. 3-5-99, cert. ef. 3-6-99 thru 3-20-99; Administrative correction 11-17-99; DFW 6-2000(Temp), f. & cert. ef. 2-1-00 thru 2-29-00; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 19-2000, f. 3-18-00, cert. ef. 3-18-00 thru 3-21-00; DFW 26-2000(Temp), f. 5-4-00, cert. ef. 5-6-00 thru 5-28-00; Administrative correction 5-22-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 14-2001(Temp), f. 3-12-01, cert. ef. 3-14-01 thru 3-21-01; Administrative correction 6-20-01; DFW 9-2002, f. & cert. ef. 2-1-02; DFW 11-2002(Temp), f. & cert. ef. 2-8-02 thru 8-7-02; DFW 17-2002(Temp), f. 3-7-02, cert. ef. 3-8-02 thru 9-1-02; DFW 18-2002(Temp), f. 3-13-02, cert. ef. 3-15-02 thru 9-11-02; DFW 134-2002(Temp), f. & cert. ef. 12-19-02 thru 4-1-03; DFW 20-2003(Temp), f. 3-12-03, cert. ef. 3-13-03 thru 4-1-03; DFW 131-2003(Temp), f. 12-26-03, cert. ef. 1-1-04 thru 4-1-04; DFW 5-2004(Temp), f. 1-26-04, cert. ef. 2-2-04 thru 4-1-04; DFW 15-2004(Temp), f. 3-8-04, cert. ef. 3-10-04 thru 4-1-04; DFW 130-2004(Temp), f. 12-23-04, cert. ef. 1-1-05 thru 4-1-05; DFW 4-2005(Temp), f. & cert. ef 1-31-05 thru 4-1-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; Administrative correction 4-20-05; DFW 3-2006(Temp), f. & cert. ef. 1-27-06 thru 3-31-06; Administrative correction 4-19-06; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 14-2007(Temp), f. & cert. ef. 3-9-07 thru 9-4-07; DFW 15-2007(Temp), f. & cert. ef. 3-14-07 thru 9-9-07; Administrative correction 9-16-07; DFW 6-2008(Temp), f. 1-29-08, cert. ef. 1-31-08 thru 7-28-08; DFW 20-2008(Temp), f. 2-28-08, cert. ef. 2-29-08 thru 7-28-08; DFW 21-2008(Temp), f. & cert. ef. 3-5-08 thru 7-28-08; DFW 22-2008(Temp), f. 3-7-08, cert. ef. 3-10-08 thru 7-28-08; Administrative correction 8-21-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0510
Applicability of Regulations

(1) The right to fish in accordance with OAR 635-041-0500 through 635-041-0520 is restricted to those members of the Confederated Tribes of Siletz Indians of Oregon, referred to in Public Law 95-195, 91 Stat. 1415 (currently codified at 25 U.S.C.S. 711-711F), and all tribal members, present and future, and applies only to the cultural fishery described in the Agreement. All other fishing by tribal members must be in accordance with state laws or rules. The attached Agreement is hereby made a part of these rules.

(2) The taking of salmon prescribed in the Agreement and by OAR 635-041-0500 through 635-041-0520 is prohibited except by persons, during times, with the fishing gear, and in the areas specified.

(3) Tribal fishers must have a valid tribal license in his or her possession at all times when fishing pursuant to the Agreement.

(4) Violation of any of the provisions of the Agreement or any of these rules is prohibited.

Stat. Auth.: ORS 496.138
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 50-1980(Temp), f. & ef. 9-22-80; FWC 35-198 (Temp), f. & ef. 9-22-81; FWC 52-1982, f. & ef. 8-9-82; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0520
Cultural Fishery Seasons and Areas

(1) Salmon may be taken for cultural fishery purposes from October 1 through November 30 in those areas described in the Agreement and more specifically:

(a) Euchre Creek Falls, a single falls located approximately between stream mile 2.8 and 3.0 in Section 11, T9S, R10W. Upstream boundary designated by an orange-painted 18 20 inch oval area located on the rock face on the right side of the stream approximately 94 feet above the base of the falls. The downstream boundary is designated by an orange-painted area on a large boulder on the left side of the stream approximately 280 feet below the base of the falls;

(b) Dewey Creek Falls, a series of three small falls located approximately between stream mile 0.4 and 0.5 in Section 8, T10S, R10W. The upstream boundary designated by an orange-colored 12 inch triangular piece of aluminum attached to an alder tree on the right side of the stream approximately 53 feet above the base of the upper falls. The downstream boundary designated by an orange-painted 18 20 inch area on a rock ledge on the right side of the stream approximately 290 feet below the base of the upper falls;

(c) Little Rock Creek, in portions flowing through the NE 1/4 and NW 1/4 of Section 7, T10S, R8W, W.M. on land owned by the Confederated Tribes of the Siletz Indians of Oregon. The upstream boundary is designated by a yellow Siletz Tribal marker at Survey Boundary Stake LS1901 located between Little Rock Creek and the Siletz-Nashville Road at approximately stream mile 0.9. The downstream boundary is designated by a yellow Siletz Tribal marker located on a fir Bearing Tree located between Little Rock Creek and the Siletz-Nashville Road at approximately stream mile 0.3;

(d) Within the cultural fishing site on Little Rock Creek, fishing is additionally regulated as follows:

(A) No fishing is allowed within an area 200 feet upstream or downstream of the fish trap operated by the Department and designated by Siletz Tribal markers;

(B) Fishing in the section of Little Rock Creek beginning at the Tribal marker 200 feet downstream from the the Department fish trap and extending downstream 300 feet to a Siletz Tribal marker must occur from platforms or other devices raised above the water surface. Such platforms or devices shall not extend more than one half the width of the stream.

(2) Salmon may be taken for cultural fishery purposes from one hour before sunrise until one hour after sunset.

(3) Salmon taken during the open season set forth in section (1) of this rule shall be tagged immediately upon landing by inserting one of the 200 salmon tags provided to the Confederated Tribe of Siletz by permanently affixing the tag around the lower jaw of the fish. It is *unlawful* to possess salmon taken during the open season set forth in section (1) of this rule which have not been so tagged.

Stat. Auth.: ORS 496.138
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 50-1980(Temp), f. & ef. 9-22-80; FWC 35-1981 (Temp), f. & ef. 9-22-81; FWC 52-1982, f. & ef. 8-9-82; FWC 54-1983, f. & ef. 9-30-83; FWC 92-1988(Temp), f. & cert. ef. 9-6-88; FWC 121-1991, f. 10-17-91, cert. ef. 10-18-91; DFW 142-2008, f. & cert. ef. 11-21-08

635-041-0600
Confederated Tribes of the Grand Ronde Community of Oregon

The Commission adopts the "Agreement among the State of Oregon, the United States of America and the Confederated Tribes of the Grand Ronde Community of Oregon to permanently define tribal hunting, fishing, trapping, and animal gathering rights of the Tribe and its members" (see Exhibit 2), signed by the Commission Chairman, Don Barth, 11-29-86, and further provided that no angling license is required for Grand Ronde members when fishing from jetties and the surf in the Pacific Ocean within the Trask unit.

Stat. Auth.: ORS 496.138
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 33-1987, f. & ef. 6-25-87; DFW 142-2008, f. & cert. ef. 11-21-08

635-042-0001
Management and Catch Reporting Areas

Management and Catch Reporting Zones shall include those waters of the Columbia River defined as follows:

(1) Zone 1 is easterly of a line projected from the knuckle of the south jetty on the Oregon bank to the inshore end of the north jetty on the

Washington bank, and westerly of a line projected from a beacon light at Grays Point on the Washington bank to the flashing 4-second red buoy "44" off the easterly tip of Tongue Point on the Oregon bank.

(2) Zone 2 is easterly of a line projected from a beacon light at Grays Point on the Washington bank to the flashing 4-second red buoy "44" off the easterly tip of Tongue Point on the Oregon bank, and westerly of a line projected from the 4-second flashing green light "81" on the Washington bank to a boundary marker on the easterly end of the Beaver Terminal Pier in Oregon, including all waters of Grays Bay, those waters of Deep River downstream of the Highway 4 Bridge, all waters of Seal Slough, those waters of Grays River downstream of a line projected between fishing boundary markers on both banks at the Leo Reisticka farm, and those waters of Elokomin Slough and Elokomin River downstream of the Highway 4 Bridge.

(3) Zone 3 is easterly of a line projected from the 4-second flashing green light "81" on the Washington bank to a boundary marker on the easterly end of the Beaver Terminal Pier in Oregon, and westerly of a line projected true west from the east or upstream bank of the Lewis River mouth in Washington.

(4) Zone 4 is easterly of a line projected true west from the east or upstream bank of the Lewis River in Washington, and westerly of a line projected true north from Rooster Rock on the Oregon bank, and those waters of Camas Slough downstream of the western most powerline crossing at the James River Mill.

(5) Zone 5 is easterly of a line projected true north from Rooster Rock on the Oregon bank, and westerly of a line projected from a deadline marker on the Oregon bank (approximately four miles downstream from Bonneville Dam Powerhouse 1) in a straight line through the western tip of Pierce Island, to a deadline marker on the Washington bank at Beacon Rock.

(6) Area 2S is from a downstream boundary of a true north/south line through flashing red 4-second light "50" near the Oregon bank to an upstream boundary of a straight line from a deadline marker on the Oregon bank (approximately four miles downstream from Bonneville Dam Powerhouse 1) through the western tip of Pierce Island, to a deadline marker on the Washington bank at Beacon Rock.

Stat. Auth.: ORS 183.325, 496.118 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 10-1988, f. & cert. ef. 3-4-88; FWC 54-1989 (Temp), f. & cert. ef. 8-7-89; FWC 90-1989, f. & cert. ef. 9-6-89; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 142-2008, f. & cert. ef. 11-21-08

635-042-0007
Definitions

(1) For the purpose of Chapter 679, Oregon Laws 1979, "Columbia River gillnet salmon fishery" means commercial salmon gillnet fishing in the Columbia River below Bonneville Dam and all tributaries thereof, including Youngs Bay, wherein commercial salmon gillnet seasons are authorized by Department rules.

(2) "Commission" means the Oregon Fish and Wildlife Commission.

(3) "Department" means the Oregon Department of Fish and Wildlife.

(4) "Director" means the Director of the Oregon Department of Fish and Wildlife.

Stat. Auth.: ORS 183.325, 496.118 & 506.119
Stats. Implemented: ORS 506.129 & 507.030
Hist.: FWC 15-1980, f. & ef. 4-16-80; FWC 1-1981, f. & ef. 1-19-81; FWC 6-1982, f. & ef. 1-28-82; FWC 4-1984, f. & ef. 1-31-84; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; DFW 142-2008, f. & cert. ef. 11-21-08

635-042-0022
Spring Chinook Gillnet and Tangle Net Fisheries

(1) Adipose fin-clipped Chinook salmon, sturgeon and shad may be taken by gillnet or tangle net for commercial purposes from the mouth of the Columbia River upstream to Kelley Point (Zones 1–3 and part of Zone 4).

(a) Individual fishing periods will not exceed sixteen hours in length during small mesh fisheries and twenty-four hours in length during large mesh fisheries. Fishing periods may occur on Tuesdays and Thursdays, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) White sturgeon possession and sales restrictions by each participating vessel will be determined inseason based on gear type and number of fish remaining on the fish guideline.

(2) An adipose fin clip salmon is defined as a hatchery salmon with a clipped adipose fin and having a healed scar at the location of the fin. The adipose fin is the small fatty fin on salmonids located between the dorsal fin and tail.

(3) During the spring Chinook gillnet fishery:

(a) It is *unlawful* to use a gillnet having a mesh size less than 8 inches or more than 9-3/4 inches.

(b) Mesh size for the fishery is determined as described in OAR 635-042-0010(4).

(4) During the spring Chinook tangle net fishery:

(a) It is *unlawful* to use other than a single-wall multi-filament net. Monofilament tangle nets are not allowed. Maximum mesh size is 4-1/4 inches stretched taut.

(b) Mesh size is determined by placing three consecutive meshes under hand tension and the measurement is taken from the inside of one vertical knot to the outside of the opposite vertical knot of the center mesh. Hand tension means sufficient linear tension to draw opposing knots of meshes into contact.

(5) Nets shall not exceed 900 feet (150 fathoms) in length. A red cork must be placed on the corkline every 25 fathoms as measured from the first mesh of the net. Red corks at 25 fathom intervals must be in color contrast to the corks used in the remainder of the net.

(6) On tangle nets, an optional use of a steelhead excluder panel of mesh may be hung between the corkline and the 4 1/4 inch maximum mesh size tangle net. The excluder panel web must be a minimum mesh size of 12 inches when stretched taut under hand tension. Monofilament mesh is allowed for the excluder panel. The excluder panel (including any associated hangings) must be a minimum of 5 linear feet in depth and not exceed 10 linear feet in depth, as measured from the corkline to the upper margin of the tangle net mesh as the net hangs naturally from a taut corkline. Weedlines or droppers (bobber-type) may be used in place of the steelhead excluder panel. A weedline-type excluder means the net is suspended below the corkline by lines of no less than five feet in length between the corkline and the upper margin of the tangle net. A dropper-type excluder means the entire net is suspended below the surface of the water by lines of no less than five feet in length extending from individual surface floats to a submersed corkline. The corkline cannot be capable of floating the net in its entirety (including the leadline) independent of the attached floats. Weedlines or droppers must extend a minimum of 5 feet above the 4-1/4 inch maximum mesh size tangle net.

(a) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, may extend to a maximum length of 1,050 feet (175 fathoms).

(b) Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers, along with a red cork every 25 fathoms as required in section (5) above, must have two red corks at each end of the net.

(7) There are no restrictions on the hang ratio. The hang ratio is used to horizontally add slack to the net. The hang ratio is determined by the length of the web per length of the corkline.

(8) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(9) Nets shall be fished for no longer than 45 minutes per set. The time of fishing is measured from when the first mesh of the net is deployed into the water until the last mesh of the net is fully retrieved from the water.

(10) It is *unlawful* for a net in whole or in part to be anchored, tied, staked, fixed, or attached to the bottom, shore, or a beached boat; left unattended at any time it is fished; or attended by more than one boat while being fished.

(11) It is *unlawful* to fish more than one net from a licensed commercial fishing boat at any one time.

(12) Nets fished from sunset to sunrise shall have lighted buoys on both ends of the net unless the net is attached to the boat then one lighted buoy on the opposite end of the net from the boat is required.

(13) Non-legal sturgeon, nonadipose fin-clipped Chinook salmon, and steelhead must be released immediately with care and the least possible injury to the fish to the river without violence or into an operating recovery box.

(a) One operating recovery box with two chambers or two operating recovery boxes with one chamber each to aid survival of released fish must be on board each fishing vessel participating in the fishery. Recovery boxes shall be operating during any time that a net is being retrieved or picked.

(b) All salmon and steelhead that are bleeding, in lethargic condition, or appearing dead must be placed in the recovery box for rehabilitation purposes prior to release to the river.

(c) Each chamber of the recovery box must meet the following dimensions as measured from within the box; the inside length measurement must be at or within 39-1/2 to 48 inches, the inside width measurement must be at or within 8 to 10 inches, and the inside height measurement must be at or within 14 to 16 inches.

(d) Each chamber of the recovery box must include an operating water pumping system capable of delivering a minimum flow of 16 gallons per minute not to exceed 20 gallons per minute of fresh river water into each chamber. The fisher must demonstrate to the Department and Washington Department of Fish and Wildlife employees, fish and wildlife enforcement officers, or other peace officers, upon request, that the pumping system is delivering the proper volume of fresh river water into each chamber.

(e) Each chamber of the recovery box must include a water inlet hole between 3/4 inch and 1 inch in diameter, centered horizontally across the door or wall of chamber and 1-3/4 inches from the floor of the chamber.

(f) Each chamber of the recovery box must include a water outlet that is at least 1 1/2 inches in diameter. The center of the outlet hole must be located a minimum of 12 inches above the floor of the box or chamber, on either the same or opposite end as the inlet.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(14) At least one fisher on each boat engaged in the fishery must have in possession a valid certificate issued by a representative of the Department or the Washington Department of Fish and Wildlife that indicates the fisher had attended a one-day workshop hosted by the Department or Washington Department of Fish and Wildlife to educate fishers on regulations and best methods for conduct of the fishery. No individual may obtain more than one Live Capture Fishery Certificate. The certificate must be displayed to the Department and Washington Department of Fish and Wildlife employees, fish and wildlife enforcement officers, or other peace officers upon request.

(15) Nothing in this section sets any precedent for any fishery after the 2006 spring Chinook fishery. The fact that an individual held a Live Capture Fishery Certificate in spring 2006 does not entitle the certificate holder to participate in any other fishery. If the Department authorizes a Live Capture fishery in the spring or at any other time, the Department may establish qualifications and requirements that are different from those established for 2006. In particular, the Department may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future Live Capture fisheries.

(16) As authorized by OAR-006-0140 owners or operators of commercial fishing vessels must cooperate with Department fishery observers, or observers collecting data for the Department, when asked by the Department to carry and accommodate an observer on fishing trips for observation and sampling during an open fishery.

(17) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, and Lewis-B sanctuary are in effect during the open fishing periods identified.

Stat. Auth.: ORS 496.138, ORS 496.146, & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 12-2004(Temp), f. & cert. ef. 3-1-04, thru 7-31-04; DFW 13-2004(Temp), f. & cert. ef. 3-3-04 thru 7-31-04; DFW 16-2004(Temp), f. & cert. ef. 3-8-04 thru 7-31-04; DFW 18-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04; DFW 20-2004(Temp) f. & cert. ef. 3-15-04 thru 7-31-04; DFW 21-2004(Temp), f. & cert. ef. 3-18-04 thru 7-31-04; DFW 25-2004(Temp), f. 3-22-04, cert. ef. 3-23-04 thru 7-31-04; DFW 26-2004(Temp), f. & cert. ef. 3-25-04 thru 7-31-04; DFW 27-2004(Temp), f. & cert. ef. 3-29-04 thru 7-31-04; Administrative correction 8-19-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 9-2005(Temp), f. & cert. ef. 3-1-05 thru 7-31-05; DFW 11-2005(Temp), f. 3-2-05, cert. ef. 3-3-05 & 7-31-05; DFW 13-2005(Temp), f. & cert. ef. 3-7-05 thru 7-31-05; DFW 14-2005(Temp), f. & cert. ef. 3-10-05 thru 7-31-05; DFW 18-2005(Temp), f. & cert. ef. 3-15-05 thru 3-21-05; DFW 20-2005(Temp), f. & cert. ef. 3-29-05 thru 3-30-05; DFW 21-2005(Temp), f. & cert. ef. 3-31-05 thru 4-1-05; Administrative correction, 4-20-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 7-2006(Temp), f. & cert. ef. 2-23-06 thru 7-31-06; DFW 9-2006(Temp), f. 3-1-06, cert. ef. 3-2-06 thru 7-31-06; DFW 10-2006(Temp), f. 3-6-06, cert. ef. 3-7-06 thru 7-31-06; DFW 11-2006(Temp), f. & cert. ef. 3-9-06 thru 7-31-06; DFW 12-2006(Temp), f. 3-13-06, cert. ef. 3-14-06 thru 7-31-06; DFW 29-2006(Temp), f. & cert. ef. 5-16-06 thru 7-31-06; DFW 30-2006(Temp), f. & cert. ef. 5-18-06 thru 7-31-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06; Administrative correction 8-22-06; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 13-2007(Temp), f. & cert. ef. 3-6-07 thru 9-1-07; DFW 17-2007(Temp), f. & cert. ef. 3-20-07 thru 9-15-07; DFW 19-2007(Temp), f. & cert. ef. 3-22-07 thru 9-17-07; DFW 44-2007(Temp), f. & cert. ef. 6-14-07 thru 9-17-07; Administrative correction 9-18-07; DFW 31-2008(Temp), f. 3-31-08, cert. ef. 4-1-08 thru 9-27-08; DFW 33-2008(Temp), f. 4-7-08, cert. ef. 4-8-08 thru 9-27-08; DFW 34-2008(Temp), f. 4-14-08, cert. ef. 4-15-08 thru 9-27-08; Suspended by DFW 71-2008(Temp), f. 6-27-08, cert. ef. 6-28-08 thru 8-31-08; Administrative correction 10-21-08; DFW 142-2008, f. & cert. ef. 11-21-08

635-042-0110
Gary Island to Bonneville Dam (Area 2S) Shad Season

(1) Shad may be taken for commercial purposes from the area of the Columbia River described in section (2) daily from 3:00 p.m. to 10:00 p.m. during open fishing periods.

(2) The area of the Columbia River open to fishing is from a downstream boundary of a true north/south line through the flashing red 4-second Light "50" near the Oregon bank to an upstream boundary of a straight line from a deadline marker on the Oregon bank, through the western tip of Pierce Island, to a deadline marker on the Washington bank at Beacon Rock, both such deadline markers located approximately four miles downstream from Bonneville Dam.

(3) It is *unlawful* to use a gillnet having a mesh size less than 5-3/8 inches or more than 6-1/4 inches with a breaking strength greater than a 10-pound pull, or to use a gillnet other than a single wall floater net, or to use a gillnet having slackers, or to use a gillnet of more than 150 fathoms in length or 40 meshes in depth. Rip lines are authorized spaced not closer than 20 corks apart.

(4) All salmon, steelhead, walleye and sturgeon taken in shad nets must be immediately returned unharmed to the water.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 85, f. & ef. 1-28-77; FWC 116(Temp), f. & ef. 6-1-77 thru 6-3-77; FWC 124(Temp), f. & ef. 6-17-77 thru 10-14-77; FWC 2-1978, f. & ef. 1-31-78; FWC 7-1978, f. & ef. 2-21-78; FWC 27-1978(Temp), f. & ef. 5-26-78 thru 9-22-78; FWC 2-1979, f. & ef. 1-25-79, Renumbered from 635-035-0275; FWC 6-1980, f. & ef. 1-28-80; FWC 25-1980(Temp), f. & ef. 6-13-80; FWC 1-1981, f. & ef. 1-19-81; FWC 18-1981(Temp), f. & ef. 6-10-81; FWC 6-1982, f. & ef. 1-28-82; FWC 36-1982 (Temp), f. & ef. 6-11-82; FWC 2-1983, f. 1-21-83, ef. 2-1-83; FWC 21-1983(Temp), f. & ef. 6-10-83; FWC 4-1984, f. & ef. 1-31-84; FWC 2-1985, f. & ef. 1-30-85; FWC 19-1985, f. & ef. 5-1-85; FWC 4-1986(Temp), f. & ef. 1-28-86; FWC 16-1986 (Temp), f. & ef. 5-23-86; FWC 79-1986(Temp), f. & ef. 12-22-86; FWC 2-1987, f. & ef. 1-23-87; FWC 23-1987(Temp), f. & ef. 5-20-87; FWC 10-1988, f. & cert. ef. 3-4-88; FWC 5-1989, f. 2-6-89, cert. ef. 2-7-89; FWC 15-1990(Temp), f. 2-8-90, cert. ef. 2-9-90; FWC 20-1990, f. 3-6-90, cert. ef. 3-15-90; FWC 10-1991, f. 2-7-91, cert. ef. 2-8-91; FWC 8-1992, f. & cert. ef. 2-11-92; FWC 34-1992(Temp), f. 5-19-92, cert. ef. 5-20-92; FWC 11-1993, f. 2-11-93, cert. ef. 2-16-93; FWC 9-1994, f. 2-14-94, cert. ef. 2-15-94; FWC 15-1995, f. & cert. ef. 2-15-95; FWC 6-1996, f. & cert. ef. 2-7-96; FWC 4-1997, f. & cert. ef. 1-30-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 36-2000(Temp), f. 6-28-00, cert. ef. 6-28-00 thru 7-1-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 6-2005, f. & cert. ef. 2-14-05; DFW 39-2005(Temp), f. & cert. ef. 5-10-05 thru 10-16-05; DFW 45-2005(Temp), f. 5-17-05, cert. ef. 5-23-05 thru 10-16-05; DFW 63-2005(Temp), f. & cert. ef. 6-29-05 thru 7-31-05; Administrative correction 11-18-05; DFW 5-2006, f. & cert. ef. 2-15-06; DFW 32-2006(Temp), f. & cert. ef. 5-23-06 thru 7-31-06; DFW 35-2006(Temp), f. & cert. ef. 5-30-06 thru 7-31-06; Administrative correction 8-22-06; DFW 7-2007(Temp), f. 1-31-07, cert. ef. 2-1-07 thru 7-30-07; DFW 9-2007, f. & cert. ef. 2-14-07; DFW 18-2008(Temp), f. 2-27-08, cert. ef. 5-12-08 thru 11-7-08; DFW 68-2008(Temp), f. 6-20-08, cert. ef. 6-21-08 thru 8-31-08; Administrative correction 9-29-08; DFW 142-2008, f. & cert. ef. 11-21-08

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Rule Caption: Amend rules relating to Cervid products.
Adm. Order No.: DFW 143-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 11-24-08
Notice Publication Date: 7-1-2008
Rules Amended: 635-049-0205
Subject: These amendments will remove the requirement that cervid part sales be reported in detail to ODFW.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-049-0205
Record keeping

Licensees must keep accurate, legible and up-to-date records of:

(1) all movement of cervids (including gametes and embryos) into or out of their facility. At minimum, these records must include all sales, purchases, loans (of cervids), trades, or other such transactions involving cervids, as well as any cervid births or deaths at the facility. Each record must refer to individual cervids by their unique mark and ear tag and list the names, addresses, and license or permit numbers of any individuals or entities involved in the transactions;

(2) Calving and fawning;

(3) Escape or release;

(4) Disease testing;

(5) Artificial insemination and embryo implants; and

(6) Each cervid's pedigree.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162, 497.228, 498.002, 498.019, 498.052 & 174.106
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162, 497.228, 498.002, 498.019, 498.052 & 174.106
Hist.: DFW 52-2008, f. & cert. ef. 5-28-08; DFW 143-2008, f. & cert. ef. 11-24-08

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Rule Caption: Rules relating to Wildlife Management Plan for black-tail deer.
Adm. Order No.: DFW 144-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 11-24-08
Notice Publication Date: 10-1-2008
Rules Adopted: 635-195-0000, 635-195-0010

Subject: Adopt rules relating to Wildlife Management Plan for black-tail deer.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-195-0000
Black-tailed Deer Management Plan

(1) The goal of black-tailed deer management is to manage black-tailed deer populations in Oregon to be consistent with both the available habitat of all lands of the state and the Oregon Conservation Strategy, compatible with primary land uses, and to provide optimum recreational benefits to the public.

(2) Objectives to accomplish this goal are to:

(a) Actively seek opportunities to work with all land owners and managers including Native American Tribes to restore, retain or develop black-tailed deer habitat.

(b) Increase cooperative efforts with private landowners to actively promote black-tailed deer habitat, considering, and remaining consistent with, primary uses of the land.

(c) Increase cooperative efforts with federal, state, and tribal land managers to actively promote creation, maintenance, enhancement, and restoration of black-tailed deer habitat.

(d) Manage black-tailed deer populations to attempt to achieve escapement (buck ratios) and populations at benchmark levels while collecting information over the next five years to develop Management Objectives.

(e) Enhance all recreational, consumptive, and cultural uses of the black-tailed deer resource.

(f) Provide timely response to property damage concerns.

(g) Identify key data needs and develop plans to promote and implement collaborative research projects.

Stat. Auth.: ORS 183 & 496
Stats. Implemented: ORS 183 & 496
Hist.: DFW 144-2008, f. & cert. ef. 11-24-08

635-195-0010
Five-year Review

The Black-tailed Deer Management Plan will be reviewed in 2013 to gauge implementation progress and will be revised in entirety beginning in 2018.

Stat. Auth.: ORS 183 & 496
Stats. Implemented: ORS 183 & 496
Hist.: DFW 144-2008, f. & cert. ef. 11-24-08

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Rule Caption: Commercial fishing vessels allowed to retrieve derelict ocean Dungeness crab gear in season.
Adm. Order No.: DFW 145-2008(Temp)
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08 thru 5-29-09
Notice Publication Date:
Rules Amended: 635-005-0055
Subject: Amended rule specifies conditions under which commercial fisherman are allowed to retrieve derelict commercial ocean Dungeness crab fishing gear and transport it to shore. Commercial fisherman may retrieve up to six Dungeness crab pots not belonging to their vessel each fishing trip provided the pots are un-baited, no crab from these pots is retained, and the document the activity in their logbook.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-005-0055
Fishing Gear

It is *unlawful* for commercial purposes to:

(1) Take crab by any means other than crab rings or crab pots (ORS 509.415); a crab ring is any fishing device that allows crab unrestricted entry or exit while fishing.

(2) Possess on a vessel, use, control, or operate any crab pot which is greater than thirteen cubic feet in volume, calculated using external dimensions.

(3) Possess on a vessel, use, control, or operate any crab pot which does not include a minimum of two circular escape ports of at least 4-1/4 inches inside diameter located on the top or side of the pot. If escape ports are placed on the side of the pot, they shall be located in the upper half of the pot.

(4) Possess on a vessel, use, control, or operate any crab pot which does not have a release mechanism. Acceptable release mechanisms are:

(a) Iron lid strap hooks constructed of iron or "mild" steel rod (not stainless steel) not to exceed 1/4-inch (6 mm) in diameter;

(b) A single loop of untreated cotton or other natural fiber twine, or other twine approved by the Department not heavier than 120 thread size between pot lid tiedown hooks and the tiedown straps; or

(c) Any modification of the wire mesh on the top or side of the pot, secured with a single strand of 120 thread size untreated cotton, natural fiber, or other twine approved by the Department which, when removed, will create an opening of at least five inches in diameter.

(5) Place, operate, or leave crab rings or pots in the Pacific Ocean and Columbia River or in any bay or estuary during the closed season, except that in only the Pacific Ocean and Columbia River, rings or pots may be placed no more than 64 hours immediately prior to the date the Dungeness crab season opens. In addition, unbaited crab rings or pots with open release mechanisms may be left in the Pacific Ocean (not including the Columbia River) for a period not to exceed 14 days following the closure of the Dungeness crab season.

(6) Have Dungeness crab gear deployed in the Pacific Ocean or Columbia River more than 14 days without making a landing of Dungeness crab.

(7) Use commercial crab pots in the Columbia River or Pacific Ocean unless the pots are individually marked with a surface buoy bearing, in a visible, legible and permanent manner, the brand of the owner and the Department buoy tag, provided that:

(a) The brand is a number registered with and approved by the Department;

(b) Only one unique buoy brand shall be registered to any one permitted vessel;

(c) All crab pots fished by a permitted vessel must use only the Oregon buoy brand number registered to that vessel in the area off of Oregon;

(d) The Department shall issue crab buoy tags to the owner of each commercial crab permit in the amount determined by OAR 635-006-1015(1)(g)(E);

(e) All buoy tags eligible to a permit holder must be purchased from the Department at cost and attached to the gear prior to setting gear; and

(f) Buoys attached to a crab pot must have the buoy tag securely attached to the first buoy on the crab pot line (the buoy closest to the crab pot) at the end away from the crab pot line;

(g) Additional buoy tags to replace lost tags will be issued by the Department as follows:

(A) As of the first business day after 30 days following the season opening in the area fished, up to ten percent of the tags initially issued for that season; or

(B) For a catastrophic loss, defined as direct loss of non-deployed gear in the event of a vessel being destroyed due to fire, capsizing, or sinking. Documentation of a catastrophic loss may include any information the Department considers appropriate, such as fire department or US Coast Guard reports; or

(C) If the Director finds that the loss of the crab pot buoy tags was:

(i) Due to an extraordinary event; and

(ii) The loss was minimized with the exercise of reasonable diligence; and

(iii) Reasonable efforts were taken to recover lost buoy tags and associated fishing gear.

(D) Upon receipt of the declaration of loss required by subsection (E) of this rule, and a request for replacement tags under subsection (C) of this rule, the Director or the Director's designee may provide an opportunity for the permit holder requesting the replacement tags to describe why the buoy tag loss meets the criteria for replacement under subsection (C). The Director or the Director's designee shall provide the Director's order to the permit holder and to the Department's License Services. The permit holder may appeal the Director's findings to the Fishery Permit Review Board under OAR 635-006-1065(1)(g).

(E) Permit holders (or their alternative designated on the buoy tag order form) must obtain, complete, and sign a declaration of loss under penalty of perjury in the presence of an authorized Department employee. The declaration shall state the number of buoy tags lost, the location and date where lost gear or tags were last observed, and the presumed cause of the loss.

(8) Remove, damage, or otherwise tamper with crab buoy or pot tags except when lawfully applying or removing tags on the vessel's buoys and pots.

(9) Possess on a vessel, use, control, or operate any crab pot which does not have a pot tag identifying the pot as that vessel's, a surface buoy

bearing the Department buoy brand registered to that vessel and a Department buoy tag issued by the Department to that vessel, except:

(a) To set gear as allowed under OAR 635-006-1015; or

(b) To retrieve from the ocean, including the Columbia River, and transport to shore up to six crab pot(s) of another vessel which were lost, forgotten, damaged, abandoned or otherwise derelict; provided that:

(A) Upon retrieval from the ocean or Columbia River, the pot(s) must be un-baited; and

(B) Crab from the retrieved pot(s) shall not be retained; and

(C) Immediately upon retrieval of pot(s), the retrieving vessel operator must document, in the retrieving vessel's logbook, the date and time of pot retrieval, number of retrieved crab pots, location of retrieval, and retrieved pot owner identification information; and

(D) Any retrieved crab pot(s) must be transported to shore during the same fishing trip that retrieval took place; or

(c) Under a waiver granted by the Department to allow one time retrieval of permitted crab gear to shore by another crab permitted vessel provided that:

(A) Vessel is incapacitated due to major mechanical failure or destroyed due to fire, capsizing, or sinking;

(B) Circumstances beyond the control of the permit holder created undue hardship as defined by OAR 635-006-1095(7)(d);

(C) A Request must be in writing and a waiver approved and issued prior to retrieval.

(D) A copy of the waiver must be on board the vessel making the retrieval. (Contact Oregon Department of Fish and Wildlife License Services, Salem for guidelines.)

(d) A vessel may transit through the Columbia River and the Pacific Ocean adjacent to Oregon while possessing crab pots not bearing Oregon buoy tags or Oregon buoy branded surface buoys, provided that the vessel is authorized to participate in the Dungeness crab fishery of an adjacent state.

(10) Attach one crab pot to another crab pot or ring net by a common groundline or any other means that connects crab pots together.

(11) Take crabs for commercial purposes by crab pots from any bay or estuary except the Columbia River.

(12) Operate more than 15 crab rings from any one fishing vessel in bays or estuaries, except the Columbia River.

(13) Take or fish for Dungeness crab for commercial purposes in the Columbia River or Pacific Ocean adjacent to the state of Oregon unless a crab pot allocation has been issued to the permit required under OAR 635-006-1015(1)(g).

(14) Deploy or fish more crab pots than the number of pots assigned by the crab pot allocation certificate or to use any vessel other than the vessel designated on the crab pot allocation, except to set gear as allowed under OAR 635-006-1015.

Stat. Auth.: ORS 506.119

Stats. Implemented: ORS 506.109 & 506.129

Hist.: FC 246, f. 5-5-72, ef. 5-15-72; FC 285(74-20), f. 11-27-74, ef. 12-25-74, Renumbered from 625-010-0160; FWC 49-1978, f. & ef. 9-27-78, Renumbered from 635-036-0130; FWC 56-1982, f. & ef. 8-27-82; FWC 81-1982, f. & ef. 11-4-82; FWC 82-1982(Temp), f. & ef. 11-9-82; FWC 13-1983, f. & ef. 3-24-83; FWC 11-1984, f. 3-30-84, ef. 9-16-84, except section (5) per FWC 45-1984, f. & ef. 8-30-84; FWC 72-1984, f. & ef. 10-22-84; FWC 30-1985, f. 6-27-85, ef. 7-1-85; FWC 78-1986 (Temp), f. & ef. 12-1-86; FWC 97-1987(Temp), f. & ef. 11-17-87; FWC 102-1988, f. 11-29-88, cert. ef. 12-29-88; FWC 107-1990, f. & cert. ef. 10-1-90; FWC 70-1993, f. 11-9-93, cert. ef. 11-11-93; FWC 84-1994, f. 10-31-94, cert. ef. 12-1-94; FWC 68-1996(Temp), f. & cert. ef. 12-5-96; FWC 2-1997, f. 1-27-97, cert. ef. 2-1-97; DFW 45-2006, f. 6-20-06, cert. ef. 12-1-06; DWF 96-2006(Temp), f. & cert. ef. 9-8-06 thru 3-6-07; DFW 97-2006(Temp), f. 9-8-06, cert. ef. 9-9-06 thru 3-7-07;DFW 123-2006(Temp), f. 11-28-06, cert. ef. 12-1-06 thru 3-7-06; DFW 135-2006(Temp), f. & cert. ef.12-26-06 thru 6-15-07; DFW 11-2007, f. & cert. ef. 2-14-07; DFW 41-2007, f. & cert. ef. 6-8-07; DFW 82-2007(Temp), f. 8-31-07, cert .ef. 9-1-07 thru 10-31-07; DFW 113-2007, f. & cert. ef. 10-25-07; DFW 127-2007(Temp), f. & cert. ef. 12-11-07 thru 6-7-08; DFW 129-2007(Temp), f. & cert. ef. 12-14-07 thru 6-7-08; DFW 29-2008(Temp), f. & cert. ef. 3-25-08 thru 8-31-08; DFW 59-2008(Temp), f.& cert. ef. 6-11-08 thru 8-28-08; DFW 98-2008(Temp), f. 8-19-08, cert. ef. 8-29-08 thru 10-31-08; Administrative correction 11-18-08; DFW 145-2008(Temp), f. 11-24-08, cert. ef. 12-1-08 thru 5-29-09

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Rule Caption: Inseason Actions Implemented by the Federal Government for Commercial Groundfish Fisheries.
Adm. Order No.: DFW 146-2008(Temp)
Filed with Sec. of State: 12-4-2008
Certified to be Effective: 12-4-08 thru 12-31-08
Notice Publication Date:
Rules Amended: 635-004-0019
Rules Suspended: 635-004-0019(T)
Subject: Amended rule adopts in-season actions implemented b the federal government for commercial groundfish fisheries including changes to limited entry trawl petrale sole trip limits.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-004-0019
Inclusions and Modifications

(1) OAR chapter 635, division 004, modifies or is in addition to provisions contained in **Code of Federal Regulations**, **Title 50**, **Part 660**, **Subpart G**, **West Coast Groundfish Fisheries**.

(2) The **Code of Federal Regulations** (**CFR**), **Title 50**, **Part 660**, **Subpart G**, provides requirements for commercial groundfish fishing in the Pacific Ocean off the Oregon coast. However, additional regulations may be promulgated subsequently, and these supersede, to the extent of any inconsistency, the **Code of Federal Regulations**.

(3) Notwithstanding the regulations as defined in OAR 635-004-0018, the National Oceanic and Atmospheric Administration (NOAA), by means of 73FR21057, announced inseason management measures effective May 1, 2008, including but not limited to: adjustments governing the limited entry non-whiting trawl fishery including changes to trip limits and Rockfish Conservation Area (RCA) boundaries; and trip limit adjustments to the open access sablefish daily trip limit fishery north of 36° N. Latitude.

(4) Notwithstanding the regulations as defined in OAR 635-004-0018, the National Oceanic and Atmospheric Administration (NOAA), by means of Federal Register/Vol. 73, No.143/Thursday, July 24, 2008, announced inseason management measures effective August 1, 2008, including but not limited to: adjustments to trip limits governing the limited entry non-whiting trawl fishery, and the limited entry fixed gear and open access sablefish daily trip limit fisheries.

(5) Notwithstanding the regulations as defined in OAR 635-004-0018, the National Oceanic and Atmospheric Administration (NOAA), by means of Federal Register/Vol. 73, No.231/Monday, December 1, 2008, announced inseason management measures effective December 1, 2008, including but not limited to: adjustments to trip limits governing the limited entry non-whiting trawl fishery.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 506.119

Stats. Implemented: ORS 506.109 & 506.129

Hist.: DFW 76-1999(Temp), f. 9-30-99, cert. ef. 10-1-99 thru 12-31-99; DFW 81-1999(Temp), f. & cert. ef. 10-12-99 thru 12-31-99; DFW 98-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 23-2005(Temp), F. & cert. ef. 4-8-05 thru 10-4-05; DFW 30-2005(Temp), f. 4-29-05, cert. ef. 5-1-05 thru 10-27-05; DFW 43-2005(Temp), f. & cert. ef. 5-13-05 thru 10-17-05; DFW 68-2005(Temp), 6-30-05, cert. ef. 7-1-05 thru 12-27-05; DFW 114-2005(Temp), f. 9-30-05, cert. ef. 10-1-05 thru 12-31-05; DFW 125-2005(Temp), f. & cert. ef. 10-19-05 thru 12-31-05; DFW 134-2005(Temp), f. & cert. ef. 11-30-05 thru 12-31-05; DFW 147-2005(Temp), f. 12-28-05, cert. ef. 1-1-06 thru 6-28-06; DFW 8-2006(Temp), f. 2-28-06, cert. ef. 3-1-06 thru 8-25-06; DFW 25-2006(Temp), f. 4-28-06, cert. ef. 5-1-06 thru 10-27-06; DFW 55-2006(Temp), f. 6-30-06, cert. ef. 7-1-06 thru 12-27-06; DFW 110-2006(Temp), f. 9-29-06, cert. ef. 10-1-06 thru 12-31-06; Administrative Correction 1-16-07; DFW 29-2007(Temp), f. & cert. ef. 5-1-07 thru 10-27-07; DFW 58-2007(Temp), f. 7-18-07, cert. ef. 8-1-07 thru 12-31-07; DFW 106-2007(Temp), f. 10-5-07, cert. ef. 10-6-07 thru 12-31-07; DFW 123-2007(Temp), f. 11-26-07, cert. ef. 11-28-07 thru 12-31-07; DFW 126-2007(Temp), f. & cert. ef. 12-11-07 thru 12-31-07; DFW 41-2008(Temp), f. 4-23-08, cert. ef. 5-1-08 thru 10-27-08; DFW 88-2008, f. & cert. ef. 8-1-08; DFW 146-2008(Temp), f. & cert. ef. 12-4-08 thru 12-31-08

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Rule Caption: Rules Relating to Shipping and Handling Fees for Mail-Order and Fax Sales of Big Game Raffle Tickets.
Adm. Order No.: DFW 147-2008(Temp)
Filed with Sec. of State: 12-9-2008
Certified to be Effective: 12-9-08 thru 6-6-09
Notice Publication Date:
Rules Amended: 635-010-0170
Subject: Amend rule to exempt mail-order and fax sales of Big Game Raffle tickets from shipping and handling charges.
Rules Coordinator: Therese Kucera—(503) 947-6033

635-010-0170
Licenses, tags or documents available by mail order, fax or Internet.

(1) All licenses, tags, permits or validations sold by the Department over the Internet fall into one of three categories concerning how the sale is made: Instant; Temporary; or Postal. Postal transactions are also available by mail order or fax.

(a) Instant: means that the internet purchase results in an immediate sale and printing of the item, allowing the purchaser to make immediate use of item purchased. No other action is required to complete the transaction. The items in this category are:

(A) Daily Angling Licenses: one-, two-, three-, four- and seven-day licenses;

(B) Three-day Nonresident Shellfish licenses;
(C) Three-day Nonresident Bird Hunting Licenses;
(D) Big Game controlled hunt applications;
(E) Game Bird controlled hunt applications;
(F) Sauvie Island Daily parking permits;
(G) Band-tailed Pigeon permits;
(H) Black Brant Permits;
(I) Sage Grouse Permits;
(J) Fern Ridge Reservation Permits;
(K) Klamath Reservation Permits; and
(L) Sauvie Island Reservation Permits.

(b) Temporary: means that the internet purchase results in an immediate sale and printing of the item, allowing the purchaser to make limited use (10 days) of the item purchased. The Department will send the final, permanent item to the purchaser via postal mail. The items in this category are:

(A) HIP Migratory Bird Validations;
(B) HIP Upland Bird Validations;
(C) HIP Crow Validations;
(D) Nonresident Game Bird Validations;
(E) Upland Game Bird Validations;
(F) Waterfowl Bird Validations;
(G) Sauvie Island Annual Parking Permits;
(H) Sea Duck Permits; and
(I) all annual hunting and angling licenses.

(c) Postal: means that the internet purchase results in an immediate sale and the printing of a transaction receipt, but that the Department mails the actual item to the purchaser via postal mail. The privilege(s) purchased is not valid until the purchaser receives the item. The items in this category are:

(A) Combined Hunting Tags;
(B) Combined Angling Tag;
(C) Hatchery Harvest Tag;
(D) All Big Game Tags (controlled hunt and general season);
(E) Pheasant Tags;
(F) NW Oregon Goose Permit; and
(G) Turkey Tags.

(2) The Department will charge shipping and handling fee of $2.00 per session whenever a person makes a purchase via Internet, fax, or mail order. Exception: Big Game Raffle tickets purchased by fax or mail order are not subject to this fee. This fee is in addition to all other document costs and covers the processing, printing, and postal mailing of the requested documents.

Stat. Auth.: ORS 496 & 497
Stats. Implemented: ORS 496 & 497
Hist.: DFW 130-2008, f. & cert. ef. 10-14-08; DFW 147-2008(Temp), f. & cert. ef. 12-9-08 thru 6-6-09

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Department of Human Services, Administrative Services Division and Director's Office
Chapter 407

Rule Caption: Procedural Rules Update to Adopt the January 1, 2008 Attorney General Model Rules.
Adm. Order No.: DHSD 9-2008
Filed with Sec. of State: 12-5-2008
Certified to be Effective: 12-5-08
Notice Publication Date: 11-1-2008
Rules Amended: 407-001-0000, 407-001-0005, 407-001-0010
Subject: The Department of Human Services' procedural rules are being amended to adopt the January 1, 2008 Attorney General's Model Rules of Procedure and to make other minor typographical adjustments.
Rules Coordinator: Jennifer Bittel—(503) 947-5250

407-001-0000
Model Rules of Procedure

The Department of Human Services (Department) adopts the Attorney General Model Rules applicable to rulemaking, effective on January 1, 2008, with the exception of 137-001-0080.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the office of the Attorney General or the Department of Human Services.]

Stat. Auth.: ORS 183.341 & 409.050
Stat. Implemented: ORS 183.341 & 409.050
Hist.: DHSD 3-2006, f. 5-11-06, cert. ef. 6-1-06; DHSD 9-2008, f. & cert. ef. 12-5-08

407-001-0005
Notice of Proposed Rulemaking and Adoption of Temporary Rules

(1) Except as provided in ORS 183.335(7) or (12) or 183.341, before permanently adopting, amending, or repealing an administrative rule, the Department shall give notice of the intended action:

(a) To legislators specified in ORS 183.335(15) at least 49 days before the effective date of the rule;

(b) To persons on the interested parties lists described in section (2) of this rule for the pertinent OAR chapter or pertinent subtopics or programs within an OAR chapter at least 28 days before the effective date of the rule;

(c) In the Secretary of State's Bulletin referred to in ORS 183.360 at least 21 days before the effective date of the rule;

(d) To other persons, agencies, or organizations that the Department is required to provide an opportunity to comment pursuant to state statute or federal law or as a requirement of receiving federal funding, at least 28 days before the effective date of the rule;

(e) To the Associated Press and the Capitol Press Room at least 28 days before the effective date of the rule; and

(f) In addition to the above, the Department may send notice of intended action to other persons, agencies, or organizations that the Department, in its discretion, believes to have an interest in the subject matter of the proposed rule at least 28 days before the effective date of the rule.

(2) Pursuant to ORS 183.335(8), the Department shall maintain an interested parties list for each OAR chapter of rules for which the Department has administrative responsibility, and an interested parties list for subtopics or programs within those chapters. A person, group, or entity that desires to be placed on such a list to receive notices regarding proposed permanent adoption, amendment, or repeal of a rule must make such a request in writing or by electronic mail to the rules coordinator for the chapter. The request must include either a mailing address or an electronic mail address to which notices may be sent.

(3) Notices under this rule may be sent by use of hand delivery, state shuttle, postal mail, electronic mail, or facsimile. The Department recognizes state shuttle as "mail" and may use this means to notify other state agencies.

(a) An email notification under section (1) of this rule may consist of any of the following:

(A) An email that attaches the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact.

(B) An email that includes a link within the body of the email, allowing direct access online to the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact.

(C) An email with specific instructions within the body of the email, usually including an electronic Universal Resource Locator (URL) address, to find the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact.

(b) The Department may use facsimile as an added means of notification, if necessary. Notification by facsimile under section (1) of this rule shall include the Notice of Proposed Rulemaking or Notice of Proposed Rulemaking Hearing and Statement of Need and Fiscal Impact, or specific instructions to locate these documents online.

(c) The Department shall honor all written requests that notification be sent by postal mail instead of electronically if a mailing address is provided.

(4) If the Department adopts or suspends a temporary rule, the Department shall notify:

(a) Legislators specified in ORS 183.335(15);

(b) Persons on the interested parties list described in section (2) of this rule for the pertinent OAR chapter or pertinent subtopics or programs within an OAR chapter;

(c) Other persons, agencies, or organizations that the Department is required to notify pursuant to state statute or federal law or as a requirement of receiving federal funding; and

(d) The Associated Press and the Capitol Press Room; and

(e) In addition to the above, the Department may send notice to other persons, agencies, or organizations that the Department, in its discretion, believes to have an interest in the subject matter of the temporary rulemaking.

(5) In lieu of providing a copy of the rule or rules as proposed with the notice of intended action or notice concerning the adoption of a temporary rule, the Department may state how and where a copy may be obtained on paper, by electronic mail, or from a specified web site.

Stat. Auth: ORS 183.341 & 409.050
Stats. Implemented: ORS 183.330, 183.335, 183.341 & 409.050
Hist.: DHSD 3-2006, f. 5-11-06, cert. ef. 6-1-06; DHSD 9-2008, f. & cert. ef. 12-5-08

407-001-0010
Delegation of Rulemaking Authority

Any officer or employee of the Department of Human Services who is identified on a completed Delegation of Authority form signed by the Director or Deputy Director of the Department and filed with the Secretary of State, Administrative Rules Unit, is vested with the authority to adopt, amend, repeal, or suspend administrative rules as provided on that form until such delegation is revoked by the Director or Deputy Director of the Department, or the person leaves employment with the Department.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 183.325, 409.050, 409.120 & 409.130
Hist.: DHSD 3-2006, f. 5-11-06, cert. ef. 6-1-06; DHSD 9-2008, f. & cert. ef. 12-5-08

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Department of Human Services, Division of Medical Assistance Programs
Chapter 410

Rule Caption: Terminology and process changes transitioning to new Medicaid Management Information System (MMIS).
Adm. Order No.: DMAP 34-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 7-1-2008
Rules Amended: 410-120-0000, 410-120-1140, 410-120-1180, 410-120-1195, 410-120-1260, 410-120-1280, 410-120-1340, 410-121-0040, 410-121-0060, 410-121-0140, 410-121-0150, 410-121-0157, 410-121-0200, 410-121-0320, 410-122-0040, 410-125-0125, 410-125-0210, 410-125-0220, 410-125-0360, 410-125-0400, 410-125-0600, 410-125-0640, 410-125-0720, 410-125-1070, 410-127-0080, 410-129-0080, 410-130-0180, 410-132-0100, 410-136-0240, 410-136-0260, 410-136-0300, 410-141-0000, 410-141-0020, 410-141-0220, 410-146-0021, 410-146-0060, 410-146-0080, 410-146-0085, 410-146-0086, 410-146-0100, 410-146-0120, 410-146-0130, 410-146-0140, 410-146-0340, 410-146-0380, 410-146-0440, 410-147-0020, 410-147-0060, 410-147-0120, 410-147-0125, 410-147-0140, 410-147-0160, 410-147-0180, 410-147-0200, 410-147-0220, 410-147-0320, 410-147-0340, 410-147-0360, 410-147-0460, 410-147-0480, 410-147-0540, 410-147-0560, 410-147-0610, 410-147-0620
Subject: The Department is converting to a new computer system called Medicaid Management Information System (MMIS). DMAP amended administrative rules to change terminology and other process aspects related to MMIS for the following service programs: General Rules, Pharmaceutical Services, Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Hospital Services, Home Health Services, Speech-Language Pathology, Audiology and Hearing Aid, Medical Surgical Services, Medical transportation services, Private Duty Nursing, Oregon Health Plan (Managed Care) Services, American Indian/Alaska Native Services, and Federally Qualified Health Centers/Rural Health Clinics.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-120-0000
Acronyms and Definitions

(1) AAA — Area Agency on Aging.

(2) Abuse — Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Division of Medical Assistance Programs (DMAP), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Recipient practices that result in unnecessary cost to DMAP.

(3) Acupuncturist — A person licensed to practice acupuncture by the relevant State Licensing Board.

(4) Acupuncture Services — Services provided by a licensed Acupuncturist within the scope of practice as defined under state law.

(5) Acute — A condition, diagnosis or illness with a sudden onset and which is of short duration.

(6) Acquisition Cost — Unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.

(7) Addiction and Mental Health Division (AMH) —An Office within DHS administering mental health and addiction programs and services.

(8) Adequate Record Keeping — Documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual Provider rules.

(9) Administrative Medical Examinations and Reports — Examinations, evaluations, and reports, including copies of medical records, requested on the DMAP 729 form through the local Department of Human Services (DHS) branch office or requested or approved by DMAP to establish Client eligibility for a medical assistance program or for casework planning.

(10) Adverse Event – An undesirable and unintentional, though not unnecessarily unexpected, result of medical treatment.

(11) All Inclusive Rate — The Nursing Facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Pharmaceutical Services and the Home Enteral/Parenteral Nutrition and IV Services Provider rules, except as specified in OAR 410-120-1340, Payment.

(12) Allied Agency — Local and regional governmental agencies and regional authorities that contract with DHS to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging (AAAs), federally recognized American Indian tribes).

(13) Ambulance — A specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of DHS or the licensing standards of the state in which the Provider is located.

(14) Ambulatory Surgical Center (ASC) — A facility licensed as an ASC by DHS.

(15) American Indian/Alaska Native (AI/AN) —A member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(16) American Indian/Alaska Native (AI/AN) clinic — Clinics recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid Services (CMS).

(17) Ancillary Services — Services supportive of or necessary to the provision of a primary service (e.g., anesthesiology is an ancillary service necessary for a surgical procedure); Typically, such medical services are not identified in the definition of a Condition/Treatment Pair, but are Medically Appropriate to support a service covered under the OHP Benefit Package; Ancillary Services and limitations are specified in the OHP Managed Care Rules related to the Prioritized List of Health Services (410-141-0480 through 410-141-0520), the General Rules Benefit Packages (410-120-1210), Exclusions (410-120-1200) and applicable individual program rules.

(18) Anesthesia Services — Administration of anesthetic agents to cause loss of sensation to the body or body part.

(19) Atypical Provider — Entity able to enroll as a Billing Provider (BP) or performing Provider for medical assistance programs related non-health care services but which does not meet the definition of health care Provider for National Provider Identification (NPI) purposes.

(20) Audiologist — A person licensed to practice Audiology by the State Board of Examiners for Speech Pathology and Audiology.

(21) Audiology —The application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(22) Automated Voice Response (AVR) — A computer system that provides information on Clients' current eligibility status from DMAP by computerized phone or Web-based response.

(23) Benefit Package — The package of covered health care services for which the Client is eligible.

(24) Billing Agent or Billing Service — Third party or organization that contracts with a Provider to perform designated services in order to facilitate an Electronic Data Interchange (EDI) transaction on behalf of the Provider.

(25) Billing Provider (BP) — A person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from DMAP on behalf of a performing Provider and has been delegated the authority to obligate or act on behalf of the performing Provider.

(26) Buying Up —The practice of obtaining Client payment in addition to the DMAP or managed care plan payment to obtain a Non-Covered Service or item. (See 410-120-1350 Buying Up)

(27) By Report (BR) — Services designated, as BR require operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature, and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(28) Children, Adults and Families Division (CAF) — An office within DHS, responsible for administering self-sufficiency and child-protective programs.

(29) Children's Health Insurance Program (CHIP) — A federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by DMAP.

(30) Chiropractor — A person licensed to practice chiropractic by the relevant State Licensing Board.

(31) Chiropractic Services — Services provided by a licensed Chiropractor within the scope of practice, as defined under State law and Federal regulation.

(32) Citizen/Alien-Waived Emergency Medical (CAWEM) — Aliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency Services for CAWEM are defined in OAR 410-120-1210 (3)(f).

(33) Claimant — a person who has requested a hearing.

(34) Client — A person who is currently receiving medical assistance (also known as a Recipient).

(35) Clinical Social Worker — A person licensed to practice clinical social work pursuant to State law.

(36) Contiguous Area — The area up to 75 miles outside the border of the State of Oregon.

(37) Contiguous Area Provider — A Provider practicing in a Contiguous Area.

(38) Copayments —The portion of a claim or medical, dental or pharmaceutical expense that a Client must pay out of their own pocket to a Provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment)

(39) Cost Effective — The lowest cost health care service or item that, in the judgment of DMAP staff or its contracted agencies, meets the medical needs of the Client.

(40) Current Dental Terminology (CDT) — A listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(41) Current Procedural Terminology (CPT) — The Physicians' CPT is a listing of descriptive terms and identifying codes for reporting Medical Services and procedures performed by Physicians and other health care Providers.

(42) Date of Receipt of a Claim — The date on which DMAP receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of Receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(43) Date of Service — The date on which the Client receives Medical Services or items, unless otherwise specified in the appropriate Provider rules. For items that are mailed or shipped by the Provider, the Date of Service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(44) Dental Emergency Services — Dental Services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(45) Dental Services — Services provided within the scope of practice as defined under State law by or under the supervision of a Dentist.

(46) Dentist — A person licensed to practice dentistry pursuant to State law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

(47) Denturist — A person licensed to practice denture technology pursuant to State law.

(48) Denturist Services — Services provided, within the scope of practice as defined under State law, by or under the personal supervision of a Denturist.

(49) Dental Hygienist — A person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(50) Dental Hygienist with Limited Access Certification (LAC) — A person licensed to practice dental hygiene with LAC pursuant to State law.

(51) Department — DHS or its Division of Medical Assistance Programs (DMAP).

(52) Department of Human Services (DHS) – The Department or DHS or any of its programs or offices means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (DMAP). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMHD). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and Families or CAF is used in contract or rule, it shall mean the Children, Adults and Families Division (CAF). Wherever the former Health Division is used in Contract or in rule, it shall mean the Public Health Division (PHD).

(53) Department Representative — A person who represents the Department in a hearing and presents the Department's position.

(54) Diagnosis Code — As identified in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), the primary Diagnosis Code is shown in all billing claims, unless specifically excluded in individual Provider rule(s). Where they exist, Diagnosis Codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(55) Diagnosis Related Group (DRG) — A system of classification of diagnoses and procedures based on the ICD-9-CM.

(56) Division of Medical Assistance Programs (DMAP) — An Office within DHS; DMAP is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs.

(57) Durable Medical Equipment (DME) and Medical Supplies — Equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

(58) Electronic Data Interchange (EDI) — The exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, using bulk transmission processes and other formats as the Department designates for EDI transactions. For purposes of these rules (OAR 407-120-0100 through 407-120-0200), EDI does not include electronic transmission by web portal.

(59) EDI Submitter —An Individual or an entity authorized to establishe an electronic media connection with DHS to conduct and EDI transaction. An EDI submitter may be a trading partner or an agent of a trading partner.

(60) Electronic Verification System (EVS) eligibility information that have met the legal and technical specifications of DMAP in order to offer eligibility information to enrolled Providers of DMAP.

(61) Emergency Department —The part of a licensed Hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(62) Emergency Medical Services — (This definition does not apply to Clients with CAWEM Benefit Package. CAWEM emergency services are governed by OAR 410-120-1210 (3)(f)(B)). If an emergency medical condition is found to exist based on a medical triage screening examination, Emergency Medical Services necessary to stabilize the condition must be provided. This includes all treatment that may be necessary to assure, within reasonable medical probability that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the Client or transfer of the Client to another facility.

(63) Emergency Transportation — Transportation necessary when a sudden, unexpected Emergency Medical Service creates a medical crisis requiring a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a Hospital, where appropriate emergency medical service is available.

(64) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (also Medicheck) — The Title XIX program of EPSDT Services for eligible Clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required

Medically Appropriate health care services and to help DMAP Clients and their parents or guardians effectively use them.

(65) Evidence Based Medicine — is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996;312:71-72 (13 January))

(66) False Claim — A claim that a Provider knowingly submits or causes to be submitted that contains inaccurate, misleading or omitted information and such inaccurate, misleading or omitted information would result, or has resulted, in an Overpayment.

(67) Family Planning — Services for Clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(68) Federally Qualified Health Center (FQHC) — A federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the Public Health Service Act; or a facility designated as a FQHC by CMS upon recommendation of the U.S. Public Health Service.

(69) Fee-for-Service Provider —A medical Provider who is not reimbursed under the terms of a DMAP contract with a Prepaid Health Plan (PHP), also referred to as a Managed Care Organization (MCO). A medical Provider participating in a PHP may be considered a Fee-for-Service Provider when treating Clients who are not enrolled in a PHP.

(70) Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable federal or state law.

(71) Fully Dual Eligible — For the purposes of Medicare Part D coverage (42 CFR 423.772), Medicare Clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by DHS for full medical assistance coverage.

(72) General Assistance (GA) — Medical Assistance administered and funded 100% with State of Oregon funds through OHP.

(73) Healthcare Common Procedure Coding System (HCPCS) — A method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. DMAP uses HCPCS codes; however, DMAP uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(74) Health Maintenance Organization (HMO) — A public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(75) Hearing Aid Dealer — A person licensed by the Board of Hearing Aid Dealers to sell, lease or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(76) Home Enteral Nutrition — Services provided in the Client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract, as described in the Home Enteral/Parenteral Nutrition and IV Services Provider rules.

(77) Home Health Agency —A public or private agency or organization which has been certified by Medicare as a Medicare Home Health Agency and which is licensed by DHS as a Home Health Agency in Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(78) Home Health Services — Part-time or intermittent skilled Nursing Services, other therapeutic services (Physical Therapy, Occupational Therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the Client's home.

(79) Home Intravenous (IV) Services — Services provided in the Client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services rules.

(80) Home Parenteral Nutrition — Services provided in the Client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services rules.

(81) Hospice — a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare, accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry.

(82) Hospital — A facility licensed by the Office of Public Health Systems as a general Hospital which meets requirements for participation in the OHP under Title XVIII of the Social Security Act. DMAP does not consider facilities certified by the Centers for Medicare and Medicaid (CMS) as Long Term Care Hospitals, Long Term Acute Care Hospitals or Religious non medical facilities as Hospitals for reimbursement purposes. Out-of-state Hospitals will be considered Hospitals for reimbursement purposes if they are licensed as a short term acute care or general Hospital by the appropriate licensing authority within that state, and if they are enrolled as a Provider of Hospital services with the Medicaid agency within that state.

(83) Hospital-Based Professional Services — Professional services provided by licensed Practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (DMAP 42) report for DMAP.

(84) Hospital Laboratory — A Laboratory providing professional technical Laboratory Services as outlined under Laboratory Services, in a Hospital setting, as either an Inpatient or Outpatient Hospital service whose costs are reported on the Hospital's cost report to Medicare and to DMAP.

(85) Indian Health Program — Any Indian Health Service facility, any Federally recognized Tribe or Tribal organization, or any FQHC with a 638 designation.

(86) Individual Adjustment Request (DMAP 1036) Form used to resolve an incorrect payment on a previously paid claim, including underpayments or Overpayments.

(87) Inpatient — a Hospital patient who is not an Outpatient.

(88) Inpatient Hospital Services — Services that are furnished in a Hospital for the care and treatment of an Inpatient. (See Hospital Services rules for Inpatient covered services.)

(89) Institutional Level of Income Standards (ILIS) — Three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a Nursing Facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' (SPD) Home and Community Based Waiver.

(90) Institutionalized — A patient admitted to a Nursing Facility or Hospital for the purpose of receiving nursing and/or Hospital care for a period of 30 days or more.

(91) International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) — Diagnosis Codes including volumes 1, 2, and 3, as revised annually.

(92) Laboratory — A facility licensed under ORS 438 and certified by CMS, Department of Health and Human Services (DHHS), as qualified to participate under Medicare, to provide Laboratory Services within or a part from a Hospital. An entity is considered a Laboratory if materials are derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one Laboratory test, including waived tests for these purposes, it is considered under the Clinical Laboratory Improvement Act (CLIA), to be a Laboratory.

(93) Laboratory Services —Those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a Physician or other licensed Practitioner of the healing arts within his/her scope of practice as defined under State law and provided to a patient by or under the direction

of a Physician or appropriate licensed Practitioner in an office or similar facility, Hospital, or independent Laboratory.

(94) Licensed Direct Entry Midwife — A practitioner licensed by DHS' Public Health Division as a Licensed Direct Entry Midwife.

(95) Liability Insurance — Insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile Liability Insurance, uninsured and underinsured motorist insurance, homeowner's Liability Insurance, malpractice insurance, product Liability Insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(96) Managed Care Organization (MCO) — Contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(97) Maternity Case Management — A program available to pregnant Clients. The purpose of Maternity Case Management is to extend prenatal services to include non-Medical Services, which address social, economic and nutritional factors. For more information refer to the Medical-Surgical Services rules.

(98) Medicaid — A federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by DHS.

(99) Medical Assistance Eligibility Confirmation — Verification through the Electronic Verification System (EVS), AVR, Secure Web site or Electronic Data interchange, or an authorized DHS representative.

(100) Medical Services — Care and treatment provided by a licensed medical Provider directed at preventing, diagnosing, treating or correcting a medical problem.

(101) Medical Transportation — Transportation to or from covered Medical Services.

(102) Medically Appropriate — Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community, Evidence Based Medicine and professional standards of care as effective;

(c) Not solely for the convenience of an OHP Client or a Provider of the service or medical supplies; and

(d) The most Cost Effective of the alternative levels of Medical Services or medical supplies which can be safely provided to an DMAP Client or Primary Care Manager (PCM) Member in the PHP's or PCM's judgment.

(103) Medicare — A federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for Inpatient services in a Hospital or skilled Nursing Facility, home health care, and Hospice care; and

(b) Medical Insurance (Part B) for Physicians' services, Outpatient Hospital services, home health care, end-stage renal dialysis, and other Medical Services and supplies;

(c) Prescription drug coverage (Part D) — Covered Part D drugs include prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Social Security Act, and vaccines licensed under section 351 of the Public Health Service Act; also includes medical supplies associated with the injection of insulin; Part D covered drugs prohibit Medicaid Title XIX Federal Financial Participation (FFP). (See OAR 410, Division 121 for limitations).

(104) Medicheck for Children and Teens — See EPSDT.

(105) National Provider Identification (NPI) — Federally directed Provider number mandated for use on HIPAA covered transactions; individuals, Provider Organizations and Subparts of Provider Organizations that meet the definition of health care Provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(106) Naturopath —A person licensed to practice naturopathy pursuant to State law.

(107) Naturopathic Services — Services provided within the scope of practice as defined under State law.

(108) Non Covered Services — Services or items for which DMAP is not responsible for payment. Non-Covered Services are identified in:

(a) OAR 410-120-1200, Excluded Services and Limitations; and,

(b) 410-120-1210, Medical Assistance Benefit Packages and Delivery System;

(c) 410-141-0480, OHP Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) The individual DMAP Provider rules.

(109) Nurse Anesthetist, C.R.N.A. — A registered nurse licensed in the State of Oregon who is currently certified by the American Association of Nurse Anesthetists Council on Certification.

(110) Nurse Practitioner — A person licensed as a registered nurse and certified by the Board of Nursing to practice as a Nurse Practitioner pursuant to State law.

(111) Nurse Practitioner Services — Services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

(112) Nursing Facility — A facility licensed and certified by the DHS' SPD defined in 411-070-0005.

(113) Nursing Services — Health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by State law.

(114) Nutritional Counseling — Counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(115) Occupational Therapist — A person licensed by the State Board of Examiners for Occupational Therapy.

(116) Occupational Therapy —The functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, aging process, or psychological disability; the treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(117) Optometric Services — Services provided, within the scope of practice of optometrists as defined under State law.

(118) Optometrist —A person licensed to practice optometry pursuant to State law.

(119) Oregon Youth Authority (OYA) — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(120) Out-of-State Providers —Any Provider located outside the borders of Oregon:

(a) Contiguous area Providers are those located no more than 75 miles from the border of Oregon;

(b) Non-Contiguous Area Providers are those located more than 75 miles from the borders of Oregon.

(121) Outpatient — a Hospital patient who:

(a) Is treated and released the same day or is admitted to the Hospital and discharged before midnight and is not listed on the following day's census, excluding a patient who:

(A) Is admitted and transferred to another Acute care Hospital on the same day;

(B) Expires on the day of admission; or

(C) Is born in the Hospital.

(b) Is admitted for ambulatory surgery, to a birthing center, a treatment or observation room, or a short-term stay bed;

(c) Receives observation services provided by a Hospital, including the use of a bed and periodic monitoring by Hospital nursing or other staff for the purpose of evaluation of a patient's medical condition for a maximum of 48 hours; or

(d) Receives routine preparation services and recovery for diagnostic services provided in a Hospital Outpatient department.

(122) Outpatient Hospital Services — Services that are furnished in a Hospital for the care and treatment of an Outpatient. (See Hospital rules for Outpatient covered services).

(123) Overdue Claim — A Valid Claim that is not paid within 45 days of the date it was received.

(124) Overpayment — Payment(s) made by DMAP to a Provider in excess of the correct DMAP payment amount for a service. Overpayments are subject to repayment to DMAP.

(125) Overuse — Use of medical goods or services at levels determined by DMAP medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(126) Panel — The Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(127) Payment Authorization —Authorization granted by the responsible DHS agency, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(128) Peer Review Organization (PRO) — An entity of health care practitioners of services contracted by the State to review services ordered or furnished by other practitioners in the same professional field.

(129) Pharmaceutical Services — Services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

(130) Pharmacist — A person licensed to practice pharmacy pursuant to state law.

(131) Physical Capacity Evaluation — An objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(132) Physical Therapist — A person licensed by the relevant State licensing authority to practice Physical Therapy.

(133) Physical Therapy — Treatment comprising exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis or treatment of a human being. Physical Therapy shall not include radiology or electrosurgery.

(134) Physician — A person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government.

(135) Physician Assistant — A person licensed as a Physician Assistant in accordance with ORS 677. Physician Assistants provide Medical Services under the direction and supervision of an Oregon licensed Physician according to a practice description approved by the Board of Medical Examiners.

(136) Physician Services — Services provided, within the scope of practice as defined under state law, by or under the personal supervision of a Physician.

(137) Podiatric Services — Services provided within the scope of practice of Podiatrists as defined under state law.

(138) Podiatrist — A person licensed to practice podiatric medicine pursuant to state law.

(139) Post-Payment Review — Review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(140) Practitioner — A person licensed pursuant to state law to engage in the provision of health care services within the scope of the Practitioner's license and/or certification.

(141) Premium Sponsorship — Premium donations made for the benefit of one or more specified DMAP Clients (See 410-120-1390).

(142) Prepaid Health Plan (PHP) —A managed health, dental, chemical dependency, or mental health organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under OHP. PHP's may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(143) Primary Care Physician — A Physician who has responsibility for supervising, coordinating and providing initial and primary care to patients, initiating Referrals for consultations and specialist care, and maintaining the continuity of patient care.

(144) Primary Care Provider (PCP) —Any enrolled medical assistance Provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified Clients. PCPs initiate Referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of Medically Appropriate Client care.

(145) Prior Authorization (PA) — Payment Authorization for specified Medical Services or items given by DMAP staff, or its contracted agencies prior to provision of the service. A Physician Referral is not a PA.

(146) Prioritized List of Health Services — Also referred to as the Prioritized List, the Oregon Health Services Commission's (HSC) listing of health services with "expanded definitions" of Ancillary Services and Preventive Services and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The Prioritized List governs medical assistance programs' health services and Benefit Packages pursuant to these General Rules (OAR 410-120-0000 et seq.) and OAR 410-141-0480 through 410-141-0520.

(147) Private Duty Nursing Services — Nursing Services provided within the scope of license by a registered nurse or a licensed practical nurse, under the general direction of the patient's Physician to an individual who is not in a health care facility.

(148) Provider — An individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing Provider, or bills, obligates and receives reimbursement on behalf of a performing Provider of services, also termed a Billing Provider (BP). The term Provider refers to both Performing Providers and BPs unless otherwise specified.

(149) Provider Organization — a group practice, facility, or organization that is:

(a) An employer of a Provider, if the Provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the Provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the Provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with DHS, and payments are made to the group practice, facility or organization.

(e) If such entity solely submits billings on behalf of Providers and payments are made to each Provider, then the entity is an agent.

(See Subparts of Provider Organization)

(150) Public Health Clinic —A clinic operated by county government.

(151) Public Rates — The charge for services and items that Providers, including Hospitals and Nursing Facilities, made to the general public for the same service on the same date as that provided to DMAP Clients.

(152) Qualified Medicare Beneficiary (QMB) —A Medicare beneficiary, as defined by the Social Security Act and its amendments.

(153) Qualified Medicare and Medicaid Beneficiary (QMM) — A Medicare Beneficiary who is also eligible for DMAP coverage.

(154) Quality Improvement Organization (QIO) — An entity that has a contract with CMS under Part B of Title XI to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare and Medicaid Clients; formerly known as a Peer Review Organization.

(155) Radiological Services —Those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a Physician or other licensed Practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a Physician or appropriate licensed Practitioner in an office or similar facility, Hospital, or independent radiological facility.

(156) Recipient — A person who is currently eligible for medical assistance (also known as a Client).

(157) Recreational therapy — recreational or other activities that are diversional in nature (includes, but is not limited to, social or recreational activities or outlets).

(158) Recoupment — An accounts receivable system that collects money owed by the Provider to DMAP by withholding all or a portion of a Provider's future payments.

(159) Referral — The transfer of total or specified care of a Client from one Provider to another. As used by DMAP, the term Referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of Clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a Referral is required before non-emergency care is covered by the PHP or DMAP.

(160) Remittance Advice (RA) — The automated notice a Provider receives explaining payments or other claim actions. It is the only notice sent to Providers regarding claim actions.

(161) Request for Hearing — A clear expression, in writing, by an individual or representative that the person wishes to appeal a Department decision or action and wishes to have the decision considered by a higher authority.

(162) Retroactive Medical Eligibility — Eligibility for medical assistance granted to a Client retroactive to a date prior to the Client's application for medical assistance.

(163) Sanction — An action against Providers taken by DMAP in cases of Fraud, misuse or Abuse of DMAP requirements.

(164) School Based Health Service — A health service required by an Individualized Education Plan (IEP) during a child's education program which addresses physical or mental disabilities as recommended by a Physician or other licensed Practitioner.

(165) Seniors and People with Disabilities Division (SPD) — An Office of DHS responsible for the administration of programs for seniors and people with disabilities.

(166) Service Agreement — An agreement between DMAP and a specified Provider to provide identified services for a specified rate. Service Agreements may be limited to services required for the special needs of an identified Client. Service Agreements do not preclude the requirement for a Provider to enroll as a Provider.

(167) Sliding Fee Schedule — A fee schedule with varying rates established by a Provider of health care to make services available to indigent and low-income individuals. The Sliding Fee Schedule is based on ability to pay.

(168) Social Worker — A person licensed by the Board of Clinical Social Workers to practice clinical social work.

(169) Speech-Language Pathologist — A person licensed by the Oregon Board of Examiners for Speech Pathology.

(170) Speech-Language Pathology Services — The application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(171) Spend-Down — The amount the Client must pay for medical expenses each month before becoming eligible for medical assistance under the Medically Needy Program. The spend-down is equal to the difference between the Client's total countable income and Medically Needy program income limits.

(172) State Facility — A Hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(173) Subparts (of a Provider Organization) — For NPI application, Subparts of a health care Provider Organization would meet the definition of health care Provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically, or has an entity do so on its behalf, could be components of an organization or separate physical locations of an organization.

(174) Subrogation — Right of the State to stand in place of the Client in the collection of Third Party Resources (TPR).

(175) Supplemental Security Income (SSI) — A program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(176) Surgical Assistant — A person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(177) Suspension — A Sanction prohibiting a Provider's participation in DHS medical assistance programs by deactivation of the Provider's DMAP assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the Suspension. The number will be reactivated automatically after the Suspension period has elapsed.

(178) Targeted Case Management (TCM) — Activities that will assist the Client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services often provided by Allied Agency Providers.

(179) Termination —A Sanction prohibiting a Provider's participation in DMAP's programs by canceling the Provider's DMAP assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of Termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by DMAP at the time of Termination.

(180) Third Party Resource (TPR) — A medical or financial resource which, under law, is available and applicable to pay for Medical Services and items for an DMAP Client.

(181) Transportation — See Medical Transportation.

(182) Type A Hospital — A Hospital identified by the Office of Rural Health as a Type A Hospital.

(183) Type B AAA Unit — A Type B Area Agency on Aging (AAA) funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(184) Type B Hospital — A Hospital identified by the Office of Rural Health as a Type B Hospital.

(185) Usual Charge (UC) —The lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The Provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The Provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the Provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources (TPR) are to be considered.

(186) Utilization Review (UR) —The process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(187) Valid Claim —An invoice received by DMAP or the appropriate Department office for payment of covered health care services rendered to an eligible Client which:

(a) Can be processed without obtaining additional information from the Provider of the goods or services or from a TPR; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 Division 120).

(188) Vision Services — Provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

Stat. Auth.: ORS 409.050, 409.010, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82, for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 81-1982, f. 8-30-82, ef. 9-1-82; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 13-1987, f. 3-31-87, ef. 4-1-87; AFS 7-1988, f. & cert. ef. 2-1-88; AFS 69-1988, f. & cert. ef. 12-5-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0005; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2000, f. & cert. ef. 6-23-00; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007 f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-120-1140

Verification of Eligibility and Coverage

(1) Providers are responsible to verify a person is an Oregon Health Plan (OHP) client with appropriate benefits prior to providing services in order to ensure reimbursement of services rendered. Providers assume full financial responsibility in serving a person who the provider did not confirm with the Division of Medical Assistance Programs (DMAP), is an OHP client who, on the date(s) of service, is enrolled in a benefit package that covers the services rendered.

(2) The standard DHS Medical Care Identification (ID) is printed on heavy paper the size of a business card listing the client's name, prime number and the date the ID was issued. When a person presents with this ID it does not guarantee that the person is an OHP client on that date of service.

(3) Providers must verify eligibility for reimbursement by verifying that the person is an OHP client and that the OHP client is in the appropriate benefit package to cover the services rendered. The ID does not guarantee that all services are covered services and will be reimbursed for this particular client. Providers must verify the client is eligible for OHP and has a benefit package that covers the service through one of the following (see the DMAP General Rules Supplemental Information guide for instructions):

(a) The DMAP MMIS Provider Web portal;

(b) The Automated Voice Response (AVR);

(c) Batch (270) or real-time (271) electronic data interchange (EDI) transactions;

(4) The client may present with a business card size ID printed on lighter paper in case of misplaced originals. This "temporary" ID must be treated the same as the standard ID. Providers must verify eligibility.

(5) The client may also present with a temporary or emergency ID. For purposes of this rule, a temporary medical care identification is the DMAP FORM 1086. This temporary ID is a full page paper form showing beginning and ending dates of coverage. This temporary ID is issued if the client needs immediate care but their information is not yet entered into the automated system for provider's use. This temporary ID does guarantee eligibility for the dates and benefit package indicated on the ID. Providers must honor the temporary ID until the information is available in the automated system.

Stat. Auth.: ORS 409.010, 409.110, 409.050
Stats. Implemented: ORS 414.065, 414.025 & 414.047
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 14-1979, f. 6-29-79, ef. 7-1-79; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82, for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 43-1986(Temp), f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 53-1987, f. 10-29-87, ef. 11-1-87; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0040; Renumbered from 461-013-0103 & 461-013-0109; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93; OMAP 10-1999, f. & cert. ef. 4-1-99, Renumbered from 410-120-0080; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-120-1180
Medical Assistance Benefits: Out-of-State Services

(1) Out-of-State Providers must enroll with the Department of Human Services as described in Oregon Administrative Rules (OAR) 407-120-0320 and 410-120-1260, Provider Enrollment. Out-of-State Providers must provide services and bill in compliance with all of these Rules and the OARs for the appropriate type of service(s) provided.

(2) DMAP reimburses enrolled Out-of-State Providers in the same manner and at the same rates as in-state Providers unless otherwise specified in the individual Provider rules or by contract or Service Agreement with the individual Provider.

(3) For enrolled non-contiguous, Out-of-State Providers, DMAP reimburses for covered services under any of the following conditions:

(a) The service was emergent; or

(b) A delay in the provision of services until the Client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;

(c) DMAP authorized payment for the service in advance of the provision of services or was otherwise authorized in accordance with Payment Authorization requirements in the individual Provider rules or in the General Rules;

(d) The service was authorized by a Prepaid Health Plan (PHP) including a Fully Capitated Health Plan (FCHP), a Physician Care Organization (PCO) or a Dental Care Organization (DCO) and payment to the Out-of-State Provider is the responsibility of the PHP;

(e) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage.

(4) DMAP may give Prior Authorization (PA) for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:

(a) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage, or

(b) DMAP covers the service or item under the specific Client's benefit package; and

(c) The service or item is not available in the State of Oregon or provision of the service or item by an Out-of-State Provider is Cost Effective, as determined by DMAP (or, for those Clients covered by a managed care plan, the plan will make that determination); and

(d) The service or item is deemed Medically Appropriate and is recommended by a referring Oregon Physician;

(e) If a Client has coverage through a managed care plan, a PHP, the request for non-emergency services must be referred to the PHP. Payment for these services is the responsibility of the PHP.

(5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered service and does not require PA. The Laboratory must meet the same certification requirements as Oregon Laboratories and must bill in accordance with DMAP rules.

(6) DMAP makes no reimbursement for services provided to a Client outside the territorial limits of the United States, unless the country operates a Title XIX medical assistance program.

(7) DMAP will reimburse, within limits described in these General Rules and in individual Provider rules, all services provided by enrolled Providers to children:

(a) Who the Department of Human Services (DHS) has placed in foster care;

(b) Who DHS has placed in a subsidized adoption outside the State of Oregon; or

(c) Who are in the custody of DHS and traveling with the consent of DHS.

(8) DMAP does not require authorization of non-emergency services for the children covered by (7), except as specified in the individual Provider rules.

(9) Payment rates for Out-of-State Providers are established in the individual Provider rules, through contracts or Service Agreements and in accordance with OAR 407-120-0350 and 410-120-1340, Payment.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110
Stats. Implemented: ORS 414.065, 414.019 & 414.025
Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 27-1978(Temp), f. 6-30-78, ef. 7-1-78; AFS 39-1978, f. 10-10-78, ef. 11-1-78; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0130, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 21-1985, f. 4-2-85, ef. 5-1-85; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0045 & 461-013-0046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0120, 410-120-0140 & 410-120-0160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-120-1195
SB 5548 Population

Effective for services rendered on or after January 1, 2004.

(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by the Department of Human Services (DHS) with specific health-related conditions as outlined in the Joint Ways and Means budget note accompanying Senate Bill 5548 (2003) shall be referred to as SB 5548 Clients.

(2) SB 5548 Clients are eligible for a State-funded, limited, prescription drug benefit for covered drugs described in subsection (3) of this rule.

(3) Eligibility for, and access to, covered drugs for SB 5548 Clients:

(a) SB 5548 Clients must have been participating in the former OSIP-MN Medically Needy Program as of January 31, 2003, and as of that date had a medical diagnosis of HIV or organ transplant status;

(b) SB 5548 Clients receiving anti-retroviral and other prescriptions necessary for the direct support of HIV symptoms:

(A) Must agree to participate in the DHS CareAssist Program in order to obtain access to this limited prescription drug benefit; and

(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at www.dhs.state.or.us/publichealth/hiv/careassist/frmlry.cfm.

(c) SB 5548 Clients receiving prescriptions necessary for the direct support of organ transplants are limited:

(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infective or other prescriptions necessary for the direct support of organ transplants.

(B) Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.

(4) Reimbursement for covered prescription drugs is limited by the terms and conditions described in this rule. This limited drug benefit provides State-funded reimbursement to pharmacies choosing to participate according to the terms and conditions of this rule:

(a) DHS will send SB 5548 Clients a letter from the Department, instead of a Medical Care Identification, which will document their eligibility for this limited drug benefit;

(b) Retail pharmacies choosing to participate will be reimbursed for covered prescription drugs for the direct support of organ transplants described in subsection (3)(c) of this rule at the lesser of billed, Average Wholesale Price (AWP) minus 15% or Oregon Maximum Allowable Cost (OMAC), plus a dispensing fee of $3.50;

(c) DHS pharmacy benefits manager, will process retail pharmacy drug benefit reimbursement claims for SB 5548 Clients;

(d) Mail order reimbursement will be subject to DHS contract rates;

(e) Prescription drugs through the CareAssist program will be subject to the DHS contract rates;

(f) Reimbursement for this limited drug benefit is not subject to the following rules:

(A) 410-120-1230, Client Copayments;

(B) 410-121-0300, Federal Upper Limit (FUL) for prescription drugs.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110

Stats. Implemented: ORS 414.019, 414.025 & 414.065

Hist.: OMAP 28-2003(Temp), f. & cert. ef. 4-1-03 thru 9-1-03; OMAP 44-2003, f. & cert. ef. 6-30-03; OMAP 45-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 89-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-120-1260

Provider Enrollment

(1) This rule applies only to Providers seeking reimbursement from the Division of Medical Assistance Programs (DMAP), except as otherwise provided in OAR 410-120-1295 or 407.

(2) Signing the Provider Agreement enclosed in the application package constitutes agreement by Performing and Billing Providers to comply with all applicable DMAP Provider rules and federal and state laws and regulations.

(3) The Department of Human Services (DHS) requires compliance with the National Provider Identification (NPI) requirements in 45 CFR Part 142. Providers that obtain an NPI should update their records with DMAP Provider Enrollment. Provider applicants that have been issued an NPI must include that NPI number with the DMAP Provider enrollment application;

(4) A Performing Provider is the Provider of a service or item. A Billing Provider is an individual, agent, business, corporation, clinic, group, institution, or other entity who, in connection with the submission of claims to the Department, receives or directs the payment (either in the name of the Performing Provider or the name of the Billing Provider) from DHS on behalf of a Performing Provider and has been delegated the authority to obligate or act on behalf of the Performing Provider

(a) A Billing Provider is responsible for identifying to DMAP and keeping current the identification of all Performing Providers for whom they bill, or receive or direct payments. This identification must include the Providers' names, DHS Provider numbers, NPIs, and either the Performing Provider's Social Security Number (SSN) or Employer Identification Number (EIN). The SSN or EIN of the Performing Provider cannot be the same as the Tax Identification Number of the Billing Provider. In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements, DHS requires Billing Providers to be enrolled consistent with the Provider enrollment process described in section (7) of this rule. A Performing Provider's use of a Billing Provider that falls within the definition of a Billing Provider but that is not enrolled with DMAP will result in denial of claims or payment;

(b) If the Performing Provider uses electronic media to conduct transactions with the Department, or authorizes a Billing Provider to conduct such electronic transactions, the Performing Provider must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Enrollment as a Performing or Billing Provider is a necessary requirement for submitting electronic claims, but the Provider must also register as a Trading Partner and identify the EDI Submitter.

(5) To be enrolled and able to bill as a Provider, an individual or organization must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations and rules, and must comply with all Oregon statutes and regulations for provision of Medicaid and SCHIP services. In addition, Providers of services within the State of Oregon must have a valid Oregon business license if such a license is a requirement of the state, federal, county or city government to operate a business or to provide services.

(6) An individual or organization that is currently subject to Sanction(s) by DMAP, another state's Medicaid program, or federal government is not eligible for enrollment (see OAR 410-120-1400, 407-120-0360 Provider Sanctions). In addition, individuals or organizations that apply for enrollment are subject to the following disclosure requirements:

(a) Before DMAP issues or renews a Provider number for Provider services, or at any time upon written request by DHS, the Provider must disclose to the Department the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or SCHIP program since the inception of those programs;

(b) A Medicaid Provider that is an entity other than an individual Practitioner or group of Practitioner's, must disclose certain information about ownership and control of the entity:

(A) The name and address of each person with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a direct or indirect ownership interest of 5 percent or more;

(B) Whether any of the persons so named is related to another as spouse, parent, child, sibling or other family members by marriage or otherwise; and

(C) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

(c) All Providers must agree to furnish to the Department or to the U.S. Department of Health and Human Services on request, information related to certain business transactions: A Provider must submit, within 35 days of the date of a request, full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request;

(d) DMAP may refuse to enter into or renew a Provider's enrollment agreement, or contract for Provider services, with a Provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid SCHIP or the Title XX services program;

(e) DMAP may refuse to enter into or may terminate a Provider enrollment agreement, or contract for Provider services, if it determines that the Provider did not fully and accurately make any disclosure required under this section (6) of this rule.

(7) Enrollment of Performing Providers. A DMAP assigned Performing Provider number will be issued to an individual or organization providing covered health care services or items upon:

(a) Completion of the application and submission of the required attachment, disclosure documents, and Provider Agreement.

(b) The signing of the Provider application by the Performing Provider or a person authorized by the Performing Provider to legally bind the organization or individual to compliance with these rules;

(c) Verification of licensing or certification. Loss of the appropriate licensure or certification will result in immediate disenrollment of the Provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Approval of the application package by DMAP or the DHS unit responsible for enrolling the Provider.

(8) Performing Providers may be enrolled retroactive to the date services were provided to a DMAP Client only if:

(a) The Provider was appropriately licensed, certified and otherwise met all DMAP requirements for Providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date the application for Provider status was received by DMAP as evidenced by the first date stamped on the paper claim(s) submitted with the application materials for those services, either manually or electronically;

(c) DMAP reserves the right to retroactively enroll the Provider prior to the 12 month period in (b) based upon extenuating circumstances outside the control of the Provider, consistent with federal Medicaid regulations, and with approval of the DMAP Provider Services Unit Manager.

(9) Issuance of a DHS assigned Provider number establishes enrollment of an individual or organization as a Provider for the specific category (ies) of services covered by the DMAP enrollment application. For example, a pharmacy Provider number applies to pharmacy services but not to Durable Medical Equipment, which requires a separate Provider application attachment and establishes a separate DHS assigned Provider number.

(10) Required Updates: A Provider is responsible for providing, and continuing to provide, to the Department accurate, complete and truthful information concerning their qualification for enrollment. An enrolled Provider must notify DMAP in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including but not limited to a change in any of the following information: address, business affiliation, licensure, certification, NPI, or Federal Tax Identification Number, or if the Provider's ownership or control information changes; or if the Provider or a person with an ownership or control interest, or an agent or managing employee of the Provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or SCHIP services program. The Provider must notify DMAP of changes in any of this information in writing within 30 calendar days of the change.

(a) Failure to notify DMAP of a change of Federal Tax Identification Number for entities or a Social Security Number or Employer Identification Number for individual Performing Providers may result in the imposition of a $50 fine;

(b) In addition to section(10) (a) of this rule, if DMAP notifies a Provider about an error in Federal Tax Identification Number including Social Security Numbers or Employer Identification Numbers for individual Performing Providers, the Provider must supply the appropriate valid Federal Tax Identification Number within 30 calendar days of the date of the DMAP notice. Failure to comply with this requirement may result in DMAP imposing a fine of $50 for each such notice. Federal Tax Identification Number requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(c) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a new application;

(d) Claims submitted by, or payments made to, Providers who have not furnished the notification required by this rule or to a Provider that has failed to submit a new application as required by DMAP under this rule may be denied or recovered.

(11) Enrollment of Out-of-State Providers: Providers of services outside the state of Oregon will be enrolled as a Provider under section (7) of this rule if they comply with the requirements of section (7) and under the following conditions:

(a) The Provider is appropriately licensed or certified and meets standards and is enrolled within the Provider's state for participation in the state's Medicaid program. Disenrollment or sanction from the other state's Medicaid program, or exclusion from any other federal or state health care program is a basis for disenrollment, termination or suspension from participation as a Provider in Oregon's medical assistance programs;

(b) Noncontiguous Out-of-State pharmacy Providers must be licensed by the Oregon Board of Pharmacy to provide pharmacy services in Oregon. In instances where clients are out of the state due to travel or other circumstances that prevent them from using a pharmacy licensed in Oregon, and prescriptions need to be filled, the pharmacy is required to be licensed in the State they are doing business where the client filled the prescription, and must be enrolled with DHS in order to submit claims. Out-of-state internet or mail order, except the Department mail order vendor, prescriptions are not eligible for reimbursement;

(c) The Provider bills only for services provided within the Provider's scope of licensure or certification;

(d) For noncontiguous Out-of-State Providers, the services provided must be authorized, in the manner required under these rules for Out-of-State Services (OAR 410-120-1180) or other applicable DHS rules:

(A) For a specific Oregon Medicaid Client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) For foster care or subsidized adoption children placed out of state; or

(C) The Provider is seeking Medicare deductible or coinsurance coverage for Oregon Qualified Medicare Beneficiaries (QMB) Clients.

(e) The services for which the Provider bills are covered services under the Oregon Health Plan (OHP);

(f) Facilities, including but not restricted to Hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, Psychiatric Hospitals, and residential care facilities, will be enrolled as Providers only if the facility is enrolled as a Medicaid Provider in the state in which the facility is located or is licensed as a facility Provider of services by the State of Oregon;

(g) Out-of-State Providers may provide contracted services per OAR 410-120-1880.

(12) Enrollment of Billing Providers:

(a) An individual or business entity that, in connection with the submission of claims to DMAP and receives or directs the payments from DMAP on the behalf of a professional Performing Provider (e.g., Physician, Physical Therapist, Speech Therapist) must be enrolled as a Billing Provider with DMAP and meet all applicable federal and state laws and regulations. A Billing Agent or Billing Service submitting claims or providing other business services on behalf of a Performing Provider but not receiving payment in the name of or on behalf of the Performing Provider does not meet the requirements for Billing Provider enrollment and is not eligible for enrollment as a Billing Provider;

(b) Billing Providers must complete an application for enrollment and submit all required documentation including a Provider Enrollment Agreement, consistent with the Provider enrollment process described in subsection (7), to obtain a DHS assigned Provider Number. A DHS assigned Billing Provider number will be issued only to Billing Providers that have a contract with an enrolled Performing Provider to provide services in connection with the submission of claims and receive or direct payments on behalf of the Performing Provider, and that have met the standards for enrollment as a Billing Provider including one of the following as applicable:

(A) A corporate or business entity related to the Performing Provider under one of the relationships authorized by 42 CFR 447.10(g) may have the authority to submit the Performing Provider enrollment application and supporting documentation on behalf of the Performing Provider. Such entities with the authority to provide services in connection with the submission of claims and obtain or direct payment on behalf of the Performing Provider must enroll as a Billing Provider;

(B) Any other contracted Billing Agent or Billing Service (except as are described in section (12)(b) (A) of this rule) that has authority to provide services in connection with the submission claims and to receive or direct payment in the name of the Performing Provider pursuant to 42 CFR 447.10(f). Such entities with the authority to obtain or direct payment on behalf of the Performing Provider in connection with the submission of claims must enroll as a Billing Provider;

(C) These Billing Provider enrollment requirements do not apply to the staff directly employed by an enrolled Performing Provider, rather than pursuant to a contractual arrangement. Nothing in this rule is meant to prevent an enrolled Performing Provider from submitting his or her own claims and receiving payment in his or her own name. Notwithstanding this provision, if the Performing Provider is conducting electronic transactions, the DHS EDI rules will apply, consistent with section (4) of this rule.

(c) A Billing Provider must maintain, and make available to DMAP, upon request, records indicating the Billing Provider's relationship with the Provider of service;

(d) Prior to submission of any claims or receipt or direction of any payment from DMAP, the Billing Provider must obtain signed confirmation from the Performing Provider that the Billing Provider has been authorized by the Performing Provider to submit claims or receive or direct payment on behalf of the Performing Provider. This authorization, and any limitations or termination of such authorization, must be maintained in the Billing Provider's files for at least five years, following the submission of claims or receipt or direction of funds from DMAP;

(e) The Billing Provider fee must not be based on a percentage of the amount billed or collected or whether or not they collect the subject's payment (42 CFR 447.10(f)).

(f) If the Billing Provider is authorized to use electronic media to conduct transactions on behalf of the Performing Provider, the Performing Provider must register with the Department as a Trading Partner and authorize the Billing Provider to act as an EDI Submitter, as required in the Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. Enrollment as a Billing Provider does not provide that authority. If the Performing Provider uses electronic media to conduct transactions, and authorizes a Billing Agent or Billing Service that is not authorized to receive reimbursement or otherwise obligate the Performing Provider, the Billing Agent or Billing Service does not meet the requirements of a Billing Provider. The Performing Provider and Billing Agent or Billing Service must comply with the DHS EDI rules, OAR 407-120-0100 through 407-120-0200.;

(g) Out-of-state Billing Providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon pursuant to 407-120-0320(15)(f).

(h) All Billing Providers are required to notify DMAP, at the time of enrollment or within 30 days of any change, of the names of all Performing Providers and their DHS Provider Number, NPI number and the Social Security Number or Employer Identification Numbers of the Performing Providers. The Performing Provider's SSN or EIN is required pursuant to 42 CFR 433.37, including federal tax laws at 26 USC 6041. SSN's and EIN's provided pursuant to this authority are used for the administration of federal, state, and local tax laws and the administration of this program for internal verification and administrative purposes including but not limited to identifying the provider for payment and collection activities. In addition, this information is necessary for DHS to timely process and pay claims.

(13) Utilization of Locum Tenens:

(a) For purposes of this rule, a locum tenens means a substitute Physician retained to take over another Physician's professional practice while he or she is absent (i.e., absentee Physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.

(b) Locum tenens are not required to enroll with DMAP; however, DMAP may enroll locum tenens Providers at the discretion of the Provider Services Manager if that Provider submits a complete enrollment application, especially in areas of the State underserved with medical Providers. In no instance may an enrolled absentee Physician utilize a substitute Physician who is, at that time, excluded from participation in or under Sanction by Medicaid or federally funded or federally assisted health programs.

(c) The absentee Physician must be an enrolled DMAP Provider and must bill with their individual DMAP assigned Provider number and receive payment for covered services provided by the locum tenens Physician. Services provided by the locum tenens must be billed with a modifier Q6:

(A) In entering the Q6 modifier, the absentee Physician is certifying that the services are provided by a substitute Physician identified in a record of the absentee Physician that is available for inspection, and are services for which the absentee Physician is authorized to submit a claim;

(B) A Physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled Provider's right to receive payment or to submit claims may be revoked.

(14) Reciprocal Billing Arrangements:

(a) For purposes of this rule, reciprocal billing arrangements are similar in nature to a locum tenens in that a substitute Physician is retained to take over another Physician's professional practice on an occasional basis if the regular Physician is unavailable (absentee Physician);

(b) Providers with reciprocal billing arrangements are not required to enroll with DMAP; however, in no instance may an enrolled absentee Physician utilize a substitute Physician who is, at that time, excluded from participation in or under Sanction by Medicaid or federally funded or federally assisted health programs;

(c) The absentee Physician must be an enrolled DMAP Provider and must bill with his or her individual DMAP assigned Provider number and receive payment for covered services provided by the substitute Physician. The absentee Physician identifies the services provided by the substitute Physician by using modifier Q5:

(A) In entering the Q5 modifier, the absentee Physician is certifying that the services are provided by a substitute Physician identified in a record of the absentee Physician that is available for inspection, and are services for which the absentee Physician is authorized to submit a claim.

(B) A Physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled Provider's right to receive payment or to submit claims may be revoked.

(d) These requirements do not apply to substitute arrangements among Physicians in the same medical practice when claims are submitted in the name of the Billing Provider or group name. Nothing in this rules prohibits Physicians sharing call responsibilities from opting out of the reciprocal billing (substitute Provider) arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled Performing Providers and as long as duplicate claims for services are not submitted.

(15) Provider Termination:

(a) The Provider may terminate enrollment at any time. The request must be in writing, and signed by the Provider. The notice shall specify the DMAP assigned Provider number to be Terminated and the effective date of Termination. Termination of the Provider enrollment does not terminate any obligations of the Provider for dates of services during which the enrollment was in effect;

(b) DMAP Provider Terminations or Suspensions may be for, but are not limited to the following reasons:

(A) Breaches of Provider agreement;

(B) Failure to comply with the statutes, regulations and policies of DHS, Federal or State regulations that are applicable to the Provider.

(C) When no claims have been submitted in an 18-month period. The Provider must reapply for enrollment.

(16) When a Provider fails to meet one or more of the requirements governing a Provider's participation in Oregon's medical assistance programs, the Provider's DMAP assigned Provider number may be immediately suspended. The Provider is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1840 to determine whether the Provider's DMAP assigned number will be revoked.

(17) The provision of health care services or items to DMAP Clients is a voluntary action on the part of the Provider. Providers are not required to serve all DMAP Clients seeking service.

(18) In the event of bankruptcy proceedings, the Provider must immediately notify the DMAP Administrator in writing.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110
Stats. Implemented: ORS 414.019, 414.025 & 414.065
Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81, Renumbered from 461-013-0060; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 73-1989, f. & cert. ef. 12-7-89; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0063, 461-013-0075 & 461-013-0180; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 51-1991(Temp), f. 11-29-91, cert. ef. 12-1-91; HR 5-1992, f. & cert. ef. 1-16-92; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0020, 410-120-0040 & 410-120-0060; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 9-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-120-1280
Billing

(1) A Provider enrolled with the Division of Medical Assistance Programs (DMAP) must bill using the DHS assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available, pursuant to 407-120-0320.

(2) For Medicaid covered services the Provider must not bill DMAP more than the Provider's Usual Charge (see definitions) or the reimbursement specified in the applicable Provider rules:

(a) A Provider enrolled with DHS or providing services to a Client in a managed care plan under the Oregon Health Plan (OHP) must not seek payment for any services covered by Medicaid fee-for-service or through contracted managed care plans, except any coinsurance, co-payments, and deductibles expressly authorized by the General Rules, OHP Rules or individual Provider rules:

(A) An DMAP Client for covered benefits; or

(B) A financially responsible relative or representative of that individual.

(b) Exceptions under which an enrolled Provider may seek payment from an eligible Client or Client representative are described below:

(A) The Provider may seek any applicable coinsurance, Copayments and deductibles expressly authorized by DMAP rules in OAR 410 division 120, OAR 410 division 141, or any other individual Provider rules;

(B) The Client did not inform the Provider of OHP eligibility, of OHP managed health plan enrollment, or of other third party insurance coverage, either at the time the service was provided or subsequent to the provision of the service or item, and as a result the Provider could not bill DMAP, the managed health care plan, or third party payer for any reason, including timeliness of claims, lack of Prior Authorization, etc. The Provider must document attempts to obtain information on eligibility or enrollment;

(C) The Client became eligible for DMAP benefits retroactively but did not meet other established criteria described in these General Rules and the appropriate Provider rules (i.e., retroactive authorization);

(D) A Third Party Resource made payments directly to the Client for services provided;

(E) The Client did not have full DMAP benefits. Clients receiving a limited Medicaid coverage, such as the Citizen Alien Waived Emergency Medical Program, may be billed for services that are not benefits of those programs. The Provider must document pursuant to section (3) of this rule that the Client was informed that the service or item would not be covered by DMAP;

(F) The Client has requested continuation of benefits during the Administrative Hearing process and final decision was not in favor of the Client. The Client will be responsible for any charges since the effective date of the initial notice of denial;

(G) A Client cannot be billed for services or treatment that has been denied due to Provider error (e.g., required documentation not submitted, Prior Authorization not obtained, etc.);

(H) The charge is for a Copayment when a Client is required to make a Copayment as outlined in DMAP General Rules (410-120-1230) and individual Provider rules;

(I) In exceptional circumstances, a Client may request continuation of a covered service while asserting the right to privately pay for that service. Under this exceptional circumstance, a Client can be billed for a covered service if the Client is informed in advance of receiving the specific service of all of the following:

(i) That the requested service is a covered service and that the Provider would be paid in full for the covered service if the claim is submitted to DMAP or the Client's managed care plan, if the Client is a member of a managed care plan; and

(ii) The estimated cost of the covered service, including all related charges, the amount that DMAP, and that the Client cannot be billed for an amount greater than the maximum DMAP reimbursable rate or managed care plan rate, if the Client is a member of a managed care plan; and

(iii) That the Provider cannot require the Client to enter into a voluntary payment agreement for any amount for the covered service; and

(iv) That the Client knowingly and voluntarily agrees to pay for the covered service, the Provider must not submit a claim for payment to DMAP or the Client's managed care plan; and

(v) The Provider must be able to document in writing, signed by the Client or the Client's representative, that the Client was provided the information described above; that the Client was provided an opportunity to ask questions, obtain additional information and consult with the Client's caseworker or Client representative; and the Client agreed to be responsible for payment by signing an agreement incorporating all of the information described above. The Client must be given a copy of the signed agreement. A Provider must not submit a claim for payment for covered services to DMAP or to the Client's managed care plan that is subject to such agreement.

(3) Non-Covered Medicaid Services:

(a) A Provider may bill a Client for services that are not covered by DMAP or the managed care plan. However, the Client must be informed in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the Client or Client's representative is financially responsible for payment for the specific service. Providers must be able to document in writing signed by the Client or Client's representative, that the Client was provided this information and the Client knowingly and voluntarily agreed to be responsible for payment;

(b) Services which are considered non-covered are listed in the following rules (in rule precedence order):

(A) OAR 410-141-0480, Benefit Package of Covered Services; and

(B) OAR 410-141-0520, Prioritized List of Health Services; and

(C) OAR 410-120-1200, Medical Assistance Benefits: Excluded services and limitations; and

(D) Applicable Provider rules.

(c) A Client cannot be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the Client or DMAP.

(4) All claims must be billed on the appropriate form as described in the individual Provider rules or submitted electronically in a manner authorized by the Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq.

(5) Upon submission of a claim to DMAP for payment, the Provider agrees that it has complied with all DMAP Provider rules. Submission of a claim, however, does not relieve the Provider from the requirement of a signed Provider agreement.

(6) All billings must be for services provided within the Provider's licensure or certification.

(7) It is the responsibility of the Provider to submit true and accurate information when billing DMAP. Use of a Billing Provider does not abrogate the Performing Provider's responsibility for the truth and accuracy of submitted information.

(8) A claim must not be submitted prior to delivery of service. A claim must not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in DMAP's individual Provider rules.

(9) A claim is considered a Valid Claim only if all required data is entered on or attached to the claim form. See the appropriate Provider rules and supplemental information for specific instructions and requirements. Also, see Valid Claim in the Definitions section of these rules.

(10) The HIPAA Codes rules, 45 CFR 162, apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for Prior Authorization, claims submissions and payments. Code Set has the meaning established in 45 CFR 162.100, and it includes the codes and the descriptors of the codes. These federal Code Set requirements are mandatory and DMAP lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services.

(a) DMAP will adhere to the national Code Set requirements in 45 CFR 162.1000 — 162.1011, regardless of whether a request is made verbally, or a claim is submitted on paper or electronically;

(b) Periodically, DMAP will update its Provider rules and tables to conform to national codes. In the event of an alleged variation between an DMAP-listed code and a national code, DMAP will apply the national code in effect on the date of request or date of service and the Provider, and the DMAP-listed code may be used for the limited purpose of describing DMAP's intent in identifying the applicable national code;

(c) Only codes with limitations or requiring Prior Authorization are noted in rules. National Code Set issuance alone should not be construed as DMAP coverage, or a covered service.

(d) DMAP adopts by reference the National Code Set revisions, deletions, and additions issued and published by the American Medical Association (Current Procedural Terminology — CPT) and on the CMS website (Healthcare Common Procedural Coding System — HCPCS) to be effective January 1, 2007. This code adoption should not be construed as DMAP coverage, or a covered service.

(11) Diagnosis Code Requirement:

(a) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis Code Set, unless specifically excluded in individual DMAP Provider rules;

(b) When billing using ICD-9-CM codes, all diagnosis codes are required to the highest degree of specificity;

(c) Hospitals are always required to bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups.

(12) For claims requiring a procedure code the Provider must bill as instructed in the appropriate DMAP Provider rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the Client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Provider rules. Hospitals must follow national coding guidelines:

(a) When there is no appropriate descriptive procedure code to bill DMAP, the Provider must use the code for Unlisted Services. Instructions on the specific use of unlisted services are contained in the individual Provider rules. A complete and accurate description of the specific care, item, or service must be documented on the claim;

(b) Where there is one CPT, CDT or HCPCS code that according to CPT, CDT and HCPCS coding guidelines or standards, describes an array of services the Provider must bill DMAP using that code rather than itemizing the services under multiple codes. Providers must not "unbundled" services in order to increase DMAP payment.

(13) No Provider or its contracted agency (including Billing Providers) shall submit or cause to be submitted to DMAP:

(a) Any false claim for payment;

(b) Any claim altered in such a way as to result in a payment for a service that has already been paid;

(c) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;

(d) Any claim for furnishing specific care, item(s), or service(s) that have not been provided.

(14) The Provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the Provider identifies an overpayment made by DMAP.

(15) A Provider who, after having been previously warned in writing by DMAP or the Department of Justice about improper billing practices, is found to have continued such improper billing practices and has had an opportunity for a contested case hearing, shall be liable to DMAP for up to triple the amount of the DMAP established overpayment received as a result of such violation.

(16) Third Party Resources (TPR):

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances DMAP will be the payer of last resort;

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include, but are not limited to:

(A) Determining the existence of insurance or other resource by asking the recipient;

(B) Using an insurance database such as Electronic Verification System (EVS) available to the Provider;

(C) Verifying the Client's insurance coverage through the Automated Voice Response (AVR) or Secure provider web portal on each date of service and at the time of billing.

(c) Except as noted in (16)(d)(A through E), when third party coverage is known to the Provider, as indicated through AVR, Secure provider web portal or any other means available, prior to billing DMAP the Provider must:

(A) Bill the TPR; and

(B) Except for pharmacy claims billed through DMAP's point-of-sale system the Provider must have waited 30 days from submission date of a clean claim and have not received payment from the third party; and

(C) Comply with the insurer's billing and authorization requirements; and

(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.

(d) In accordance with federal regulations the Provider must bill the TPR prior to billing DMAP, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility Services for the Mentally Retarded (ICF/MR);

(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;

(C) The covered health services are prenatal and preventive pediatric services;

(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the Provider may bill the insurer or liable party or place a lien against a settlement or the Provider may bill DMAP. The Provider may not both place a lien against a settlement and bill DMAP. The Provider may withdraw the lien and bill DMAP within 12 months of the date of service. If the Provider bills DMAP the Provider must accept payment made by DMAP as payment in full.

(F) The Provider must not return the payment made by DMAP in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement:

(i) In the circumstances outlined in (16)(d)(A through E) above, the Provider may choose to bill the primary insurance prior to billing DMAP. Otherwise, DMAP will process the claim and, if applicable, will pay the DMAP allowable rate for these services and seek reimbursement from the liable third party insurance plan;

(ii) In making the decision to bill DMAP the Provider should be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than DMAP, and that, once DMAP makes payment no additional billing to the third party is permitted by the Provider.

(e) The Provider may bill DMAP directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant Provider rules. Documentation must be on file in the Provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual Provider rules for further information on services that must be billed to Medicare first;

(f) Providers are required to submit an Individual Adjustment Request showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit the Individual Adjustment Request within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery and/or sanction;

(A) When a Provider receives a payment from any source prior to the submission of a claim to DMAP, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) Except as described in (15), any Provider who accepts third party payment for furnishing a service or item to a DMAP Client shall:

(i) Submit an Individual Adjustment Request after submitting a claim to DMAP following instructions in the individual Provider rules and supplemental billing information, indicating the amount of the third party payment; or

(ii) When the Provider has already accepted payment from DMAP for the specific service or item, the Provider shall make direct payment of the amount of the third party payment to DMAP. When the Provider chooses to directly repay the amount of the third party payment to DMAP, the Provider must indicate the reason the payment is being made and must submit with the check:

(I) An Individual Adjustment Request which identifies the original claim, name and number of the Client, date of service and item(s) or service(s) for which the repayment is made; or

(II) A copy of the Remittance Advice showing the original DMAP payment.

(g) DMAP reserves the right to make a claim against any third party payer after making payment to the Provider of service. DMAP may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, requesting the Provider to bill the third party and to refund DMAP in accordance with (15) of this rule;

(h) For services rendered to a Medicare and Medicaid dual eligible Client, DMAP may request the Provider to submit a claim for Medicare payment and the Provider must honor that request. Under federal regulation, a Provider agrees not to charge a beneficiary (or the state as the beneficiary's subrogee) for services for which a Provider failed to file a timely claim (42 CFR 424) with Medicare despite being requested to do so.

(i) If Medicare is the primary payer and Medicare denies payment, Medicare appeals must be timely pursued and Medicare denial must be obtained prior to submitting the claim for payment to DMAP. Medicare denial on the basis of failure to submit a timely appeal may result in DMAP reducing from the amount of the claim any amount DMAP determines could have been paid by Medicare.

(17) Full Use of Alternate Resources:

(a) DMAP will generally make payment only when other resources are not available for the Client's medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in subsection (18) of this rule, alternate resources may be available:

(A) Under a federal or state worker's compensation law or plan;

(B) For items or services furnished by reason of membership in a prepayment plan;

(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity, such as:

(i) Armed Forces Retirees and Dependents Act (CHAMPVA);

(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); and

(iii) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or

(E) Through other reasonably available resources.

(18) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 35.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under a section 638 agreement are payers of last resort, and are not considered an alternate resource or TPR;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPR.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110

Stats. Implemented: ORS 414.019, 414.025, 414.065 & 414.085

Hist.: PWC 683, f. 7-19-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 5-1981, f. 1-23-81, ef. 3-1-81, Renumbered from 461-013-0050, 461-013-0060, 461-013-0090 & 461-013-0020; AFS 47-1982, f. 4-30-82, & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 45-1983, f. 9-19-83, ef. 10-1-83; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 36-1984, f. & ef. 8-20-84; AFS 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; AFS 43-1986, f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 14-1987, f. 5-31-87, ef. 4-1-87; AFS 38-1988, f. 5-17-88, cert. ef. 6-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0140, 461-013-0150, 461-013-0175 & 461-013-0180; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0260, 410-120-0280, 410-120-0300 & 410-120-0320; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-10-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 30-2001, f. 9-24-01, cert. ef 10-1-01; OMAP 23-2002, f. 6-14-02 cert. ef. 8-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 73-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 67-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-120-1340
Payment

(1) The Division of Medical Assistance Programs (DMAP) will make payment only to the enrolled Provider who actually performs the service or to the Provider's enrolled Billing Provider for covered services rendered to

eligible Clients. Any contracted Billing Agent or Billing Service submitting claims on behalf of a Provider but not receiving payment in the name of or on behalf of the Provider does not meet the requirements for Billing Provider enrollment. If electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. DMAP may require that payment for services be made only after review by DMAP.

(2) DMAP or the Department of Human Services (DHS) office administering the program under which the billed services or items are provided sets Fee-for-Service (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the DMAP maximum allowable amount or the reimbursement specified in the individual program Provider rules:

(a) Amount billed may not exceed the Provider's Usual Charge (see definitions);

(b) DMAP's maximum allowable rate setting process uses the following methodology. The rates are posted on the DMAP web site at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml, and updated periodically:

(A) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight DMAP converted to the 2007 Fully Implemented Non-Facility Total RVU weights published in the Federal Register, Vol. 71, December 1, 2006 to be effective January 1, 2008, except in cases where the Fully Implemented Non-Facility Total RVU weight was a significant change from the previous year's RVU Total. In those cases the transitional year Total will be adopted:

(i) The conversion factor for labor and delivery (59400-59622) is $40.20;

(ii) CPT codes 92340-92342 and 92352-92353 remain at a flat rate of $25.90;

(iii) All remaining RVU weight based CPT/HCPCS codes have a conversion factor of $26.88;

(B) Surgical assist reimburses at 20% of the surgical rate;

(C) The base rate for anesthesia services 00100-01996 is $24.19 and is based on per unit of service;

(D) Clinical lab codes are priced based upon the Centers for Medicare and Medicaid Service (CMS) mandates. Other Non-RVU weight based Lab vary by code are generally between 62% to 97% of Medicare's rates;

(E) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of Medicare's fee schedule;

(F) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate will be based upon Average Wholesale Price (AWP). Pricing information for AWP is provided by First Data Bank. These rates may change periodically based on drug costs;

(G) All procedures used for vision materials and supplies are based on contracted rates which include acquisition cost plus shipping and handling;

(c) Individual Provider rules may specify reimbursement rates for particular services or items.

(4) DMAP reimburses Inpatient Hospital service under the DRG methodology, unless specified otherwise in the Hospital services rules. Reimbursement for services, including claims paid at DRG rates, will not exceed any Upper Limits established by federal regulation.

(5) DMAP reimburses all out-of-state Hospital services at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 Division 125) unless the Hospital has a contract or Service Agreement with DMAP to provide highly specialized services.

(6) Payment rates for in-home services provided through DHS Seniors and People with Disabilities Division (SPD) will not be greater than the current DMAP rate for Nursing Facility payment.

(7) DHS sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate:

(a) That is consistent with similar services provided in the State of Oregon; and

(b) Is the lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) Is the rate established by SPD for out-of-state Nursing Facilities.

(8) DMAP will not make payment on claims that have been assigned, sold, or otherwise transferred or on which the Billing Provider, Billing Agent or Billing Service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a Provider for accounts receivable.

(9) DMAP will not make a separate payment or copayment to a Nursing Facility or other Provider for services included in the Nursing Facility's All-Inclusive Rate. The following services are not included in the All-Inclusive Rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services (OAR 410 division 121) and Home Enteral/Parenteral Nutrition and IV Services Provider rules, (OAR 410 division 148);

(b) Physical Therapy, Speech Therapy, and Occupational Therapy provided by a non-employee of the Nursing Facility within the appropriate program Provider rules, (OAR 410 division 131 and 129);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Provider rules, (OAR 410 division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(f) Medical services provided by Physician or other Provider of medical services, such as radiology and Laboratory, as outlined in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122).

(10) DMAP reimburses Hospice services on a per diem basis dependent upon the level of care being provided. A separate payment will not be made for services included in the core package of services as outlined in OAR 410 division 142.

(11) Payment for DMAP Clients with Medicare and full Medicaid:

(a) DMAP limits payment to the Medicaid allowed amount less the Medicare payment up to the Medicare co-insurance and deductible, whichever is less. DMAP payment cannot exceed the co-insurance and deductible amounts due;

(b) DMAP pays the DMAP allowable rate for DMAP covered services that are not covered by Medicare.

(12) For Clients with Third-Party Resources (TPR), DMAP pays the DMAP allowed rate less the TPR payment but not to exceed the billed amount.

(13) DMAP payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For DMAP such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding DMAP's allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain Payment Authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual Provider rules.

(14) Payment by DMAP does not limit DHS or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110

Stats. Implemented: ORS 414.019, 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742 & 414.743

Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; Renumbered from 461-013-0061; PWC 833, f. 3-18-77, ef. 4-1-77; Renumbered from 461-013-0061; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 50-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0081, 461-013-0085, 461-013-0175 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0220, 410-120-0200, 410-120-0240 & 410-120-0320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0040
Prior Authorization Required for Drugs and Products

(1) Prescribing practitioners are responsible for obtaining Prior Authorization (PA) for the drugs and categories of drugs requiring PA in this rule, using the procedures required in OAR 410-121-0060.

(2) All drugs and categories of drugs, including but not limited to those drugs and categories of drugs that require PA as described in this rule, are subject to the following requirements for coverage:

(a) Each drug must be prescribed for conditions funded by OHP in a manner consistent with the Prioritized List of Health Services (OAR 410-141-0480 through 410-141-0520). If the medication is for a non-covered diagnosis, the medication will not be covered unless there is a co-morbid condition for which coverage would be extended. The use of the medication must meet corresponding treatment guidelines, be included within the client's benefit package of covered services, and not otherwise excluded or limited.

(b) Each drug must also meet other criteria applicable to the drug or category of drug in these Pharmacy Provider rules, including PA requirements imposed in this rule.

(3) The Department of Human Services (DHS) may require PA for individual drugs and categories of drugs to ensure that the drugs prescribed are indicated for conditions funded by OHP and consistent with the Prioritized List of Health Services and its corresponding treatment guidelines (see OAR 410-141-0480). The drugs and categories of drugs for which DHS requires PA for this purpose are listed in **Table 410-121-0040-1**, with their approval criteria.

(4) DHS may require PA for individual drugs and categories of drugs to ensure medically appropriate use or to address potential client safety risk associated with the particular drug or category of drug, as recommended by the Drug Use Review (DUR) Board and adopted by the Department in this rule (see OAR 410-121-0100 for a description of the DUR program). The drugs and categories of drugs for which DHS requires PA for this purpose are included in **Table 410-121-0040-2**, with their approval criteria.

(5) PA is required for brand name drugs that have two or more generically equivalent products available. Criteria for approval are:

(a) If criteria established in subsection (3) or (4) of this rule applies, follow that criteria.

(b) If (5)(a) does not apply, the prescribing practitioner must document that the use of the generically equivalent drug is medically contraindicated, and provide evidence that either the drug has been used and has failed or that its use is contraindicated based on evidence-based peer reviewed literature that is appropriate to the client's medical condition.

(6) PA may not be required

(a) When the prescription ingredient cost plus the dispensing fee is less than the PA processing fees as determined by DHS or,

(b) For over-the-counter (OTC) covered drugs when prescribed for conditions covered under OHP.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 2-1990, f. & cert. ef. 1-16-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0170; HR 10-1991, f. & cert. ef. 2-19-91; HR 14-1993, f. & cert. ef. 7-2-93; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 18-1996(Temp), f. & cert. ef. 10-1-96; HR 8-1997, f. 3-13-97, cert. ef. 3-15-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2002, f. & cert. ef. 10-1-02; OMAP 66-2002, f. 10-31-02, cert. ef. 11-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 87-2003(Temp), f. & cert. ef. 12-15-03 thru 5-15-04; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 71-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 74-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 4-2006(Temp), f. & cert. ef. 3-15-06 thru 9-7-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 41-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 9-2008, f. 3-31-08, cert. ef. 4-1-08; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0060
How to Get Prior Authorization for Drugs

(1) A prescriber electing to order a drug requiring Prior Authorization (PA)may have any licensed medical personnel in their office call the Pharmacy Benefit Manager (PBM) Prior Authorization Help Desk to request the PA. The PA request may also be transmitted to the PBM Help Desk by FAX using the request form shown in the Pharmaceutical Services Supplemental Information on the Department of Human Services website.

(2) PA approval:

(a) If the PA request is approved, the PBM Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(A) PA approvals are given for a specific date of service and for specific NDC numbers or products.

(B) PA approvals do not guarantee eligibility or reimbursement.

(b) It is the pharmacist's responsibility to check whether the drugs are covered, whether the client is eligible, and to note restrictions such as date ranges and quantities before dispensing any medications that require PA.

(c) The pharmacy must also check whether the client's prescribed medications are covered by a managed care plan because an enrollment may have taken place after PA was received. If the client is enrolled in a managed care plan and the pharmacy receiving the PA is not a participating pharmacy provider in the managed care plan's network, the pharmacy must inform the client that it is not a participating provider in the managed care plan's network and must also recommend that the client contact his or her managed care plan for a list of pharmacies participating in its network..

(d) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy provider, if consistent with all other applicable administrative rules. There is no need for a PA number.

(3) If the PA request has been denied, the PBM Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(4) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from the PBM when the client is eligible for covered fee-for-service drug prescriptions.

(a) Clients who do not have a PA pending may receive an emergency dispensing for a 96-hour supply.

(b) Clients who do have a PA pending may receive an emergency dispensing up to a seven-day supply.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0180; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0140
Definition of Terms

(1) Actual Acquisition Cost: The net amount paid per invoice line item to a supplier. This net amount does not include separately identified discounts for early payment.

(2) Average Manufacturer's Price (AMP): The average price at which manufacturers sell medication to wholesalers and retail pharmacies, as further clarified in 42 CFR 447.

(3) Bulk Dispensing: Multiple doses of medication packaged in one container labeled as required by pertinent Federal and State laws and rules.

(4) Community Based Care Living Facility: For the purposes of the Division of Medical Assistance Programs (DMAP) Pharmacy Program, a home, facility, or supervised living environment licensed or certified by the state of Oregon which provides 24 hour care, supervision, and assistance with medication administration. These include, but are not limited to:

(a) Supportive Living Facilities;

(b) 24-Hour Residential Services;

(c) Adult Foster Care;

(d) Semi-independent Living Programs;

(e) Assisted Living and Residential Care Facilities;

(f) Group Homes and other residential services for people with developmental disabilities or needing mental health treatment; and

(g) Inpatient hospice.

(5) Compounded Prescriptions:

(a) A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid ingredient that must be a reimbursable item or a legend drug in a therapeutic amount;

(b) Compounded prescription is further defined to include the Oregon Board of Pharmacy definition of Compounding (see OAR 855-006-0005).

(6) Dispensing: Issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist.

(7) Drug Order/Prescription:

(a) A medical practitioner's written or verbal instructions for a patient's medications; or

(b) A medical practitioner's written order on a medical chart for a client in a nursing facility.

(8) Durable Medical Equipment and supplies (DME): Equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

(19) Estimated Acquisition Cost (EAC): The estimated cost at which the pharmacy can obtain the product listed in OAR 410-121-0155.

(10) Intermediate Care Facility: A facility providing regular health-related care and services to individuals at a level above room and board, but less than hospital or skilled nursing levels as defined in ORS 442.015.

(11) Long Term Care Facility: Includes skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455.

(12) Maintenance medication: Drugs that have a common indication for treatment of a chronic disease and the therapeutic duration is expected to exceed one year. This is determined by a First DataBank drug code maintenance indicator of "Y" or "1".

(13) Nursing Facility: An establishment that is licensed and certified by the DHS Seniors and People with Disabilities Division (SPD) as a Nursing Facility.

(14) Point-of-Sale (POS): A computerized, claims submission process for retail pharmacies that provides on-line, real-time claims adjudication.

(15) Prescription Splitting: Any one or a combination of the following actions:

(a) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than 34 days (see OAR 410-121-0146);

(b) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing fee for the quantity billed;

(c) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or

(d) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.

(16) Unit Dose: A sealed, single unit container of medication, so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for unit dose dispensing system established by the Oregon Board of Pharmacy.

Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065
Hist.: PWC 818(Temp), f. 10-22-76, ef. 11-1-76; PWC 831, f. 2-18-77, ef. 3-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 28-1982, f. 6-17-81, ef. 7-1-81; AFS 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82; AFS 54-1985(Temp), f. 9-23-85, ef. 10-1-85 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 11-1987, f. 3-3-87, ef. 4-1-87; AFS 2-1989(Temp), f. 1-27-89, cert. ef. 2-1-89; AFS 17-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 42-1989, f. & cert. ef. 7-20-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0010; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0190; HR 52-1991(Temp), f. 11-29-91, cert. ef. 12-1-91; HR 6-1992, f. & cert. ef. 1-16-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 14-1993, f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 6-1996(Temp), f. & cert. ef. 8-1-96; HR 27-1996, f. 12-11-96, cert. ef. 12-15-96; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 49-2001, f. 9-28-01, cert. ef. 10-1-01 thru 3-15-02; OMAP 59-2001, f. & cert. ef. 12-11-01; OMAP 37-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 9-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 18-2003(Temp), f. 3-14-03, cert. ef. 4-1-03 thru 9-1-03 (Suspended by OMAP 27-2003, f. 3-31-03, cert. ef. 4-1-03 thru 4-15-03); OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 42-2003(Temp), f. 5-30-03, cert. ef. 6-1-03 thru 11-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 72-2003(Temp), f. 9-23-03, cert. ef. 11-1-03 thru 4-15-04; OMAP 84-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0150
Billing Requirements

(1) When billing the Division of Medical Assistance Programs (DMAP) for drug products, the provider must:

(a) Not bill in excess of the usual and customary charge to the general public;

(b) Indicate the National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed;

(c) Bill the actual metric decimal quantity dispensed;

(d) When clients have other insurances, bill the other insurances as primary and DMAP as secondary;

(e) When clients have Medicare prescription drug coverage, bill Medicare as primary and DMAP as secondary.

(2) When submitting a paper claim, the provider must accurately furnish all information required on the 5.1 Universal Claims Form.

(3) The prescribing provider's Medicaid Provider Identification (ID) number or National Provider Identifier (NPI) is mandatory on all fee-for-service client drug prescription claims. Claims will deny for a missing or invalid prescriber Medicaid Provider ID Number or National Provider Identifier. An exception to this includes, but is not limited toa Prescribing provider who does not have a Medicaid Provider ID Number for billing, but who prescribes fee-for-service prescriptions for clients under prepaid health plans (PHP), long-term care, or other capitated contracts. This provider is to be identified with the:

(a) Non-billing Provider ID Number assigned for prescription writing only;

(b) Clinic or facility Medicaid Provider ID Number until an individual Non-billing Provider ID Number is obtained; or

(c) Supervising physician's Provider ID Number when billing for prescriptions written by the physician assistant, physician students, physician interns, or medical professionals who have prescription writing authority;

(4) Billing for Death With Dignity services:

(a) Claims for Death With Dignity services cannot be billed through the Point-of-Sale system;

(b) Services must be billed directly to DMAP, even if the client is in a PHP;

(c) Prescriptions must be billed on a 5.1 Universal Claims Form paper claim form using an NDC number. Claims should be submitted to the address indicated at the DMAP Supplemental Information for Pharmaceutical Services.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 15-1987, f. 3-31-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89, Renumbered from 461-016-0093; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0240; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 44-1998(Temp), f. 12-1-98, cert. ef. 12-1-98 thru 5-1-99; OMAP 11-1999(Temp), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 25-1999, f. & cert. ef. 6-4-99; OMAP 5-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 43-2003(Temp), f. 6-10-03, cert. ef. 7-1-03 thru 12-15-03; OMAP 49-2003, f. 7-31-03 cert. ef. 8-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0157
Participation in the Medicaid Drug Rebate Program

(1) The Oregon Medicaid Pharmaceutical Services Program is a participant in the Centers for Medicare and Medicaid Services (CMS) Medicaid Drug Rebate Program, created by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by CMS's Center for Medicaid and State Operations (CMSO). Pharmaceutical companies participating in this program have signed agreements with CMS to provide rebates to the Division of Medical Assistance Programs (DMAP) on all their drug products. DMAP will reimburse providers only for outpatient drug products manufactured or labeled by companies participating in this program.

(2) Documents in rule by reference: Names and Labeler Code numbers for participants in the Medicaid Drug Rebate Program are the responsibility of and maintained by CMS. DMAP receives this information from CMS in the form of numbered and dated Releases. DMAP includes in rule by reference, the following CMS Releases and subsequent DMAP Master Pharmaceutical Manufacturer's Rebate Lists: Release # 141, dated May 4, 2006; Release # 142, dated July 3, 2006, and Lists updated July 12, 2006; Release # 143, dated August 23, 2006, and Lists updated August 29, 2006; Release #144, dated December 15, 2006; Release #145, dated March 7, 2007; Release #146, dated June 26, 2007; Release #147, dated August 15, 2007;Release #148, dated January 28, 2008; and Release #149, dated May 6, 2008. All CMS Releases are available on the Department of Human Services' website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/main.html CMS Releases Drug Product Data and Drug Company Contact information are available at: www.cms.hhs.gov/MedicaidDrugRebateProgram/02_StateReleases.asp

(3) Retroactive effective dates: The CMS Medicaid Drug Rebate Program experiences frequent changes in participation and often this information is submitted to DMAP after the effective date(s) of some changes. Therefore, certain participant additions and deletions may be effective retroactively. See specific instructions in the CMS Releases for appropriate effective date(s) of changes.

(4) DMAP contracts with a Pharmacy Benefit Manager (PBM) to manage the Medicaid Rebate Dispute Resolution program. Pharmacy providers must verify the accuracy of their Medicaid pharmacy claims with the PBM within 30 days of request in instances where drug manufacturers dispute their claim information. Verification can be photocopies of drug invoices showing that the billed products were in stock during the time of the date of service.

(5) The actual National Drug Code (NDC) dispensed and the actual metric decimal quantity dispensed, must be billed.

Stat. Auth.: ORS 409.050 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 16-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; HR 22-1991, f. & cert. ef. 5-16-91; HR 23-1991(Temp), f. 6-14-91, cert. ef. 6-17-91; HR 31-1991, f. & cert. ef. 7-16-91; HR 36-1991(Temp), f. 9-16-91, cert. ef. 10-1-91; HR 45-1992, f. & cert. ef. 10-16-91; HR 50-1991(Temp), f. & cert. ef. 10-29-91; HR 1-1992, f. & cert. ef. 1-2-92; HR 13-1992, f. & cert. ef. 6-1-92; HR 21-1992, f. 7-31-92, cert. ef. 8-1-92; HR 31-1992, f. & cert. ef. 10-1-92; HR 34-1992, f. & cert. ef. 12-1-92; HR 4-1993, f. 3-10-93, cert. ef. 3-11-93; HR 7-1993 (Temp), f. & cert. ef. 4-1-93; HR 14-1993, f. & cert. ef. 7-2-93; HR 24-1993, f. & cert. ef. 10-1-93; HR 17-1994, f. & cert. ef. 4-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2000(Temp), f. 12-29-00, cert. ef. 1-1-01 thru 5-1-01; OMAP 3-2001, f. & cert. ef. 3-16-01; OMAP 24-2001(Temp) f. 5-9-01, cert. ef. 5-10-01 thru 11-1-01; OMAP 25-2001(Temp) f. 6-28-01, cert. ef. 7-1-01 thru 12-1-01; OMAP 27-2001(Temp) f. 7-30-01, cert. ef. 8-1-01 thru 1-26-02; OMAP 48-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 56-2001(Temp), f. & cert. ef. 11-1-01 thru 4-15-02; OMAP 57-2001(Temp), f. 11-28-01, cert. ef. 12-1-01 thru 4-15-02; OMAP 66-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 4-2002(Temp), f. & cert. ef. 3-5-02 thru 8-1-02; OMAP 16-2002(Temp) f. & cert. ef. 4-12-02 thru 9-1-02; OMAP 20-2002(Temp), f. & cert. ef. 5-15-02 thru 10-1-02; OMAP 34-2002(Temp), f. & cert. ef. 8-14-02 thru 1-15-03; OMAP 67-2002(Temp), f. & cert. ef. 11-1-02 thru 3-15-03; OMAP 6-2003(Temp), f. & cert. ef. 2-14-03 thru 7-1-03; OMAP 38-2003, f. & cert. ef. 5-9-03; OMAP 39-2003(Temp), f. & cert. ef. 5-15-03; OMAP 48-2003, f. & cert. ef. 7-7-03; OMAP 74-2003, f. & cert. ef. 10-1-03; OMAP 5-2004(Temp), f. & cert. ef. 2-4-04 thru 6-15-04; OMAP 24-2004, f. & cert. ef. 3-30-04; OMAP 31-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 42-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 53-2004(Temp), f. & cert. ef. 9-10-04 thru 2-15-05; OMAP 82-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 1-2005(Temp), f. & cert. ef. 1-14-05 thru 6-1-05; OMAP 6-2005, f. 3-1-05, cert. ef. 3-31-05; OMAP 7-2005(Temp), f. 3-1-05, cert. ef. 4-1-05 thru 8-1-05; OMAP 30-2005, f. & cert. ef. 6-6-05; OMAP 55-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 5-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 7-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 12-2006, f. 5-26-06, cert. ef. 6-1-06; OMAP 49-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0200
Billing Forms

(1) Prescription Drug Invoice 5.1 Universal Claim Form:

(a) This form is used to bill for all pharmacy services, except durable medical equipment and home enteral/parenteral nutrition and IV services identified with a five-digit HCPCS codes in the Home Enteral/Parenteral Nutrition and IV Services Administrative Rules (OAR 410 Division 148);

(b) The provider may bill on the form when a valid DHS Medical Care Identification has been presented (Refer to OAR 410-120-1140 Verification of Eligibility).

(c) All completed 5.1 Universal Claim Forms should be mailed to the Division of Medical Assistance Programs (DMAP)

(2) All durable medical equipment and certain enteral/parenteral nutrition and IV services must be billed on the CMS-1500, using the billing instructions found in the DMAP Durable Medical Equipment and Medical Supplies Administrative Rules and Supplemental Information, and the DMAP Home Enteral/Parenteral Nutrition and IV Services Administrative Rules and Supplemental Information.

[ED NOTE: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.050 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-121-0320
Oregon Maximum Allowable Cost (OMAC)

(1) The Oregon maximum allowable cost, or the maximum amount that the Division of Medical Assistance Programs (DMAP) will reimburse for prescribed drugs, is determined by the DMAP contracted Pharmacy Benefits Manager (PBM). The PBM determines the maximum allowable cost on selected multiple-source drug designation when a bioequivalent drug product is available from at least two wholesalers serving the State of Oregon.

(2) The PBM generates and maintains all official OMAC lists and provides a copy of each list to DMAP. OMAC lists are generated monthly and each list indicates the amount, per product, that DMAP will reimburse to providers for products provided to DMAP clients during that particular month. For example: The OMAC list, January 1, 2008, includes the amounts DMAP will reimburse for products provided during the month of January 2008; the list, February 1, 2008, covers the month of February 2008, etc.

(3) DMAP includes in rule by reference the OMAC lists for January 1, 2006, February 1, 2006, March 1, 2006, April 1, 2006, May 1, 2006, June 1, 2006, July 1, 2006, August 1, 2006, September 1, 2006, October 1, 2006, November 1, 2006, and December 1, 2006.

(4) DMAP includes in rule by reference the OMAC lists for January 1, 2007, February 1, 2007, March 1, 2007, April 1, 2007, May 1, 2007, June 1, 2007, July 1,2007, August 1, 2007, September 1, 2007, October 1, 2007, November 1, 2007 and December 1, 2007.

(5) DMAP includes in rule by reference the OMAC lists for January 1 2008. February 1 2008, March 1 2008, April 1 2008, May 1 2008, June 1 2008, July 1 2008, August 1, September 1 2008, October 1 2008, November 1 2008, December 1 2008.

(6) Current OMAC lists are available for review and/or downloading on the DMAP website: www.dhs.state.or.us/policy/healthplan/guides/pharmacy/. Future lists, referenced in this rule, will be available and posted to the DMAP website upon receipt from the PBM.

(7) The OMAC list does not apply if a prescriber certifies that a single-source (brand) drug is medically necessary.

Stat. Auth.: ORS 184.750, 184.770, 411.300 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-29-89, cert. ef. 10-1-89; HR 3-1990(Temp), f. & cert. ef. 2-23-90; HR 13-1990, f. & cert. ef. 4-20-90, Renumbered from 461-016-0340; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 61-2001(Temp), f. 12-13-01, cert. ef. 12-15-01 thru 3-15-02; OMAP 1-2002, cert. ef. 2-15-02; OMAP 6-2002(Temp), f. & cert. ef. 3-5-02 thru 8-1-02; OMAP 17-2002(Temp), f. & cert. ef. 4-12-02 thru 9-1-02; OMAP 28-2002(Temp), f. 6-28-02, cert. ef. 7-1-02 thru 12-1-02; OMAP 35-2002(Temp), f. & cert. ef. 8-14-02 thru 1-1-03; OMAP 38-2002(Temp), f. & cert. ef. 8-30-02 thru 1-15-03; OMAP 40-2002(Temp), f. & cert. ef. 10-1-02 thru 2-15-03; OMAP 68-2002(Temp), f. & cert. ef. 11-15-02 thru 4-1-03; OMAP 7-2003, f. & cert. ef. 2-14-03 thru 7-1-03; OMAP 52-2003, f. & cert. ef. 8-5-03; OMAP 3-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 96-2004, f.12-30-04, cert. ef. 1-1-05; OMAP 69-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 51-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-122-0040
Prior Authorization

(1) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) providers must obtain prior authorization (PA) for Healthcare Common Procedure Coding System (HCPCS) Level II codes as specified in rule, unless otherwise noted.

(2) Providers must request PA as follows (see the DMEPOS Supplemental Information for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (DMAP).

(3) For clients with Medicare coverage, PA is only required for DMEPOS not covered by Medicare.

(4) For DMEPOS provided after normal working hours, providers must submit PA requests within five working days from the initiation of service.

(5) See OAR 410-120-1320 for more information about PA.

Stat. Auth.: ORS 409.010, 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 14-1984 (Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 13-1991, f. & cert. ef. 3-1-91, Renumbered from 461-024-0010; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 6-2004, f. 2-10-04 cert. ef. 3-15-04; OMAP 20-2004(Temp), f. & cert. ef. 3-15-04 thru 4-30-04; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 26-2004, f. 4-15-04 cert. ef. 5-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0125
Free-Standing Inpatient Psychiatric Facilities (IMDS)

Free-standing inpatient psychiatric facilities (Institutions for Mental Diseases), including Oregon's state-operated psychiatric and training facilities, are reimbursed according to the terms of an agreement between the Addictions and Mental Health, Seniors and People with Disabilities, and the hospital.

Stat. Auth.: ORS 184.750, 184.770, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 68-1981, f. 9-30-81, ef. 10-1-82; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987 (Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989 (Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0006, 461-015-0036, 461-015-0065 & 461-015-0124; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0580; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR

2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991 (Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0860; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0210
Third Party Resources and Reimbursement

(1) The Division of Medical Assistance Programs (DMAP) establishes maximum allowable reimbursements for all services. When clients have other third party payers, the payment made by that payer is deducted from the DMAP maximum allowable payment.

(2) DMAP will not make any additional reimbursement when a third party pays an amount equal to or greater than the DMAP reimbursement. DMAP will not make any additional reimbursement when a third party pays 100 percent of the billed charges, except when Medicare Part A is the primary payer.

(3) When Medicare is Primary:

(a) DMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient and Outpatient Rates Calculations Sections above;

(b) Payment is the DMAP allowable payment, less the Medicare payment, up to the amount of the deductible and/or coinsurance due. For clients who are Qualified Medicare Beneficiaries DMAP does not make any reimbursement for a service that is not covered by Medicare. For clients who are Qualified Medicare/Medicaid Beneficiaries DMAP payment is the DMAP allowable, less the Part A payment up to the amount of the deductible due for services by either Medicare or Medicaid.

(4) When Medicare is Secondary:

(a) An individual admitted to a hospital may have Medicare Part B, but not Part A. DMAP calculates the reimbursement for these claims in the same manner as described in the Inpatient Rates Calculations Section above. Payment is the DMAP allowable payment, less the Medicare Part B payment;

(b) An individual receiving services in the outpatient setting may have most services covered by Medicare Part B. DMAP payment is the DMAP allowable payment, less the Part B payment, up to the amount of the coinsurance and deductible due. For services provided in the outpatient setting which are not covered by Medicare, (for example, Take Home Drugs), DMAP payment is the DMAP allowable payment as calculated in the Outpatient Rates Calculation Section above;

(c) Most Medicare-Medicaid clients have Medicare Part A, Part B, and full Medicaid coverage. DMAP refers to these clients as Qualified Medicare-Medicaid Beneficiaries (QMM). However, a few individuals have Medicare coverage and only limited additional coverage through Medicaid. DMAP refers to these clients as Qualified Medicare Beneficiaries (QMB). For QMB clients, DMAP does not make reimbursement for a service that is a not covered service for Medicare.

(d) Clients who are Qualified Medicare-Medicaid Beneficiaries will have coverage for services that are not covered by Medicare if those services are covered by DMAP.

(5) For clients with Physician Care Organization (PCO) or Prepaid Health Plan (PHP) Coverage, DMAP payment is limited to those services that are not the responsibility of the PCO or PHP. Payment is made at DMAP rates.

(6) Other Insurance:

(a) DMAP pays the maximum allowable payment as described in the Inpatient and Outpatient Rates Calculations, less any third party payments;

(b) DMAP will not make additional reimbursements when a third party payor (other than Medicare) pays an amount equal to or greater than the DMAP reimbursement, or 100 percent of billed charges.

(7) Medically Needy with Spend-Down. Reimbursement is the DMAP maximum allowable payment for covered services less the amount of the spend-down due.

Stat. Auth.: ORS 184.750, 184.770, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 46-1987, f. & ef. 10-1-87; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0056; HR 18-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0640; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-1000; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0220
Services Billed on the Electronic 837I or on the Paper UB-04 and Other Claim Forms

(1) All inpatient and outpatient services provided by the hospital or hospital employees, unless otherwise specified below, are billed on the electronic 837I (837 Institutional) or on the paper CMS 1450 (UB-04) claim form.

(2) Professional staff and other providers: Services provided by other providers or professional staff with whom the hospital has a contract or agreement regarding provision of services and whom the hospital reimburses a salary or a fee are billed on the electronic 837I or paper CMS 1450 (UB-04) along with other inpatient or outpatient charges if such costs are reported on the hospital's Medicare Cost Report as a hospital cost.

(3) Residents and medical students: Professional services provided by residents or medical students serving in the hospital as residents or students at the time services are provided are reimbursed by the Division of Medical Assistance Programs (DMAP) through graduate medical education, for the hospitals that qualify (See OAR 410-125-0141) for payments and may not be billed on the electronic 837I or paper CMS 1450 (UB-04).

(4) Diagnostic and similar services provided by another provider or facility outside the hospital: When diagnostic or short-term services are provided to an inpatient by another provider or facility because the admitting hospital does not have the equipment or facilities to provide all services required and the patient is returned within 24 hours to the admitting hospital, the admitting hospital should add the following charges to the inpatient electronic 837I or paper CMS 1450 (UB-04) claim:

(a) Charges from the other provider or hospital under the appropriate Revenue Code. The admitting hospital is responsible for reimbursing the other provider or hospital. DMAP will not reimburse the other provider or hospital; and

(b) Charges for transportation to the other facility or provider. These must be billed under Revenue Code 542. No prior authorization of the transport is required. The hospital will arrange for the transport and pay the transportation provider for the transport. DMAP will not reimburse the transportation provider. This is the only instance in which transportation charges can be billed on the electronic 837I or paper CMS 1450 (UB-04).

(5) Orthotics, prosthetics, durable medical equipment and implants:

(a) When a provider of orthotic or prosthetic devices provides services or materials to an inpatient through an agreement or arrangement with the hospital, the cost of those services will be billed by the hospital on the electronic 837I or the paper CMS 1450 (UB-04), along with all other inpatient services. The hospital is responsible for reimbursing the provider. DMAP will not reimburse the provider;

(b) Wheelchairs provided to the client for the client's use after discharge from the hospital may be billed separately by the Durable Medical Equipment supplier or by the hospital if the hospital is the supplier.

(6) Pharmaceutical and Home Parenteral/ Enteral Services: All hospital pharmaceutical charges must be billed on the electronic 837I or paper UB-04, except home parenteral and enteral services and medications provided to patients who are in nursing homes:

(a) Home parenteral and enteral services, including home hyperalimentation, Home IV Antibiotics, home IV analgesics, home enteral therapy, home IV chemotherapy, home IV hydrational fluids, and other home IV drugs, require prior authorization and must be billed on the Pharmacy Invoice Form in accordance with the rules in the Home Enteral/Parenteral rules (chapter 410 division 148);

(b) Medications provided to clients who are in nursing homes must be billed on the Pharmacy Invoice Form in accordance with the rules in the Pharmaceutical Services rules (chapter 410 division 121).

(7) Dental services: Dental services provided by hospitals are billed on the electronic 837I or paper CMS 1450 (UB-04). Reimbursement for dental services provided by hospitals is restricted to those identified in the Dental Services rules (chapter 410 division 123) as covered services.

(8) End-stage renal dialysis facilities: Hospitals providing end-stage renal dialysis and free-standing end-stage renal dialysis facilities will bill on the electronic 837I or paper CMS 1450 (UB-04) as described in these rules and instructions and will be reimbursed at the hospital's interim rate.

(9) Maternity case management:

(a) Hospital clinics may serve as maternity case managers for pregnant clients. The Medical-Surgical rules (chapter 410 division 130) contain information on the scope of services, definition of program terms, procedure codes, and provider qualifications. These services are billed by hospitals on the electronic 837I or paper CMS 1450 (UB-04); and

(b) Providers must bill using Revenue Code 569.

(10) Home health care services. Hospitals that operate home health care services must obtain a separate provider number and bill for these services in accordance with the Home Health Care Services rules (chapter 410 division 127).

(11) Hospital operated air and ground ambulance services. A hospital which operates an air or ground ambulance service may apply to DMAP for a provider number as an air or ground ambulance provider. If costs for staff and equipment are reported on the Medicare Cost Report, these costs must be identifiable. DMAP will remove these costs from the Medicare Cost Report in calculating the hospital's cost-to-charge ratio for outpatient services. These services are billed on the electronic 837P (837 Professional) claim form or the paper CMS-1500 in accordance with the rules and restrictions contained in the Medical Transportation rules (chapter 410 division 136).

(12) Supervising physicians providing services in a teaching setting:

(a) Services provided on an inpatient or outpatient basis by physicians who are on the faculty of teaching hospitals may be billed on the electronic 837I or paper CMS 1450 (UB-04) with other inpatient or outpatient charges only when:

(A) The physician is serving as an employee of the hospital, or receives reimbursement from the hospital for provision of services, during the period of time when services are provided; and

(B) The hospital does not report these services as a direct medical education cost on the Medicare and DMAP cost report.

(b) The services of supervising faculty physicians are not to be billed to DMAP on either the electronic 837P, the paper CMS-1500 or the electronic 837I or paper CMS 1450 (UB-04)if the hospital elects to report the cost of these professional services as a direct medical education cost on the Medicare and DMAP cost report; and

(c) The services of supervising faculty physicians are billed on the electronic 837P or the paper CMS-1500 if the physician is serving in a private capacity during the period of time when services are provided, i.e., the physician is receiving no reimbursement from the hospital for the period of time during which services are provided. Refer to the Medical-Surgical Services rules (chapter 410 division 130) or additional information on billing on the electronic 837P or the paper CMS-1500.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 414.019, 414.025 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 44-1985, f. & ef. 7-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0055, 461-015-0130, 461-015-0135; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0260, 461-015-0290, 461-015-0300, 461-015-0310, 461-015-0320, 461-015-0420, 461-015-0430; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0280, 410-125-0300, 410-125-0320, 410-125-0340, 410-125-0540 & 410-125-0560; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 13-2005, f. 3-11-05, cert. ef. 4-1-05; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0360
Definitions and Billing Requirements

(1) Total days on an inpatient claim must equal the number of accommodation days. Do not count the day of discharge when calculating the number of accommodation days.

(2) Inpatient services are services to patients who typically are admitted to the hospital before midnight and listed on the following day's census, with the following exceptions:

(a) A patient admitted and transferred to another acute care hospital on the same day is considered an inpatient;

(b) A patient who expires on the day of admission is an inpatient; and

(c) Births.

(3) Outpatient services:

(a) Outpatient services are services to patients who are treated and released the same day;

(b) Outpatient services also include services provided prior to midnight and continuing into the next day if the patient was admitted for ambulatory surgery, admitted to a birthing center, a treatment or observation room, or a short term stay bed;

(c) Outpatient observation services are services provided by a hospital, including the use of a bed and periodic monitoring by hospital nursing or other staff for the purpose of evaluation of a patient's medical condition. A maximum of 48 hours of outpatient observation will be reimbursed. An outpatient observation stay that exceeds 48 hours must be billed as inpatient; and

(d) Outpatient observation services do not include the following:

(A) Services provided for the convenience of the patient, patient's family or physician but which are not medically necessary;

(B) Standard recovery period; and

(C) Routine preparation services and recovery for diagnostic services provided in a hospital outpatient department.

(4) Outpatient and inpatient services provided on the same day: If a patient receives services in the emergency room or in any outpatient setting and is admitted to an acute care bed in the same hospital on the same day, combine the emergency room and other outpatient charges related to that admission with the inpatient charges. Bill on a single UB-04 for both inpatient and outpatient services provided under these circumstances:

(a) If on the day of discharge, the client uses outpatient services at the same hospital, these must be billed on the UB-04 along with other inpatient charges, regardless of the type of service provided or the diagnosis of the client. Prescription medications provided to a patient being discharged from the hospital may be billed separately as outpatient Take Home Drugs if the patient receives more than a three-day supply.

(b) Inpatient and outpatient services provided to a client on the same day by two different hospitals will be reimbursed separately. Each hospital will bill for the services provided by that hospital.

(5) Outpatient procedures which result in an inpatient admission: If, during the course of an outpatient procedure, an emergency develops requiring an inpatient stay, place a "1" in the Type of Admission field. The principal diagnosis should be the condition or complication that caused the admission. Bill charges for the outpatient and inpatient services together.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 414.019, 414.025, 414.065 & 414.743
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 37-1983 (Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0055; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0330, 461-015-0340 & 461-015-0380; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0380 & 410-125-0460; HR 22-1993 (Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0400
Discharge

(1) A discharge from a hospital is the formal release of a patient to home, to another facility, such as an intermediate care facility or nursing home, to a home health care agency, or to another provider of health care services.

(2) For services beginning January 1, 1993, and later, the transfer of a patient from acute care to a distinct part physical rehabilitation unit (i.e., a unit exempt from the Medicare Prospective Payment System) within the same hospital will be considered a discharge. The admission to the rehabilitation unit is billed separately. All other transfers occurring within a hospital, including transfers to Medicare PPS-exempt psychiatric units, will not be considered discharges and all charges for services must be submitted on a single UB-04 billing for the admission.

(3) Transfer from a hospital occurs when an individual is formally released to another acute care hospital, to a skilled nursing facility, or an intermediate care facility. When a physician sends a patient directly to another hospital for further inpatient care, the discharge should be billed as a transfer, regardless of the mode of transportation.

(4) When the Division of Medical Assistance Programs (DMAP) receives claims from two hospitals for the same patient, and the date of discharge from one hospital is the same as the date of admission to the other, DMAP will assume that a transfer has occurred. DMAP will change the discharge status code on the first claim to 02 (Transferred to Another Acute Care Facility), automatically generating an adjustment if the claim has already been adjudicated, unless discharge status on the claim is already 02 (Transfer) or 07 (Discharge AMA). If it is believed that DMAP made an error in assigning Discharge Status code 02 to a claim, the hospital may submit an Adjustment Request along with supporting documentation from the medical record.

(5) A transfer between units within a hospital is not a transfer for billing purposes, except in the case of transfers to distinct part physical rehabilitation units. Note that transfers in the other direction, from rehabil-

itative care to acute care, are not considered discharges from the rehabilitation unit unless the stay in the acute setting exceeds seven days. Stays of seven days or less in the acute care setting should not be billed separately.

(6) Some transfers, including transfers to distinct part rehabilitation units, require prior authorization.

Stat. Auth.: ORS 414.019, 414.025, 414.065 & 414.743
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0600
Non-Contiguous Out-of-State Hospital Services

(1) Non-contiguous out-of-state hospitals are those hospitals located more than 75 miles from the Oregon border.

(2) The hospital must be enrolled as a provider with Oregon Medical Assistance Programs to receive payment. Contact the Division of Medical Assistance Programs (DMAP) for information on enrollment.

(3) Billings are sent to DMAP.

(4) When the service provided is emergent or urgent, no prior authorization is required. The claim should be sent to DMAP along with documentation supporting the emergent or urgent requirement for treatment.

(5) In a non-emergency situation, prior authorization is required for all services. Contact: DMAP.

(6) Claims must be billed on the electronic 837I or on a paper CMS 1450 (UB-04), unless other arrangements are made for billing through the DMAP.

Stat. Auth.: ORS 414.019, 414.025 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0450; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0640
Third Party Payers — Other Resources, Client Responsibility and Liability

(1) Medicare: Do not send claims to the Division of Medical Assistance Programs (DMAP) until they have been billed to and adjudicated by Medicare:

(a) Exception: Take home drugs and other services, which are not covered by Medicare, may be billed directly to DMAP without billing Medicare first;

(b) See: billing instructions in the Hospital Services Supplemental Information on the DMAP website for additional information on billing Medicare claims.

(2) Other Insurance. With the exception of services described in the General Rules, bill all other insurance first before billing DMAP. Report the payments made by the other insurers.

(3) Motor vehicle accident fund:

(a) Enter 01 (Auto Accident) in the Occurrence Code Block and give the date of the accident;

(b) For all other clients, bill all other resources before billing DMAP. Do not bill the Motor Vehicle Accident Fund.

(4) Employment Related Injuries: Enter 04 (Employment Related Accident) in the Occurrence Code Block and give the date of the injury.

(5) Liability:

(a) Liability refers to insurance that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under state "wrongful death" statutes that provide payment for medical damages;

(b) The provider may bill the insurer for liability prior to billing DMAP. The provider may not bill both DMAP and the insurer;

(c) The provider may bill DMAP after receiving a payment denial from the insurer; however, the DMAP billing must be within 12 months of date of service. Payment accepted from DMAP is payment in full;

(d) The provider may bill DMAP without billing the liability insurer. However, payment accepted from DMAP is payment in full. The payment made by DMAP may not later be returned in order to pursue payment from the liability insurer. When the provider bills DMAP, the provider agrees not to place any lien against the client's liability settlement;

(e) The provider has 12 months from the date of service to bill DMAP. No payment will be made by DMAP under any circumstances once the one year limit has passed if no billing has been received within that time.

(6) Adoption Agreements. Adopting parents and/or an adoption agency may be considered a prior resource. In some instances, DMAP makes reimbursement to hospitals and other providers for services provided to a mother whose baby is to be adopted. DMAP may also make reimbursement for services provided to the infant. Some adoption agreements, however, stipulate that the adoptive parents will make payment for part or all of the medical costs for the mother and/or the child. In these instances, the adoptive parent(s) and/or agency are a third party resource and should be billed before billing DMAP for this service.

(7) Veteran's Administration Benefits:

(a) Some clients have limited benefits through the Veterans' Administration. Hospitals must bill the Veterans' Administration for VA covered services before billing DMAP;

(b) The Veterans' Administration requires notification within 72 hours of an emergency admission to a non-VA hospital.

(8) Trust Funds. Some individuals will have trust funds that will pay for medical expenses. Occasionally a special trust fund will be set up to pay for extraordinary medical expenses, such as a transplant. These, and other trusts which pay medical expenses, are considered a prior resource. Bill the trust fund prior to billing DMAP for services that are covered by the trust fund.

(9) Billing the Client. A provider may bill the client or any financially responsible relative or representative of that individual only as allowed in OAR 410-120-1280.

(10) The hospital may not bill the client under the following circumstances:

(a) For services which are covered by DMAP;

(b) For services for which DMAP has made payment;

(c) For services billed to DMAP for which no payment is made because third party reimbursement exceeds the DMAP maximum allowed amount;

(d) For any deductible, coinsurance or co-pay amount;

(e) For services for which DMAP has denied payment to the hospital as a result of one of the following:

(A) The hospital failed to supply the correct information to DMAP to allow processing of the claim in a timely manner as described in these rules and the General Rules;

(B) The hospital failed to obtain prior authorization as described in these rules;

(C) The service provided by the hospital was determined by or DMAP not to be medically appropriate; or

(D) The service provided by the hospital was determined by the QIO not to be medically appropriate, necessary, or reasonable.

Stat. Auth.: ORS 414.019, 414.025 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 60-1982, f. & ef. 7-1-82; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 46-1987, f. & ef. 10-1-87; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0080 & 461-015-0126; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0470 & 461-015-0480; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0660; HR 22-1992, f. 7-31-92, cert. ef. 8-1-92; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-0720
Adjustment Requests

(1) Most overpayment and under-payments are resolved through the adjustment process. Only paid claims can be adjusted. If no payment was made, the claim must be submitted using a CMS 1450 (UB-04) for processing. All overpayments must be reported. Overpayments will be taken from future payments.

(2) Much of the information required on the Adjustment Request Form is printed on the paper Remittance Advice or the electronic 835. Documentation may be submitted to support the request. Attach a copy of the claim and paper Remittance Advice or the electronic 835 to the Adjustment Request (DMAP 1036). Adjustment requests must be submitted in writing to the Division of Medical Assistance Programs (DMAP).

(3) Complete adjustment instructions can be found in Hospital Services Supplemental Information.

[Publications: Publications referenced are available from the agency.]
Stat Auth.: ORS 184.750, 184.770, 411 & 414
Stats. Implemented: ORS 414.065
Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89; HR 21 1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0510; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef 1-4-91; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-125-1070
Type A and Type B Hospitals

(1) Type A and Type B hospitals must submit the following information to the Division of Medical Assistance Programs (DMAP):

(a) The aggregate percent increase in patient charges and the effective date of the increase within 30 days following the end of their fiscal year for increases in the preceding year. Aggregate percent increase in patient charges is defined as the percent increase in patient revenues due to charge increases; and

(b) The amount of payment received by the hospital, from each DMAP contracted managed care plan and third-party payers, for inpatient and outpatient hospital services provided to managed care members, within the hospital's fiscal year.

(2) When a hospital is contracted with a Prepaid Health Plan (PHP), within thirty (30) days of the DMAP request the hospital will supply DMAP the following information:

(a) The name of the contracting PHP; and

(b) The dates for which the contract will be effective; and

(c) The contracted services and reimbursement rates.

(3) The hospital and PHP must coordinate payment information to verify and return the PHP payment data file sent by DMAP within ninety (90) days from date the data file is received by the hospital.

(4) Failure to supply the requested information within timelines stated may result in a discretionary sanction or fine (see OAR 410-120-1440). No sanction or fine will be imposed if DMAP determines, at its sole discretion, that the hospital was unable to coordinate payment information with the PHP through no fault of the hospital's own.

Stat. Auth.: ORS 414.019, 414.025, 414.065, 414.727 & 414.728
Stats. Implemented: ORS 414.065
Hist.: OMAP 12-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2005, f. 6-20-05, cert. ef. 7-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-127-0080
Prior Authorization

(1) Home health providers must obtain prior authorization (PA) for services as specified in rule.

(2) Providers must request PA as follows (see the Home Health Supplemental Information booklet for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (DMAP).

(3) For services requiring authorization, providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request will be honored as the request date. It is the provider's responsibility to obtain payment authorization.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065
Stats. Implemented: ORS 414.065
Hist.: PWC 682, f. 7-19-74, ef. 8-11-74; PWC 798, f. & ef. 6-1-76; AFS 8-1979, f. 3-30-79, ef. 4-1-79; Renumbered from 461-019-0410 by Chapter 784, OL 1981 & AFS 69-1981, f. 9-30-81, ef. 10-1-81; SSD 4-1983, f. 5-4-83, ef. 5-5-83; SSD 6-1986, f. & ef. 4-24-86; SSD 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 28-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 411-075-0005; HR 12-1991, f. & cert. ef. 3-1-91; HR 30-1992(Temp), f. & cert. ef. 9-25-92; HR 2-1993, f. 2-19-93, cert. ef. 2-20-93; HR 15-1995, f. & cert. ef. 8-1-95; OMAP 15-1999, f. & cert. ef. 4-1-99; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; OMAP 91-2003, f. 12-30-03 cert. ef. 1-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-129-0080
Prior Authorization

(1) Speech-Language Pathology, Audiology and hearing aid providers must obtain prior authorization (PA) for services as specified in rule.

(2) Providers must request PA as follows (see the Speech-Language Pathology, Audiology and Hearing Aid Services Supplemental Information booklet for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (DMAP).

(3) For services requiring authorization, providers must contact the responsible unit for authorization within five working days following initiation or continuation of services. The FAX or postmark date on the request will be honored as the request date. It is the provider's responsibility to obtain payment authorization.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409.010, 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1982, f. 2-16-82, ef. 3-1-82; AFS 49-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; AFS 67-1985, f. 11-19-85, ef. 12-1-85; AFS 7-1988, f. & cert. ef. 2-1-88; HR 5-1991, f. 1-18-91, cert. ef. 2-1-91, Renumbered from 461-021-0310; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 38-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 85-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 57-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 40-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-130-0180
Drugs

(1) The Division of Medical Assistance Programs' (DMAP) Medical-Surgical Services Program reimburses practitioners for drugs only when administered by the practitioner in the office, clinic or home settings. DMAP does not reimburse practitioners for drugs that are self-administered by the client, EXCEPT contraceptives such as birth control pills, spermicides and patches:

(a) Use an appropriate CPT therapeutic injection code for administration of injections;

(b) Use an appropriate HCPCS code for the specific drug. Do not bill for drugs under code 99070;

(c) When billing unclassified drugs and other drug codes listed below, bill at acquisition cost (purchase price plus postage) and use the following codes:

(A) J1815-J1817;
(B) J3490;
(C) J3950
(D) J7699;
(E) J7799;
(F) J8499;
(G) J8999
(H) J9999;
(I) Include the name of the drug, NDC number, and dosage.

(d) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(2) DMAP requires both the NDC number and HCPCS codes on all claim forms.

(3) For Not Covered/Bundled services or Prior Authorization Requirements refer to OAR 410-130-0200 Table 130-0200-1 and 410-130-0220 Table 130-0220-1.

(4) Not covered services and supplies include:

(a) Laetrile;

(b) Home pregnancy kits and products designed to promote fertility;

(c) DMSO, except for instillation into the urinary bladder for symptomatic relief of interstitial cystitis;

(d) Infertility drugs;

(e) Sodium hyaluronate and Synvisc ;

(f) Omalizumab (Xolair);

(g) Idursulfase (Elaprase).

(5) Follow criteria outlined in the following:

(a) Billing Requirements — OAR 410-121-0150;

(b) Brand Name Pharmaceuticals — OAR 410-121-0155;

(c) Prior Authorization Procedures — OAR 410-121-0060;

(d) Drugs and Products Requiring Prior Authorization — OAR 410-121-0040;

(e) Drug Use Review — OAR 410-121-0100;

(f) Participation in Medicaid's Drug Rebate Program — OAR 410-121-0157.

(A) DMAP cannot reimburse providers for a drug unless the drug manufacturer has signed an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicaid Drug Rebate Program.

(B) To verify that a drug manufacturer participates in the Medicaid Drug Rebate Program, visit the CMS website below to verify that the first five digits of the NDC number (labeler code) are listed as a participating drug company: http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

(6) Clozapine Therapy:

(a) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications;

(b) Clozapine Supervision is the management and record keeping of Clozapine dispensing as required by the manufacturer of Clozapine:

(A) Providers billing for Clozapine supervision must document all of the following:

(i) Exact date and results of White Blood Counts (WBC), upon initiation of therapy and at recommended intervals per the drug labeling;

(ii) Notations of current dosage and change in dosage;

(iii) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;

(iv) Dates provider sent required information to manufacturer.

(B) Only one provider (either a physician or pharmacist) may bill per week per client;

(C) Limited to five units per 30 days per client;

(D) Use code 90862 with modifier TC to bill for Clozapine supervision.

[ED. NOTE: Tables & forms referenced are available from the agency.]

Stat. Auth.: ORS 409.110, 409.050, 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90, Renumbered from 461-014-0620; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; HR 10-1996, f. 5-31-96, cert. ef. 6-1-96; HR 4-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 3-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 13-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 33-2002, f. & cert. ef. 8-1-02; OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 52-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 26-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 5-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 20-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-132-0100

Prior Authorization

(1) Private duty nursing providers must obtain prior authorization (PA) for all services.

(2) Providers must request PA as follows (see the Private Duty Nursing Services Supplemental Information booklet for contact information):

(a) For Medically Fragile Children's Unit (MFCU) clients, from the Department of Human Services (DHS) MFCU;

(b) For clients enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program, from the MCM contractor;

(c) For clients enrolled in a prepaid health plan (PHP), from the PHP;

(d) For all other clients, from the Division of Medical Assistance Programs (DMAP).

Stat. Auth.: ORS 409.010, 409.050, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: PWC 681, f. & ef. 7-17-74; PWC 759, f. 9-5-75, ef. 10-1-75; PWC 799, f. & ef. 6-1-76; AFS 43-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 9-1983, f. 2-17-83, ef. 3-2-83; AFS 14-1984(Temp), f. & ef. 4-2-84; AFS 22-1984(Temp), f. & ef. 5-1-84; AFS 40-1984, f. 9-18-84, ef. 10-1-84; HR 9-1991, f. 1-28-91, cert. ef. 3-1-91, Renumbered from 461-019-0210; HR 6-1997, f. & cert. ef. 2-19-97; OMAP 7-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 93-2003, f. 12-30-03 cert. ef. 1-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-136-0240

Secured Transports

(1) The Division of Medical Assistance Programs (DMAP) will reimburse for secured transports when the following conditions are met:

(a) The provider must be able to transport children and adults who are in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse;

(b) DMAP must recognize the provider as a provider of secured transports. This requires written advance notice to DMAP (prior to or at the time of enrollment) that the provider has met the requirements of the secure transport provider protocol as established in OARs 309-033-0200 through 309-033-0970;

(c) When medically appropriate (to administer medications, etc. in-route) or in those cases where legal requirements must be satisfied (i.e., a parent, legal guardian or escort is required during transport), one additional person will be allowed to escort at no additional charge to DMAP. The DMAP reimbursement is considered to be payment in full for the transport.

(2) The provider must submit a copy of all rates charged to the general public to DMAP, Provider Enrollment, at the time of enrollment. The provider must submit any changes to those rates to DMAP in writing within 30 days of the change. The notification must indicate the rate changes and effective date. If subsequent review by DMAP discloses that the written notice is not accurate, DMAP may recoup payments.

(3) DMAP will authorize reimbursement on an individual client basis in keeping with the DMAP rules regarding level of transport needed, eligibility, cost effectiveness and medical appropriateness. In the event the provider gave transport on an emergent basis, DMAP will authorize when appropriate after provision of service.

(4) DMAP will not reimburse for any secured transport provided to a client in the custody of or under the legal jurisdiction of any law enforcement agency or institution. DMAP will not reimburse for any transport resulting from a court ordered placement, any transport to/from a court hearing, or to/from a commitment hearing.

(5) The DMAP Medical Care identification (ID) does not guarantee eligibility. The Provider is responsible for verifying client eligibility prior to providing services. This includes determining if DMAP or a managed care plan is responsible for reimbursement. The Provider assumes full financial risk in serving a person who is not confirmed eligible by DMAP as eligible for the service provided on the date(s) of service.

(6) Refer to OAR 410-120-1140 Verification of Eligibility (also see the DMAP General Rules Supplemental Information guide for instructions). It is the responsibility of the Provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service for the service provided and whether a managed care plan or DMAP is responsible for reimbursement. The Provider assumes full financial risk in serving a person not identified as eligible or not confirmed by DMAP as eligible for the service provided on the date(s) of service. The Client's Medical Care Identification is confirmation of eligibility for medical services, subject to the limitations contained in these General Rules and the appropriate individual Provider rules.

(7) The DMAP Medical Care IDMedicaid member identification care is printed on paper and is the size of a business card.a permanent plastic ID. The ID lists the client's name, prime number and the date the ID was issued.The card can be used for accessing the electronic verification system to verify a clients eligibility before providing services.The purpose of the ID card is to give sufficient information to verify eligibility and is not a guarantee of eligibility itself. Providers need a Personal Identification Number (PIN) to access the secure web portal or EVS.

(8) The provider must transport the client to a Title XIX eligible or enrolled facility recognized by DMAP as having the ability to treat the immediate medical, mental and/or emotional needs of a client in crisis.

(9) DMAP must assume that a client being returned to place of residence is no longer in crisis or at immediate risk of harming him/herself or others, and is, therefore, able to utilize non-secured transport. In the event a secured transport is medically appropriate to return a client to place of residence, the branch must obtain written documentation stating the circumstances and the treating physician must sign the documentation. The branch must retain the documentation in the branch record (along with a copy of the order) for DMAP review.

Stat. Auth.: ORS 409.010, 409.050, 409.065 & 409.110

Stats. Implemented: ORS 414.065

Hist.: HR 28-1994, f. & cert. ef. 9-1-94; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-136-0260

Neonatal Intensive Care Transport

(1) The Division of Medical Assistance Programs (DMAP) will make reimbursement for a neonatal intensive care transport when the conditions listed below are met and the transport has been prior authorized by the Department of Human Services (DHS) branch/DMAP and meets all other eligibility requirements.

(2) The DMAP Medical Care identification (ID) does not guarantee eligibility. The Provider is responsible for verifying client eligibility prior to providing services. This includes determining if DMAP or a managed care plan is responsible for reimbursement. The Provider assumes full financial risk in serving a person who is not confirmed eligible by DMAP as eligible for the service provided on the date(s) of service.

(3) Refer to OAR 410-120-1140 Verification of Eligibility (also see the DMAP General Rules Supplemental Information guide for instructions).

(4) The DMAP Medical Care ID is printed on paper and is the size of a business card. The ID lists the client's name, prime number and the date the ID was issued.

(5) The provider must be recognized by DMAP as a provider of neonatal intensive care transports. This requires advance written notice to DMAP that the provider has met each of the following conditions:

(a) The conveyance vehicle must:

(A) Have the ability to generate 110 volts for a minimum of two hours;

(B) Carry two size 80 (or equivalent) oxygen tanks;

(C) Have lock-down for isolette;

(D) Have the ability to regulate oxygen tanks at 50 PSI;

(E) Have sufficient capacity to transport isolette and four team members;

(F) Have immobilized compressed air and oxygen.

(a) The transport destination point must be recognized by DMAP as a tertiary neonatal intensive care hospital unit.

(6) If subsequent review by DMAP discloses that the written notice is not accurate, payments may be recouped.

Stat. Auth.: ORS 409.010, 409.050, 409.065, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 54-1981, f. 8-19-81, cert. ef. 10-1-81; AFS 5-1984, f. & cert. ef. 2-3-84; AFS 30-1985, f. 5-30-85, cert. ef. 7-1-85; AFS 64-1986, f. 9-8-86, cert. ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93, Renumbered from 461-020-0032; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-136-0300
Authorization

(1) For the purposes of the Administrative Rules governing provision of Medical Transportation Services, authorization is defined to be authorization in advance of the service being accessed or provided.

(2) Retroactive authorization for medical transportation will be made only under the following circumstances:

(a) "After hours" transports to obtain urgent medical care. Medical appropriateness will be determined by branch or the Division of Medical Assistance Programs (DMAP) review;

(b) Secured transports provided to clients in crisis on weekends, holidays or after normal branch office hours. Medical appropriateness for secured transports will be determined by branch/DMAP review to ensure authorization is given and/or reimbursement made only for those transports that meet criteria set forth in 410-136-0240.

(3) Authorization of payment is required for the following:

(a) Non-emergency ambulance;

(b) Non-emergency air ambulance;

(c) Stretcher car (including stretcher car services provided by an ambulance);

(d) Wheelchair car/van;

(e) Taxi;

(f) Secured transport (including those arranged for and/or provided outside of normal branch office hours);

(g) Client reimbursed transportation (including medically appropriate meals, lodging, attendant);

(h) Fixed route public bus systems;

(i) All special/bid transports.

(4) Authorization will be made for the services identified above when:

(a) The transport is medically appropriate considering the medical condition of the client;

(b) The destination is to a medical service covered under the Medical Assistance program;

(c) The client medical transportation eligibility screening indicates the client has no resources or that no alternative resource is available to provide appropriate transportation without cost or at a lesser cost to DMAP;

(d) The transport is the least expensive medically appropriate mode of conveyance available considering the medical condition of the client.

(5) The DMAP Medical Care identification (ID) does not guarantee eligibility. The Provider is responsible for verifying client eligibility prior to providing services. This includes determining if DMAP or a managed care plan is responsible for reimbursement. The Provider assumes full financial risk in serving a person who is not confirmed eligible by DMAP as eligible for the service provided on the date(s) of service.

(6) Refer to OAR 410-120-1140 Verification of Eligibility (also see the DMAP General Rules Supplemental Information guide for instructions). It is the responsibility of the Provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service for the service provided and whether a managed care plan or DMAP is responsible for reimbursement. The Provider assumes full financial risk in serving a person not identified as eligible or not confirmed by DMAP as eligible for the service provided on the date(s) of service. The Client's Medical Care Identification is confirmation of eligibility for medical services, subject to the limitations contained in these General Rules and the appropriate individual Provider rules.

(7) The DMAP Medical Care IDMedicaid member identification care is printed on paper and is the size of a business card.a permanent plastic ID. The ID lists the client's name, prime number and the date the ID was issued.The card can be used for accessing the electronic verification system to verify a clients eligibility before providing services.The purpose of the ID card is to give sufficient information to verify eligibility and is not a guarantee of eligibility itself. Providers need a Personal Identification Number (PIN) to access the secure web portal or EVS.

(8) Authorization must be obtained in advance of service provision. Branch telephone numbers can be found in the DMAP General Rules. A provider authorized to provide transportation will receive a completed Medical Transportation Order (DMAP 405T or DMAP 406). All transportation orders, including any equivalent, must contain the following:

(a) Provider name or number;

(b) Client name and ID number;

(c) Pickup address;

(d) Destination name and address;

(e) Second (or more) destination name and address;

(f) Appointment date and time;

(g) Trip information, e.g., special client requirements;

(h) Mode of transportation, e.g., taxi;

(i) 1 way, round trip, 3-way;

(j) Current date;

(k) Branch number;

(l) Worker/clerk ID;

(m) Dollar amount authorized (if special/secured transport).

(8) If the Medical Transportation Order indicates 'on-going' transports have been authorized, the following information is also required:

(a) Begin and end dates;

(b) Appointment time(s);

(c) Days of week.

(9) Additional information identifying any special needs of the individual client should also be indicated on the order in the "Comments" section. If the order is for a secured transport the name and telephone number of the medical professional requesting the transport, as well as information regarding the nature of the crisis is required.

(10) Authorization for non-emergency services after service provided:

(a) Occasionally a client may contact the provider directly "after hours" (i.e., when the branch office is closed) and order an urgent care medical transport. Only in this case, is it appropriate for the provider to initiate the Medical Transportation Order. All required information (except the branch number, worker/clerk ID and dollars authorized) must be completed by the provider before submitting the order to the branch for authorization. The provider must also indicate on the order the time and day of week the client called. The partially completed authorization order must be received at the appropriate branch office within 30 calendar days following provision of the service;

(b) After branch review (and if approved) the branch will complete the branch number, dollars authorized (if special or secured transport) worker/clerk ID and current date, and return the order to the provider within 30 calendar days. The provider may not bill DMAP until the final approved order is received;

(c) A provider requesting branch authorization for "after hours" rides may be at risk of non-payment if the branch determines the ride was not for the purpose of obtaining urgent medical services covered under the Medical Assistance Programs.

(11) For client reimbursed transportation and fixed route public bus systems, the client must contact the branch office in advance of the travel. Once the transportation has been authorized, money for bus tickets/passes or the actual bus tickets/passes will be disbursed at the branch level. If a client is requesting mileage reimbursement, the branch is to provide assistance using the current guidelines and methodologies as indicated in the DHS Worker Guide.

(12) Authorization will not be made nor reimbursement provided:

(a) To return a client from any foreign country to any location within the United States even though the medical care needed by the client is not available in the foreign country;

(b) To return a client to Oregon from another state or provide mileage, meals or lodging to the client, unless the client was in the other state for the purpose of obtaining services or treatment approved by DMAP or approved by the client's Prepaid Health Plan with subsequent DMAP approval for the travel;

(c) To or from court ordered services.

(13) Authorization does not guarantee reimbursement:

(a) Check eligibility on the date of service by calling Automated Information System (AIS) or requesting a copy of the client's Medical Care Identification;

(b) Ensure the service to be provided is currently a medical service covered under the Medical Assistance program;

(c) Ensure the claim is for the actual services and/or number of services provided.

(d) Per OAR 410-136-0280, for all claims submitted to DMAP, the provider record must contain completed documentation pertinent to the service provided.

(14) DMAP may not be billed for services and/or dollars in excess of the number of services and/or dollars authorized.

Stat. Auth.: ORS 409.010, 409.050, 409.065 & 409.110
Stats. Implemented: ORS 414.065
Hist.: AFS 7-1982, f. 1-22-82, ef. 2-1-82; AFS 21-1982(Temp), f. & ef. 3-23-82; AFS 92-1982, f. & ef. 10-8-82; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93, Renumbered from 461-020-0021; HR 30-1993, f. & cert. ef. 10-1-93; HR 28-1994, f. & cert. ef. 9-1-94; HR 9-1995, f. 3-31-95, cert. ef. 4-1-95; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; HR 10-1997, f. 3-28-97, cert. ef. 4-1-97; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 55-2002, f. & cert. ef. 10-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-141-0000
Definitions

(1) Action — In the case of a Prepaid Health Plan (PHP):

(a) The denial or limited authorization of a requested Covered Service, including the type or level of service;

(b) The reduction, suspension or termination of a previously authorized service;

(c) The denial in whole or in part, of payment for a service;

(d) The failure to provide services in a timely manner, as defined by the Division of Medical Assistance Programs (DMAP);

(e) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For a DMAP Member in a single Fully Capitated Health Plan (FCHP) or Mental Health Organization (MHO) Service Area, the denial of a request to obtain Covered Services outside of the FCHP or MHO's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(2) Addictions and Mental Health Division (AMH) — The DHS office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.

(3) Administrative Hearing — A Department of Human Services (DHS) hearing related to an Action, including a denial, reduction, or termination of benefits that is held when requested by the Oregon Health Plan (OHP) Client or DMAP Member. A hearing may also be held when requested by an OHP Client or DMAP Member who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(4) Advance Directive —A form that allows a person to have another person make health care decisions when he/she cannot make decisions and tells a doctor if the person does not want any life sustaining help if he/she is near death.

(5) Aged — Individuals who meet eligibility criteria established by DHS Seniors and People with Disabilities Division (SPD) for receipt of medical assistance because of age.

(6) Americans with Disabilities Act (ADA) — Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(7) Alternative Care Settings — Sites or groups of Practitioners that provide care to DMAP Members under contract with the DMAP Member's PHP. Alternative Care Settings include but are not limited to urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, and outpatient surgicenters.

(8) Ancillary Services — Those medical services under the OHP not identified in the definition of a Condition/Treatment Pair, but Medically Appropriate to support a service covered under the OHP Benefit Package. Ancillary Services and limitations are referenced in the General Rules Benefit Packages (410-120-1210), Exclusions (410-120-1200) and applicable individual program rules.

(9) Appeal — A request for review of an Action as defined in this rule.

(10) Automated Voice Response (AVR) — A computer system that provides information on the current eligibility status for clients under the Medical Assistance Program by phone or by Web access.

(11) Blind — Individuals who meet eligibility criteria established by DHS' SPD for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(12) Capitated Services — Those Covered Services that a PHP or Primary Care Manager (PCM) agrees to provide for a Capitation Payment under a DMAP OHP Contract or agreement.

(13) Capitation Payment:

(a) Monthly prepayment to a PHP for the provision of all Capitated Services needed by OHP Clients who are enrolled with the PHP;

(b) Monthly prepayment to a PCM to provide Primary Care Management Services for an OHP Client who is enrolled with the PCM. Payment is made on a per OHP Client, per month basis.

(14) Centers for Medicare and Medicaid Services (CMS) — The federal agency under the Department of Health and Human Services (DHHS), responsible for approving the waiver request to operate the OHP Medicaid Demonstration Project.

(15) CFR — Code of Federal Regulations.

(16) Chemical Dependency Organization (CDO) — a PHP that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the OHP. All Chemical Dependency Services covered under the OHP are covered as Capitated Services by the CDO.

(17) Chemical Dependency Services — Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent Clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

(18) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by DHS' DMAP (see Medical Assistance).

(19) Children Receiving Children, Adults and Families (CAF) Child Welfare or Oregon Youth Authority (OYA) Services — Individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (o), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of CAF, DHS, or OYA who are in placement outside of their homes.

(20) Claim:

(a) A bill for services;

(b) A line item of a service; or

(c) All services for one Client within a bill.

(21) Clinical Record — The Clinical Record includes the medical, dental, or mental health records of an OHP Client or DMAP Member. These records include the PCP's record, the inpatient and outpatient hospital records and the Exceptional Needs Care Coordinator (ENCC), Complaint and Disenrollment for cause records which may reside in the PHP's administrative offices.

(22) Cold Call Marketing — Any unsolicited personal contact by a PHP with a Potential Member for the purpose of Marketing as defined in this rule.

(23) Comfort Care — The provision of medical services or items that give comfort and/or pain relief to an individual who has a Terminal Illness. Comfort care includes the combination of medical and related services designed to make it possible for an individual with Terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort Care includes but is not limited to care provided through a hospice program (see Hospice rules), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort Care includes nutrition, hydration and medication for disabled infants whose life-threatening conditions are not covered under Condition/Treatment Pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 — Patient Self Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness with the intent to prolong life.

(24) Community Mental Health Program (CMHP) — The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the DHS Addictions and Mental Health Division (AMH).

(25) Co-morbid Condition —A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or more other current and existing conditions/diagnoses in the same patient.

(26) Complaint — A DMAP Member's or DMAP Member's Representative's expression of dissatisfaction to a PHP or Participating Provider about any matter other than an Action, as "Action" is defined in this rule.

(27) Community Standard — Typical expectations for access to the health care delivery system in the DMAP Member's or PCM Member's community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, DMAP requires that the health care delivery system available to DMAP Members in PHPs and to PCM Members take into consideration the Community Standard and be adequate to meet the needs of DMAP and PCM Members.

(28) Condition/Treatment Pair — Diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9-CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the DHS AMH Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are referred to in OAR 410-141-0520.

(29) Continuing Treatment Benefit — A benefit for OHP Clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to an OHP Benefit Package that doesn't cover the treatment.

(30) Co-payment — The portion of a Covered Service that a DMAP Member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.

(31) Contract — The Contract between the State of Oregon, acting by and through its DHS, DMAP and an FCHP, Dental Care Organization (DCO), Physician Care Organization (PCO), or a CDO, or between AMH and an MHO for the provision of Covered Services to eligible DMAP Members for a Capitation Payment. Also referred to as a Service Agreement.

(32) Covered Services — Are Medically Appropriate health services that are funded by the Legislature and described in ORS 414.705 to 414.750; OAR 410-120-1210; OAR 410-141-0120; OAR 410-141-0520; and OAR 410-141-0480; except as excluded or limited under OAR 410-141-0500 and rules in Chapter 410, Division 120.

(33) Dentally Appropriate — Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the OHP Member or a Provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a DMAP Member.

(34) Dental Care Organization (DCO) — A PHP that provides and coordinates capitated dental services. All dental services covered under the OHP are covered as Capitated Services by the DCO; no dental services are paid by DMAP on a Fee-for-Service (FFS) basis for OHP Clients enrolled with a DCO Provider.

(35) Dental Case Management Services — Services provided to ensure that eligible DMAP Members obtain dental services including a comprehensive, ongoing assessment of the dental and medical needs related to dental care of the DMAP Member plus the development and implementation of a plan to ensure that eligible DMAP Members obtain Capitated Services.

(36) Dental Emergency Services — Dental services that may include but are not limited to severe tooth pain, unusual swelling of the face or gums, and an avulsed tooth.

(37) Dental Practitioner —A Practitioner who provides dental services to DMAP Members under an agreement with a DCO, or is a FFS Practitioner. Dental Practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.

(38) Department of Human Services (DHS) — The Department or DHS or any of its programs or offices means the Department of Human Services established in ORS Chapter 409, including such divisions, programs and offices as may be established therein. Wherever the former Office of Medical Assistance Programs or OMAP is used in contract or in administrative rule, it shall mean the Division of Medical Assistance Programs (DMAP). Wherever the former Office of Mental Health and Addiction Services or OMHAS is used in contract or in rule, it shall mean the Addictions and Mental Health Division (AMH). Wherever the former Seniors and People with Disabilities or SPD is used in contract or in rule, it shall mean the Seniors and People with Disabilities Division (SPD). Wherever the former Children Adults and Families or CAF is used in contract or rule, it shall mean the Children, Adults and Families Division (CAF). Wherever the former Health Division is used in Contract or in rule, it shall mean the Public Health Division (PHD).

(39) Diagnostic Services — Those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(40) Disabled — Individuals who meet eligibility criteria established by the DHS' SPD for receipt of Medical Assistance because of a disability.

(41) Disenrollment — The act of discharging an OHP Client from a PHP's or PCM's responsibility. After the effective date of Disenrollment an OHP Client is no longer required to obtain Capitated Services from the PHP or PCM, nor be referred by the PHP for Medical Case Managed Services or by the PCM for PCM Case Managed Services.

(42) Division of Medical Assistance Programs (DMAP) — The Office of DHS responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and CHIP. DMAP writes and administers the state Medicaid rules for medical services, contracts with Providers, maintains records of client eligibility and processes and pays DMAP providers.

(43) Emergency Medical Condition — a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

(44) Emergency Services — Covered Services furnished by a Provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(45) Enrollment — OHP Clients, subject to OAR 410-141-0060, become DMAP Members of a PHP or PCM Members of a PCM that contracts with DMAP to provide Capitated Services. An OHP Client's Enrollment with a PHP indicates that the DMAP Member must obtain or be referred by the PHP for all Capitated Services and referred by the PHP for all Medical Case Managed Services subsequent to the effective date of Enrollment. An OHP Client's Enrollment with a PCM indicates that the PCM Member must obtain or be referred by the PCM for preventive and primary care and referred by the PCM for all PCM Case Managed Services subsequent to the effective date of Enrollment.

(46) Enrollment Area — Client Enrollment is based on the Client's residential address and zip code. The address is automatically assigned a county code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the DHS worker that PHPs are in the area.

(47) Enrollment Year — A twelve-month period beginning the first day of the month of Enrollment of the OHP Client in a PHP and, for any subsequent year(s) of continuous Enrollment, beginning that same day in each such year(s). The Enrollment Year of OHP Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(48) End Stage Renal Disease (ESRD) — End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.

(49) Exceptional Needs Care Coordination (ENCC) — A specialized case management service provided by FCHPs to DMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405. ENCC includes:

(a) Early identification of those DMAP Members who are Aged, Blind or Disabled who have disabilities or complex medical needs;

(b) Assistance to ensure timely access to providers and Capitated Services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of Capitated Services and discharge planning; and

(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

(50) Family Health Insurance Assistance Program (FHIAP) — A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the Federal Poverty Level (FPL). FHIAP is funded with federal and states funds through Title XIX, XXI or both.

(51) Family Planning Services — Services for clients of childbearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(52) Fee-for-Service (FFS) Health Care Providers — Health care providers who bill for each service provided and are paid by DMAP for services as described in DMAP provider rules. Certain services are covered but are not provided by PHPs or by PCMs. The client may seek such services from an appropriate FFS Provider. PCMs provide primary care services on a FFS basis and might also refer PCM Members to specialists and other Providers for FFS care. In some parts of the state, the State may not enter into contracts with any managed care Providers. OHP Clients in these areas will receive all services from FFS Providers.

(53) FPL — Federal Poverty Level.

(54) Free-Standing Mental Health Organization (MHO) — The single MHO in each county that provides only mental health services and is not affiliated with an FCHP for that service area. In most cases this "carve-out" MHO is a county CMHP or a consortium of CMHPs, but may be a private behavioral health care company.

(55) Fully Capitated Health Plan (FCHP) — PHPs that contract with DMAP to provide Capitated Services under the OHP. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(56) Fully Dual Eligible — For the purposes of Medicare Part D coverage, Medicare Clients who are also eligible for Medicaid, meeting the income and other eligibility criteria adopted by DHS for full medical assistance coverage, including those not enrolled in a Medicare Part D plan.

(57) Grievance System —The overall system that includes Complaints and Appeals handled at the PHP level and access to the state fair hearing process. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the DMAP Member's rights.

(58) Health Care Professionals — Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: Medical Doctors (including Psychiatrists), Dentists, Osteopathic Physicians, Psychologists, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Medical Assistants, Licensed Physicians Assistants, Qualified Mental Health Professionals (QMHPs), and Qualified Mental Health Associates (QMHAs), Dental Hygienists, Denturists, and Certified Dental Assistants. These professionals may conduct health, mental health or dental assessments of DMAP Members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification.

(59) Health Insurance Portability and Accountability Act (HIPAA) of 1996 — HIPAA is a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(60) Health Maintenance Unit (HMU) —The DMAP unit responsible for adjustments to enrollments, retroactive Disenrollment and Enrollment of newborns.

(61) Health Plan New/Noncategorical Client (HPN) — A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an OHP Client.

(62) Health Services Commission — An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.

(63) Hospice Services — A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

(64) Hospital Hold —A Hospital Hold is a process that allows a hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the OHP due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP if clients become eligible through a Hospital Hold process and are placed in the adults/couples category.

(65) Line Items — Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the OHP Medicaid Demonstration Project.

(66) Local and Regional Allied Agencies include the following: local Mental Health Authority; CMHPs; local DHS offices; Commission on Children and Families; OYA; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.

(67) Marketing — Any communication from a PHP to an OHP Client who is not enrolled in that PHP which can reasonably be interpreted as an attempt to influence the OHP Client:

(a) To enroll in that particular PHP;

(b) To either Disenroll or not to enroll with another PHP.

(68) Marketing Materials —Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for Marketing as defined in this rule.

(69) Medicaid — A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by DHS.

(70) Medical Assistance Program — A program for payment of health care provided to eligible Oregonians. Oregon's Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and CHIP. The Medical Assistance Program is administered by DMAP, of DHS. Coordination of the Medical Assistance Program is the responsibility of DMAP.

(71) Medical Care Identification — The preferred term for what is commonly called the "medical card" that is the size of a business card and issued to Medical Assistance Program Clients.

(72) Medical Case Management Services — Services provided to ensure that DMAP Members obtain health care services necessary to maintain physical and emotional development and health. Medical Case Management Services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are Capitated Services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.

(73) Medically Appropriate — Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an OHP Client or a Provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a DMAP Member or PCM Member in the PHP's or PCM's judgment.

(74) Medicare — The federal health insurance program for the Aged and Disabled administered by CMS under Title XVIII of the Social Security Act.

(75) Medicare Advantage —A capitated health plan that meets specific referral lines and contracts with CMS to provide Medicare benefits to Medicare enrollees.

(76) Mental Health Assessment — The determination of a DMAP Member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a Member's mental status, psychosocial history and current problems through interview, observation and testing.

(77) Mental Health Case Management — Services provided to DMAP Members who require assistance to ensure access to benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the DMAP Member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring DMAP Members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services. ENCC Services are separate and distinct from Mental Health Case Management.

(78) Mental Health Organization (MHO) — A PHP under contract with AMH that provides mental health services as Capitated Services under the OHP. MHOs can be FCHPs, CMHPs or private behavioral organizations or combinations thereof.

(79) Non-Capitated Services — Those OHP-covered services that are paid for on a FFS basis and for which a capitation payment has not been made to a PHP.

(80) Non-Covered Services — Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the OHP. Non-Covered Services for the OHP are identified in:

(a) OAR 410-141-0500;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual Provider administrative rules.

(81) Non-Participating Provider — A provider who does not have a contractual relationship with the PHP, i.e. is not on their panel of Providers.

(82) DMAP Member — An OHP Client enrolled with a PHP.

(83) Ombudsman Services — Services provided by DHS to Aged, Blind and Disabled OHP Clients by DHS Ombudsman Staff who may serve as the OHP Client's advocate whenever the OHP Client, Representative, a physician or other medical personnel, or other personal advocate serving the OHP Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the OHP. Ombudsman Services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about OHP systems.

(84) Oregon Health Plan (OHP) —The Medicaid demonstration project that expands Medicaid eligibility to eligible OHP Clients. The OHP relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(85) Oregon Health Plan (OHP) Plus Benefit Package — A benefit package available to eligible OHP Clients as described in OAR 410-120-1210.

(86) Oregon Health Plan (OHP) Standard Benefit Package —A benefit package available to eligible OHP Clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210.

(87) Oregon Health Plan (OHP) Client —An individual found eligible by DHS to receive services under the OHP. The OHP categories eligible for enrollment are defined as follows:

(a) Temporary Assistance to Needy Families (TANF) are categorically eligible with income under current eligibility rules;

(b) CHIP — children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;

(c) Poverty Level Medical (PLM) Adults under 100% of the FPL are OHP Clients who are pregnant women with income under 100% of FPL;

(d) PLM Adults over 100% of the FPL are OHP Clients who are pregnant women with income between 100% and 185% of the FPL;

(e) PLM children under one year of age have family income under 133% of the FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 185% of the FPL and do not meet one of the other eligibility classifications;

(h) OHP Adults and Couples are OHP Clients aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(i) OHP Families are OHP Clients, aged 19 or over and not Medicare eligible, with income below 100% of the FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) General Assistance (GA) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(k) Assistance to Blind and Disabled (AB/AD) with Medicare Eligibles are OHP Clients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(m) Old Age Assistance (OAA) with Medicare Eligibles are OHP Clients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(p) CAF Children are OHP Clients who are children with medical eligibility determined by CAF or OYA receiving OHP under ORS 414.025(2)(f), (I), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of CAF or OYA who are in placement outside of their homes.

(88) Oregon Youth Authority (OYA) — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(89) Participating Provider — An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to DMAP Members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.

(90) PCM Case Managed Services include the following: Preventive Services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics (RHC), Migrant and Community Health Clinics, Federally Qualified Health Centers (FQHC), County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, CMHPs, MHOs; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(91) PCM Member — An OHP Client enrolled with a PCM.

(92) PHP Coordinator — the DHS DMAP employee designated by DMAP as the liaison between DMAP and the PHP.

(93) Physician Care Organization (PCO) — PHP that contracts with DMAP to provide partially capitated health services under the OHP. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.

(94) Post Hospital Extended Care Benefit — A 20-day benefit for non- Medicare DMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(95) Post Stabilization Services — Covered Services, related to an Emergency Medical Condition that are provided after an DMAP Member is stabilized in order to maintain the stabilized condition or to improve or resolve the DMAP Member's condition.

(96) Potential DMAP Member — An OHP Client who is subject to mandatory Enrollment in managed care, or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.

(97) Practitioner — A person licensed pursuant to State law to engage in the provision of health care services within the scope of the Practitioner's license and/or certification.

(98) Prepaid Health Plan (PHP) —A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with DMAP and/or AMH on a case managed, prepaid, capitated basis under the OHP. PHPs may be DCOs, FCHPs, MHOs, PCOs or CDOs.

(99) Preventive Services — Those services as defined under Expanded Definition of Preventive Services for OHP Clients in OAR 410-141-0480, and 410-141-0520.

(100) Primary Care Management Services — Primary Care Management Services are services provided to ensure PCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care Management Services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that

are preventive or primary care services or PCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(101) Primary Care Manager (PCM) — A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician backups, who agrees to provide Primary Care Management Services as defined in rule to PCM Members. PCMs may also be hospital primary care clinics, RHCs, Migrant and Community Health Clinics, FQHCs, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCM provides Primary Care Management Services to PCM Members for a Capitation Payment. The PCM provides preventive and primary care services on a FFS basis.

(102) Primary Care Dentist (PCD) — A Dental Practitioner who is responsible for supervising and coordinating initial and primary dental care within their scope of practice for DMAP Members. PCDs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(103) Primary Care Provider (PCP) —A Practitioner who has responsibility for supervising and coordinating initial and primary care within their scope of practice for DMAP Members. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(104) Prioritized List of Health Services — The listing of Condition and Treatment Pairs developed by the Health Services Commission for the purpose of implementing the OHP Demonstration Project. See OAR 410-141-0520, for the listing of Condition and Treatment Pairs.

(105) Proof of Indian Heritage — Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service — services provided by Indian Health Service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.

(106) Provider — An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(107) Quality Improvement — Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(108) Representative —A person who can make OHP related decisions for OHP Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is designated as the OHP Client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the OHP Client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

(109) Rural —A geographic area 10 or more map miles from a population center of 30,000 people or less.

(110) Seniors and People with Disabilities Division (SPD) — The division within DHS responsible for providing services such as:

(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;

(b) Cash assistance grants for persons with long-term disabilities through GA and the Oregon Supplemental Income Program (OSIP); and

(c) Administration of the federal Older Americans Act.

(111) Service Area — The geographic area in which the PHP has identified in their Contract or Agreement with DHS to provide services under the OHP.

(112) Stabilize — No material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

(113) Terminal Illness —An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

(114) Triage — Evaluations conducted to determine whether or not an emergency condition exists, and to direct the DMAP Member to the most appropriate setting for Medically Appropriate care.

(115) Urban —A geographic area less than 10 map miles from a population center of 30,000 people or more.

(116) Urgent Care Services — Covered Services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of an DMAP Member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services.

(117) Valid Claim:

(a) An invoice received by the PHP for payment of covered health care services rendered to an eligible Client that:

(A) Can be processed without obtaining additional information from the Provider of the service or from a third party; and

(B) Has been received within the time limitations prescribed in these Rules.

(b) A Valid Claim does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A Valid Claim is synonymous with the federal definition of a Clean Claim as defined in 42 CFR 447.45(b).

(118) Valid Pre-Authorization — A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000. f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 23-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-141-0020
Administration of Oregon Health Plan Regulation and Rule Precedence

(1) The Department of Human Services (DHS) and its Division of Medical Assistance Programs (DMAP) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.725 (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, DMAP will construe them as much as possible to be complementary. In the event that DMAP policies, procedures, rules and interpretations may not be complementary, DMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to DMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, DMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(i) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted DMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(ii) Oregon Revised Statutes governing medical assistance programs;

(iii) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, DMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(iv) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to DMAP Clients are provided in DMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage

described in OAR 410-141-0480 to 410-141-0520,and the provider rules applicable to the category of medical service; and

(v) Any other applicable duly promulgated rules issued by DMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs, such as Electronic Data Transaction Rules in OAR 407-120-0100 to 407-120-0200; and

(vi) The basic framework for provider enrollment in OAR 407-120-0300 through 407-120-0380 generally applies to providers enrolled with DHS, subject to more specific requirements applicable to the administration of the Oregon Health Plan and medical assistance programs administered by DMAP. For purposes of this rule, "more specific" means the requirements, laws and rules applicable to the provider type and covered services described in subsections (i)–(v) of this section.

(b) For purposes of contract administration solely as between DMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to DMAP Clients.

(i) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(ii) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 409.010, 409.110 & 409.050
Stats. Implemented: 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-141-0220
Oregon Health Plan Prepaid Health Plan Accessibility

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all DMAP Members. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Participating Provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between DMAP Members and non-DMAP members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures which ensure that for 90% of their DMAP Members in each Service Area, routine travel time or distance to the location of the PCP does not exceed the Community Standard for accessing health care Participating Providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by DMAP:

(A) In urban areas — 30 miles, 30 minutes or the Community Standard, whichever is greater;

(B) In rural areas — 60 miles, 60 minutes or the Community Standard, whichever is greater.

(b) PHPs shall maintain and monitor a network of appropriate Participating Providers sufficient to ensure adequate service capacity to provide availability of, and timely access to, Medically Appropriate covered services for DMAP Members:

(A) PHPs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced Participating Provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act;

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to DMAP Members in terms of timeliness, amount, duration and scope as those services are to non-DMAP persons within the same Service Area. If the PHP is unable to provide those services locally, it must so demonstrate to DMAP and shall provide reasonable alternatives for DMAP Members to access care that must be approved by DMAP. PHPs shall have a monitoring system that will demonstrate to DMAP or AMH, as applicable, that the PHP has surveyed and monitored for equal access of DMAP Members to referral Providers pharmacy, hospital, vision and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that DMAP Members who are Aged, Blind, or Disabled or who are children receiving CAF (SOSCF services) or OYA services have access to primary care, dental care, mental health Providers and referral, as applicable. These Providers shall have the expertise to treat, take into account and accommodate the full range of medical, dental or mental health conditions experienced by these DMAP Members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs and Primary Care Managers (PCMs) Enrollment Standards:

(a) PHPs and PCMs shall remain open for Enrollment unless DHS has closed Enrollment because the PHP or PCM has exceeded their Enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by DMAP or AMH, as appropriate, and the PHP or PCM;

(b) PHPs Enrollment may also be closed by DMAP or AMH, as appropriate due to sanction provisions;

(c) PHPs and PCMs shall accept all OHP Clients, regardless of health status at the time of Enrollment, subject to the stipulations in Contracts/agreements with DHS to provide covered services or Primary Care management services;

(d) PHPs and PCMs may confirm the Enrollment status of an OHP Client by one of the following:

(A) The individual's name appears on the monthly or weekly Enrollment list produced by DMAP;

(B) The individual presents a valid Medical Care Identification that shows he or she is enrolled with the PHP or PCM;

(C) The Automated Voice Response(AVR) verifies that the individual is currently eligible and enrolled with the PHP or PCM;

(D) An appropriately authorized staff member of DHS states that the individual is currently eligible and enrolled with the PHP or PCM.

(e) PHPs shall have open Enrollment for 30 continuous calendar days during each twelve-month period of January through December, regardless of the PHPs Enrollment limit. The open Enrollment periods for consecutive years may not be more than 14 months apart.

(3) If a PHP is assumed by another PHP, DMAP Members shall be automatically enrolled in the succeeding PHP. The DMAP Member will have 30 calendar days to request Disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare Advantage plan, those DMAP Members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered Enrollment in the succeeding PHP.

(4) If a PHP engages in an activity, such as the termination of a Participating Provider or Participating Provider group which has significant impact on access in that Service Area and necessitates either transferring DMAP Members to other Providers or the PHP withdrawing from part or all of a Service Area, the PHP shall provide DHS at least 90 calendar days written notice prior to the planned effective date of such activity:

(a) A PHP may provide less than the required 90 calendar days notice to DHS upon approval by DHS when the PHP must terminate a Participating Provider or Participating Provider group due to problems that could compromise DMAP Member care, or when such a Participating Provider or Participating Provider group terminates its contract with the PHP and refuses to provide the required 90 calendar days notice;

(b) If DHS must notify DMAP Members of a change in Participating Providers or PHPs, the PHP shall provide DHS with the name, prime number, and address label of the DMAP Members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide DMAP Members with at least 30 calendar-days notice of such changes.

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of DMAP Member appointments are appropriate to the reasons for, and urgency of, the visit:

(a) PHPs shall have written policies and procedures and a monitoring system to assure that DMAP Members have access to appointments according to the following standards:

(A) FCHPs and PCOs:

(i) Emergency Care —The DMAP Member shall be seen immediately or referred to an emergency department depending on the DMAP Member's condition;

(ii) Urgent Care — The DMAP Member shall be seen within 48 hours; and

(iii) Well Care — The DMAP Member shall be seen within 4 weeks or within the Community Standard.

(B) DCOs:

(i) Emergency Care — The DMAP Member shall be seen or treated within 24-hours;

(ii) Urgent Care — The DMAP Member shall be seen within one to two weeks depending on DMAP Member's condition; and

(iii) Routine Care — The DMAP Member shall be seen for routine care within an average of eight (8) weeks and within twelve (12) weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.

(C) MHOs and CDOs:

(i) Emergency Care — DMAP Member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care — DMAP Member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care — DMAP Member shall be seen for an intake assessment within 2 weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of DMAP Members through the office such that DMAP Members are not kept waiting longer than non-DMAP Member patients, under normal circumstances. If DMAP Members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, DMAP Members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through Complaint and Appeal reviews, DMAP termination reports, and DMAP Member surveys to determine if waiting times for clients in all settings are appropriate;

(c) PHPs shall have written procedures and a monitoring system for timely follow-up with DMAP Member(s) when Participating Providers have notified the PHP that the DMAP Member(s) have failed to keep scheduled appointments. The procedures shall address determining why appointments are not kept, the timely rescheduling of missed appointments, as deemed Medically or Dentally Appropriate, documentation in the Clinical Record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the DMAP Member's diagnosis or disability or is due to lack of transportation to the PHP's Participating Provider office or clinic, PHPs shall provide outreach services as Medically Appropriate;

(d) PHPs shall have policies and procedures that ensure Participating Providers will attempt to contact DMAP Members if there is a need to cancel or reschedule the DMAP Member's appointment and there is sufficient time and a telephone number available;

(e) PHPs shall have written policies and procedures to Triage the service needs of DMAP Members who walk into the PCP's office or clinic with medical, mental health or dental care needs. Such Triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) DMAP Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the DMAP Member's needs or be evaluated for treatment within two hours by a medical, mental health or dental Provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by DMAP and/or AMH because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics, as an operative element of FCHP's and PCO's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate Clinical Record of the DMAP Member regardless of who responds to the call or the time of day the call is received. PHPs shall monitor for compliance with this requirement;

(d) Such policies and procedures shall include a written protocol specifying when a medical, mental health or dental Provider must be consulted. When Medically Appropriate, all such calls shall be forwarded to the on-call PCP who shall respond immediately to calls which may be emergent in nature. Urgent calls shall be returned appropriate to the DMAP Member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's Participating Providers) have sufficient communication skills and training to reassure DMAP Members and encourage them to wait for a return call in appropriate situations. PHPs shall have written procedures and trained staff to communicate with hearing impaired DMAP Members via TDD/TTY;

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take corrective action as needed, and report findings to the PHP's Quality Improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours, including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with, and providing care to DMAP Members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of DMAP Member services and Complaint and Grievance representatives and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health or dental care visits, including home health visits, to interpret for DMAP Members with hearing impairment or in the primary language of non-English speaking DMAP Members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the DMAP Member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the Provider to be able to understand the DMAP Member's complaint; to make a diagnosis; respond to DMAP Member's questions and concerns; and to communicate instructions to the DMAP Member;

(c) PHPs shall ensure the provision of care and interpreter services which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the DMAP Member;

(d) PHPs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all DMAP Members and shall arrange for services to be provided by Non-Participating referral Providers when necessary:

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether DMAP Members are receiving accommodations for access and to determine what will be done to remove existing barriers and/or to accommodate the needs of DMAP Members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all DMAP Members including, but not limited to, the following:

(i) Street level access or accessible ramp into facility;

(ii) Wheelchair access to lavatory;

(iii) Wheelchair access to examination room; and

(iv) Doors with levered hardware or other special adaptations for wheelchair access.

(e) PHPs shall ensure that Participating Providers, their facilities and personnel are prepared to meet the special needs of DMAP Members who require accommodations because of a disability:

(A) PHPs shall have a written plan for meeting the needs of DMAP Members;

(B) PHPs shall monitor Participating Providers for compliance with the access plan and take corrective action, when necessary.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 38-1998, f. & cert. ef. 10-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0021
American Indian/Alaska Native (AI/AN) Provider Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (DMAP) requirements for IHS and Tribal 638 clinics to enroll as AI/AN providers. Refer also to OAR 410-120-1260 Provider Enrollment.

(2) An IHS or Tribal 638 clinic that operates a retail pharmacy, provides durable medical equipment, prosthetics, orthotics, and supplies

(DMEPOS); or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS and/or TCM provider. Refer to OAR 410 Division 121, Pharmaceutical; OAR 410 Division 122, DMEPOS; and OAR 410 Division 138, TCM for specific information.

(3) To enroll with DMAP as an AI/AN provider, a health center must be one of the following:

(a) A Indian Health Service (IHS) direct health care services facility established, operated, and funded by IHS; or

(b) A Tribally-owned and operated facility funded by Title I or V of the Indian Self Determination and Education Assistance Act (Public Law 93-638, as amended) and is referenced throughout these rules as a "Tribal 638" provider;

(A) A Tribal 638 facility that under Self-Determination, contracts with IHS under Title I to have the administrative control, operation, and funding for health programs transferred to AI/AN tribal governments;

(B) A Tribal 638 facility that under Self-Determination has a compact with IHS under Title V and assumes autonomy for the provision of the tribe's own health care services.

(4) Eligible IHS and Tribal 638 providers who want to enroll with DMAP as an AI/AN provider must submit the following information:

(a) Completed DHS provider enrollment forms with attachments as required in OAR 407-0120-0300 through -0320;

(b) A Tribal facility must submit documentation verifying they are a 638 provider:

(A) A letter from IHS, applicable-Area Office or Central Office, indicating that the facility (identified by name and address) is a 638 facility;

(B) A written assurance from the Tribe that the facility (identified by name and site address) is owned or operated by the Tribe or a Tribal organization with funding directly obtained under a 638 contract or compact. A copy of the relevant provision of the Tribe's current 638 contract or compact must accompany the written assurance;

(c) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220, Certificates of Approval for Mental Health Services; 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(d) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(e) A list of all Prepaid Health Plan (PHP) contracts;

(f) A list of all practitioners contracted with or employed by the IHS or Tribal 638 Facility including names, legacy DMAP provider numbers, National Provider Numbers (NPI) and associated taxonomy codes; and

(g) A list of all clinics affiliated or owned by the IHS or Tribal 638 Facility including business names, legacy DMAP provider numbers, National Provider Numbers (NPI) and associated taxonomy codes.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0060
Prior Authorization

(1) Some covered services or items require Prior authorization (PA) by DMAP before the service can be provided or before payment will be made. Refer to Oregon Administrative Rule (OAR) 410-120-1320 Authorization of Payment.

(2) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Refer to OAR 410-120-1140 Verification of Eligibility.

(3) An OHP client who is a Native American or Alaska Native (AI/AN) with Proof of Indian Heritage is exempt from mandatory enrollment in a PHP, and can request disenrollment from a PHP if mandatorily enrolled. An AI/AN OHP client can choose to remain in the Medicaid fee-for-service (FFS) delivery system for physical, dental and/or mental (including alcohol and chemical dependency) health care and receive services from an Indian Health Service facility, tribal health clinic/program or urban clinic. Refer to OAR 410-141-0060(4)(d).

(4) If a client is enrolled in a PHP there may be PA requirements for some services that are provided through the PHP. It is the AI/AN providers' responsibility to contact the PHP prior to providing services to any:

(a) Non-AI/AN OHP client enrolled in a PHP and with whom the AI/AN provider has a contract, to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP. The AI/AN provider needs to contact the client's PHP for specific instructions;

(b) AI/AN OHP client enrolled in a PHP with whom the AI/AN provider does not have a contract, to comply with PA requirements in these rules, the General Rules and applicable DMAP program rules.

(5) If a client receives services on a FFS basis or is an AI/AN PHP-enrolled client with whom the AI/AN provider does not have a contract and plans to bill DMAP directly FFS, a PA may be required from DMAP for certain services. An AI/AN provider assumes full financial risk in providing services to a client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OAR).

(6) If the service or item is subject to Prior Authorization, the AI/AN provider must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OAR 410-120-1360, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with the services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0080
Professional Ambulatory Services

(1) Professional Ambulatory services for AI/AN providers include Medical, Diagnostic, Screening, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services.

(2) Providers must use the following guidelines in conjunction with all individual program-specific DMAP administrative rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages:

(a) American Indian/Alaska Native (AI/AN) Services administrative rules (OAR 410 Division 146),

(b) General Rules (OAR 410 Division 120);

(c) OHP Administrative Rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520), and

(d) The Health Services Commission's (HSC) Prioritized List of Health Services (List). (3) IHS and Tribal 638 facilities are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also AI/AN OAR 410-146-0085(13).

(4) The date of service determines the appropriate version of the AI/AN Services Rules, General Rules, and the HSC Prioritized List that AI/AN providers should use to determine coverage.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0085
DMAP Encounter and Recognized Practitioners

(1) AI/AN DMAP-enrolled providers will bill services, items and supplies to the Division of Medical Assistance Programs (DMAP) and will be reimbursed for services that meet the criteria of a valid encounter in

Sections (5) through (7) of this rule and are limited to DMAP Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by DMAP.

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon Administrative Rule (OAR) 410-147-0120 DMAP Encounter and Recognized Practitioners.

(3) AI/AN providers reimbursed according to the IHS rate are subject to the requirements of this rule.

(4) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) and Qualified Medicare Beneficiary (QMB) only clients are not billed according to encounter criteria and not reimbursed at the IHS encounter rate. Refer to OARs 410-120-1210 Medical Assistance Benefit Packages and Delivery System.

(5) For the provision of services defined in Titles XIX and XXI, and provided through an IHS or Tribal 638 facility, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (7) of this rule outlines limitation's for telephone contacts that qualify as encounters.

(6) An encounter includes all services, items and supplies provided to a client during the course of an office visit, and "incident-to" services (except as excluded in section (15) of this rule). The following services are inclusive of the visit with the core provider meeting the criteria of a reimbursable valid encounter and are not reimbursed separately:

(a) Drugs or medication treatments provided during the clinic visit, with the exception of contraception supplies and medications as costs for these items are excluded from the IHS encounter rate calculation. Refer to OAR 410-146-0200 Pharmacy;

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace); and

(c) Venipuncture for laboratory tests.

(7) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and 410-130-0190, Tobacco Cessation. See also 410-120-1200(2)(y). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(8) The following services may be Medicaid-covered services according to an Oregon Health Plan (OHP) client's benefit package as a stand alone service; however, when furnished as a stand-alone service are not reimbursable:

(a) Case management services for coordinating care for a client;

(b) Sign language and oral interpreter services;

(c) Supportive rehabilitation services including, but not limited to, environmental intervention, supported employment, or skills training and activity therapy to promote community integration and job readiness.

(9) AI/AN providers may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment and that require separate enrollment. Refer to OAR 410-146-0021(2) American Indian/Alaska Native (AI/AN) Provider Enrollment. These services include:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (e.g. diabetic supplies) (DMEPOS) not generally provided during the course of a clinic visit. Refer to OAR 410 Division 122, DMEPOS;

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to DMAP through the pharmacy program. Refer to OAR 410 Division 121, Pharmaceutical Services;

(c) Targeted case management (TCM) services. Refer to OAR 410 Division 138, TCM for specific information.

(10) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. For exceptions to this rule, refer to OAR 410-146-0086 for reporting multiple encounters.

(11) For claims requiring a procedure code the provider must bill as instructed in the appropriate DMAP program rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the Client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Provider rules. Refer to OARs 410-120-1280 Billing and 410-146-0040 ICD-9-CM Diagnosis Codes and CPT/HCPCs Procedure Codes,

(12) Services furnished by AI/AN enrolled providers that may meet the criteria of a valid encounter are (Refer to individual program administrative rules for service limitations.):

(a) Medical (OAR 410 Division 130);

(b) Diagnostic: DMAP covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, DMAP will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-146-0140);

(d) Dental — Refer to OAR 410-146-0380 and 410 Division 123;

(e) Vision (OAR 410 Division 140);

(f) Physical Therapy (OAR 410 Division 131);

(g) Occupational Therapy (OAR 410 Division 131);

(h) Podiatry (OAR 410 Division 130);

(i) Mental Health (OAR 309 Division 16);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 415 Divisions 50 and 51). Requires a letter or licensure of approval by the Addictions and Mental Health Division (AMH). Refer to OAR 410-146-0021 (4)(c) and (d);

(k) Maternity Case Management (OAR 410-146-0120);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) DMAP considers a home visit for assessment, diagnosis, treatment or Maternity Case Management (MCM) as an encounter. DMAP does not consider home visits for MCM as Home Health Services;

(o) Professional services provided in a hospital setting;

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and DMAP Administrative Rules.

(13) The following practitioners are recognized by DMAP:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Nurse Practitioners;

(d) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by DMAP in this section and who is authorized to independently diagnose and treat according to OAR 851 Division 45);

(e) Nurse Midwives;

(f) Dentists;

(g) Dental Hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. See the section on Limited Access Permits, ORS 680.200 and OAR 818-035- 0065 through 818-035-0100 for more information;

(h) Pharmacists;

(i) Psychiatrists;

(j) Licensed Clinical Social Workers;

(k) Clinical psychologists;

(l) Acupuncturists (refer to OAR 410 Division 130 for service coverage and limitations); and

(m) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(i) Their individual provider's certification or license; or

(ii) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-146-0021 sections (4)(c) and (d).

(14) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (including drugs and biologicals) furnished on a part-time or intermittent basis to home-bound AI/AN clients residing on tribal land and any other ambulatory services covered by DMAP are also reimbursable as permitted within the clinic's scope of services (see OAR 410-146-0080).

(15) DMAP reimburses the following services fee-for-service outside of the IHS all-inclusive encounter rate and according to the physician fee schedule:

(a) Laboratory and/or radiology services;

(b) Contraception supplies and medications. Refer to OAR 410-146-0200 Pharmacy;

(c) Administrative medical examinations and report services (See OAR 410 Division 150); and

(d) Death with Dignity services (See OAR 410-130-0670).

(16) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances DMAP will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing DMAP. Refer to OAR 410-120-1140 Verification of Eligibility.

(17) When a Provider receives a payment from any source prior to the submission of a claim to DMAP, the amount of the payment must be shown as a credit on the claim in the appropriate field. Refer to OARs 410-120-1280 Billing and 410-120-1340 Payment.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: 409.050, 404.110, 414.065

Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05; Renumbered from 410-146-0080, DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0086

Multiple Encounters

(1) An encounter is defined in OAR 410-146-0085.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (Refer to OAR 410-146-0085 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (Section (4) of this rule, and OAR 410 Division 130);

(b) Dental (OAR 410-146-0380 and 410 Division 123);

(c) Mental Health (OAR 309 Division 016). If a client is also seen for a medical office visit and receives a mental health diagnosis, then the client contacts are a single encounter;

(d) Addiction, Alcohol and Chemical Dependency (OAR 415 Divisions 50 and 51). If a client is also seen for a medical office visit and receives an addiction diagnosis, then the client's contacts are a single encounter;

(e) Ophthalmology — fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR 410 Division 140);

(f) Maternity Case Management MCM (OAR 410-146-0120);

(g) Physical or occupational therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR 410 Division 131); and

(h) Immunizations — if no other medical office visit occurs on the same date of service.

(3) Division of Medical Assistance Programs (DMAP) expects that multiple encounters will occur on an infrequent basis.

(4) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first Medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in Section (2) of this rule.

(5) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(6) Similar services, even when provided by two different health care practitioners is considered a single encounter, and not multiple encounters. Services that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist; and

(f) Any time a client receives only a partial service with one provider and partial service from another provider.

(7) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service.

(8) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

Stat. Auth.: 409.050, 404.110, 414.065

Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 16-2005, f. 3-11-05, cert. ef. 4-1-05; Renumbered from 410-146-0080, DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0100

Vaccines for Children (VFC)

(1) The Vaccines for Children (VFC) program supplies federally purchased free vaccines for immunizing eligible client's ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Department of Human Services Immunization Program. Refer to the AI/AN Supplemental Information for instructions and OAR 410-130-0255(4) VFC Program.

(2) The Division of Medical Assistance Programs (DMAP) will reimburse for the administration of vaccines to eligible clients according to the AI/AN provider's IHS or cost-based rate.

Stat. Auth.: 409.050, 404.110, 414.065

Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 61-2005, f. 11-29-05, cert. ef. 12-1-05; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0120

Maternity Case Management Services

(1) The Division of Medical Assistance Programs (DMAP) will reimburse American Indian/Alaska Native (AI/AN) providers for Maternity Case Management (MCM) services according to their encounter rate.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill DMAP directly per the clinic's encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, and services were furnished to a:

(A) Non-AI/AN client, the provider needs to request the necessary authorizations from the PHP;

(B) AI/AN client enrolled with a PHP with which the AI/AN provider does not have an agreement, the AI/AN provider can bill DMAP directly.

(3) Clients records' must clearly document all MCM services provided including all mandatory topics. Refer to Medical/Surgical OAR 410-130-0595 Maternity Case Management (MCM) for specific requirements.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation prior to the day of delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day do not qualify as multiple encounters.

(6) A medical/prenatal visit encounter and an MCM encounter can qualify as two separate encounters when furnished on the same day only when the MCM service is:

(a) The initial evaluation to receive MCM services; or

(b) A nutritional counseling MCM service provided after the initial evaluation visit. See Section (7)(c) of this rule for limitations.

(7) MCM Services limitations:

(a) DMAP reimburses the initial evaluation one time per pregnancy per provider;

(b) Providers may bill DMAP for case management visits four times per pregnancy. In addition, if a client is identified as high risk; the practitioner may bill six additional case management visits;

(c) DMAP reimburses Nutritional Counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(d) DMAP reimburses a Home/Environmental Assessment one time per pregnancy, and is included in the total number of case management visits in Section (7)(b) of this rule.

(8) A client may only participate in a single case management program. DMAP does not allow multiple case management billings. This includes Maternity Case Management (MCM), and any Targeted Case Management (TCM) Program outlined in OAR 410 Division 138.

(9) Community Health Representatives (CHR) may be eligible to provide specific MCM services, with the exclusion of the initial assessment (G9001), while working under the supervision of a licensed health care practitioner listed in OAR 410-130-0595(6)(a). Refer to 410-130-0595(6)(d).

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0130
Modifiers

(1) The Division of Medical Assistance Programs (DMAP) uses HIPAA compliant modifiers for many services.

(2) The following services require the use of a modifier for all services for all procedures:

(a) Family Planning Service — FP, Refer to OAR 410-130-0585 Family Planning Services;

(b) Vaccine for Children — SL or 26, Refer to OAR 410-130-0255(4).

(3) When billing for services that are reimbursed outside an AI/AN provider's cost-based or IHS rate, a clinic must use the required modifier(s) listed in the individual program-specific Administrative Rules.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0140
Tobacco Cessation

(1) The Division of Medical Assistance Programs (DMAP) will reimburse AI/AN providers for tobacco cessation services at the AI/AN provider's IHS or cost-based rate.

(2) AI/AN providers will bill services with a primary diagnosis code 305.1 (Tobacco Use Disorder) when the client is enrolled in a tobacco cessation program or if the primary purpose of the visit is for tobacco cessation services.

(3) Refer to OAR 410-130-0190, Tobacco Cessation for specific requirements and treatment limitations.

(4) Tobacco Cessation, a specific DMAP prevention program, does not qualify as a separate encounter when a medical, dental, mental health or addiction service encounter occurs on the same date of service.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0340
Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Division of Medical Assistance (DMAP) Program coverage, providers must bill Medicare first.

(2) All claims submitted by AI/AN providers to DMAP for clients who have both Medicare and DMAP coverage must be billed on a CMS-1500 claim form or by 837P transmission. See also Billing for Medicare/Medicaid Clients in the AI/AN Services Supplemental Information.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill DMAP using a CMS-1500 claim form or 837P transmission, but only after that carrier has made payment determination.

(4) When billing on a CMS-1500 claim form or 837P transmission for a client with both Medicare and DMAP Oregon Health Plan (OHP) coverage:

(a) Bill all services provided to an OHP beneficiary;

(b) Bill the clinic's encounter rate; and

(c) Enter the total Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resources (TPR) explanation. Refer to CMS-1500 or 837P detailed billing instructions.

(5) Claims for Qualified Medicare Beneficiary (QMB)-only clients must be billed on CMS-1500 claim form or 837P transmission. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information and instructions are located in the AI/AN Services Supplemental Information billing guide:

(a) The total charged amount must equal the total Medicare allowed/covered charges. AI/AN providers are not to bill their encounter rate for services provided to Qualified Medicare Beneficiary (QMB)-only clients;

(b) AI/AN providers must bill each service, treatment or item provided to a QMB-only beneficiary on the CMS-1500 claim form or 837P transmission identical to how Medicare was billed;

(c) AI/AN providers must apply any reductions and/or adjustments by Medicare to the Medicare payment, such that the difference between the Medicare allowed/covered amount and the amount paid by Medicare as reported on the claim equals only the Medicare coinsurance and/or deductible;

(d) For claims to process payment correctly, AI/AN providers billing multiple services need to apply the total charge calculated, according to section (a) above, to the first detail line and zero charge all subsequent lines. The billed charge at the detail line level must equal the total charge.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0380
OHP Standard Emergency Dental Benefit

(1) Clients with the OHP Standard benefit package have a limited dental benefit. The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Services are limited to the treatment of conditions listed in Oregon Administrative Rule (OAR) 410-123-1670(3) OHP Standard Limited Emergency Dental Benefit.

(2) Hospital Dentistry is not a covered benefit for the OHP Standard population, except for clients specified in OAR 410-123-1670(4).

(3) Dental services for the OHP standard population are limited to those procedures listed in OAR 410-123-1260, Table 123-1260-1.

(4) Any limitations or prior authorization requirements for services listed in OARs 410-123-1160 and 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an AI/AN provider.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 24-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-146-0440
Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (DMAP) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP). AI/AN providers that are not FQHCs, and that elect to receive payment under Title XIX and XXI according to the IHS rate under the Memorandum of Agreement effective July 11, 1996 will also be eligible to receive supplemental payments in the same manner as an FQHC under 1902(bb)(5).

(2) AI/AN providers reimbursed according to a cost-based rate under the Prospective Payment System (PPS) are directed to Oregon Administrative Rule (OAR) 410-147-0460 Prepaid Health Plan Supplemental Payments.

(3) The PHP Supplemental Payment represents the difference, if any, between the payment received by the AI/AN provider from the PHP(s) for treating the PHP enrollee and the payment to which the AI/AN provider would be entitled if they had billed DMAP directly for these encounters according to the clinic's IHS rate. Refer to OAR 410-146-0020.

(4) In accordance with federal regulations, the provider must take all reasonable measures to ensure that in most instances, with the exception of IHS, Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP. Refer to OAR 410-120-1140 Verification of Eligibility.

(5) When any other coverage is known to the provider, the provider must bill the other resource(s) prior to billing the PHP. When a provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120- 1280 Billing and 410-120-1340 Payment.

(6) Supplemental payment by DMAP for encounters submitted by AI/AN providers for purposes of this rule is reduced by any and all payments received by the AI/AN provider from outside resources, including Medicare, private insurance or any other coverage. Therefore, AI/AN providers are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third Party Resource(s) (TPR).

(7) DMAP will calculate the PHP Supplemental Payment in the aggregate of the difference between total payments received by the AI/AN provider, to include payments as listed in Section (6) of this rule and the payment to which the AI/AN provider would have been eligible to claim as an encounter if they had billed DMAP directly according to the IHS encounter rate.

(8) AI/AN providers must submit their clinic's data using the Managed Care Data Submission Template developed by DMAP to report all PHP encounter and payment activity.

(9) To facilitate DMAP processing PHP supplemental payments, the AI/AN must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The AI/AN National Provider Identifier (NPI) number and applicable associated taxonomy code registered with DMAP for the health center must be used when submitting all claims to the PHPs;

(b) To DMAP:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template Coversheet;

(C) Payments are to be reported at the detail line level on the Managed Care Data Submission Template Worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (Medical, Dental, Mental Health, or Alcohol and Chemical Dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the IHS or Tribal 638 facility or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) A list of individual practitioners with active DMAP enrollment including, names, legacy DMAP provider number and NPI number assigned to practitioners associated with the IHS or Tribal 638 facility. "Associated" refers o a practitioner who is either subcontracted or employed by the AI/AN provider. A practitioner associated with an AI/AN provider can only retain active DMAP enrollment under one of the two situations:

(i) The practitioner maintains a private practice; or

(ii) The practitioner is also employed by a non-IHS or non-Tribal 638 site.

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to DMAP no later than October 31 of each year.

(10) PHP Supplemental Payment process:

(a) DMAP processes PHP Supplemental Payments on a quarterly basis. The quarterly settlement includes a final reconciliation for the reported time period.

(b) Upon processing a clinic's data and the PHP Supplemental Payment, DMAP will:

(A) Send a check to the AI/AN provider for PHP Supplemental Payment calculated from clinic data DMAP was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by DMAP;

(c) The AI/AN provider is responsible for reviewing the data DMAP was unable to process for accuracy and completeness. The clinic has 30 days, from the date of DMAP's cover letter under Section (9)(b) of this rule, to make any corrections to the data and resubmit to DMAP for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by DMAP prior to expiration of the 30 days, and must:

(A) Be requested in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing DMAP the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of DMAP's receipt of the re-submitted data, DMAP will:

(A) Review the data and issue a check for all encounters DMAP verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The AI/AN provider should submit data to DMAP within the timelines provided by DMAP.

(11) Clinics must carefully review in a timely fashion the data that DMAP was unable to process and returns to the AI/AN provider. If clinics do not bring any incomplete, inaccurate or missing data to DMAP's attention within the time frames outlined, DMAP will not process an adjustment.

(12) DMAP encourages AI/AN providers to request PHP Supplemental Payment in a timely manner.

(13) Clinics must exclude from a clinic's data submission for PHP supplemental payment, services provided to a PHP-enrolled non-AI/AN client denied by the PHP because the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family Planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP Supplemental Payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP Supplemental Payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to DMAP. (See also OAR 410-146-0060).

(14) If a PHP denies payment to a contracted AI/AN provider for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-146-0085, for the reason that all services, items and supplies are non-covered by the plan, DMAP is not required to make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(15) DMAP will not reimburse some Medicaid-covered services that are only reimbursed by PHPs, and are not reimbursed by DMAP. DMAP will not make PHP supplemental payment for these services, as DMAP does not reimburse these services when billed directly to DMAP.

(16) It is the responsibility of the AI/AN provider to refer PHP-enrolled non-AI/AN clients back to their PHP if the AI/AN provider does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The provider assumes full financial risk in serving a person not confirmed by DMAP as eligible on the date(s) of service. See OAR 410-120-1140, Verification of Eligibility. It is the responsibility of the provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an "open card" or fee-for-service basis.

Stat. Auth.: 409.050, 404.110, 414.065
Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 24-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0020
Professional Ambulatory Services

(1) Providers must use the following rules in conjunction with all individual program rules to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: Medical, EPSDT, Diagnostic, Dental, Vision, Physical Therapy, Occupational Therapy, Podiatry, Mental Health, Alcohol and Chemical Dependency, Maternity Case Management, Speech, Hearing, and Home Health services are governed by the Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules (OAR 410 Division 147), General Rules (410 Division 120), OHP Administrative Rules (410-141-0480, 410-141-0500, and 410-141-0520), and the Health Services Commission's (HSC) Prioritized List of Health Services (List), and Department of Human Services Administrative Services Division and Director's Office rules related to Provider Enrollment and Claiming (407-0120-300 through 0380).

(2) Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are eligible for reimbursement of covered professional services provided within the scope of the clinic and within the individual practitioner's scope of license or certification. See also OAR 410-147-0120(6). For the purposes of this rule, a clinic's "scope" refers to authorization or certification to provide services if required:

(a) For FQHCs only, services must be provided in accordance with the FQHC's scope as approved by the Health Resources and Services Administration (HRSA) Notice of Grant Award Authorization; and

(b) Both FQHCs and RHCs must provide services within the scope of the Addictions and Mental Health Division (AMH) certification for the facility, if required. See OAR 410-147-0320(3) and (5).

(3) The date of service determines the appropriate version of the FQHC and RHC rules, General Rules, and HSC Prioritized List to determine coverage.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0500; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0140; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0060
Prior Authorization

(1) Most Oregon Health Plan (OHP) clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Client's who are not enrolled in a PHP, receive services on an "open card" or "fee-for-service" (FFS) basis.

(2) It is the responsibility of the Provider to verify whether a PHP or DMAP is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) If a client is enrolled in a PHP there may be Prior Authorization (PA) requirements for some services that are provided through the PHP. It is the FQHC or RHC's responsibility to comply with the PHP's PA requirements or other policies necessary for reimbursement from the PHP before providing services to any OHP Client enrolled in a PHP. The FQHC or RHC needs to contact the client's PHP for specific instructions.

(4) Clients who are enrolled in a PHP can receive family planning services, human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services (excludes any treatment for HIV or AIDS) through an FQHC or RHC without PA from the PHP as provided under the terms of Oregon's Section 1115 (CMS) Waiver. If the FQHC or RHC does not have a contract or other arrangements with a PHP, and the PHP denies payment, the Division of Medical Assistance Programs (DMAP) will reimburse for these services per a clinic's encounter rate (see OAR 410-147-0120(12)(b)).

(5) If a client receives services on a "fee-for-service" basis, a PA may be required by DMAP for certain covered services or items before the service can be provided or before payment will be made. An FQHC or RHC assumes full financial risk in providing services to a "fee-for-service" client prior to receiving authorization, or in providing services that are not in compliance with Oregon Administrative Rules (OARs). See OAR 410-120-1320 Authorization of Payment and any applicable program rules.

(6) If the service or item is subject to Prior Authorization, the FQHC or RHC must follow and comply with PA requirements in these rules, the General Rules and applicable program rules, including but not limited to:

(a) The service is adequately documented (see OARs 410-120-1360 and 407-120-0370, Requirements for Financial, Clinical and Other Records). Providers must maintain documentation in the provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;

(b) The services provided are consistent with the information submitted when authorization was requested;

(c) The services billed are consistent with those services provided; and

(d) The services are provided within the timeframe specified on the authorization of payment document.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0640; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0080; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0120
DMAP Encounter and Recognized Practitioners

(1) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services billed to the Division of Medical Assistance Programs (DMAP) are reimbursed according to the Prospective Payment System (PPS) when the service(s) meet the criteria of a valid encounter as defined in Sections (2) through (4) of this rule. Reimbursement is limited to DMAP Medicaid-covered services according to a client's Oregon Health Plan (OHP) benefit package. These services include ambulatory services included in the State Plan under Title XIX or Title XXI of the Social Security Act. Other services that are not defined in this rule or the State Plan under Title XIX or Title XXI of the Social Security Act are not reimbursed by DMAP.

(2) For the provision of services defined in Titles XIX and XXI and provided through an FQHC or RHC, an "encounter" is defined as a face-to-face or telephone contact between a health care professional and an eligible OHP client within a 24-hour period ending at midnight, as documented in the client's medical record. Section (4) of this rule outlines limitations for telephone contacts that qualify as encounters.

(3) An encounter includes all services, items and supplies provided to a client during the course of an office visit (except as excluded in Sections (6) and (12) of this rule) and those services considered "incident-to." These services are inclusive of the visit with the core provider meeting the criteria a valid encounter and reimbursed at the PPS all-inclusive encounter rate. These services include:

(a) Drugs or medication treatments provided during a clinic visit are inclusive of the encounter, with the exception of contraception supplies and medications as costs for these items are excluded from the PPS encounter rate calculation. Refer to OAR 410-147-0280 Drugs and 410-147-0480 Cost Statement (DMAP 3027) Instructions;

(b) Medical supplies, equipment, or other disposable products (e.g. gauze, band-aids, wrist brace) are inclusive of an office visit;

(c) Laboratory and/or radiology services (even if performed on another day);

(d) Venipuncture for lab tests. DMAP does not deem a visit for lab test only to be a clinic encounter;

(4) Telephone encounters only qualify as a valid encounter for services provided in accordance with OAR 410-130-0595, Maternity Case Management (MCM) and 410-130-0190, Tobacco Cessation. See also 410-120-1200(2)(y). Telephone encounters must include all the same components of the service when provided face-to-face. Providers must not make telephone contacts at the exclusion of face-to-face visits.

(5) Extended care services furnished under a contract between a county Community Mental Health Program (CMHP) of the FQHC and Addictions and Mental Health Division (AMH) are reimbursed outside of the PPS. Extended care services are those services provided under licensure requirements found in OAR 309-032-0720 through 0830 and 309-035-0100 through 0600 and receive reimbursement under the terms and conditions of OAR 309-016-0000 through 0450.

(6) Some DMAP Medicaid-covered services are not reimbursable when furnished according to Oregon Health Plan (OHP) client's benefit package as a stand alone service. Although costs incurred for furnishing these services are inclusive of the PPS all-inclusive rate calculation, visits where these services were furnished as a stand alone service were excluded from the denominator for the PPS rate calculation, Refer to OAR 410-147-0480, Cost Statement (DMAP 3027) Instructions. The following services when furnished as a stand-alone service are not reimbursable:

(a) Case management services, including case management by a Primary Care Manager (PCM) as defined in OHP Administrative Rules (OAR 410-141-0700) and previously provided under a PCM contract;

(b) Sign language and oral interpreter services;

(c) Supportive rehabilitation services including, but not limited to, environmental intervention, supported housing and employment, or skills training and activity therapy to promote community integration and job.

(7) FQHCs and RHCs may provide certain services, items and supplies that are prohibited from being billed under the health centers provider enrollment, and requires separate enrollment. Refer to OAR 410-147-0320(1)(b) Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment. These services:

(a) Durable medical equipment, prosthetics, orthotics or medical supplies (e.g. diabetic supplies) (DMEPOS) not generally provided during the course of a clinic visit. Refer to OAR 410 Division 122, DMEPOS;

(b) Prescription pharmaceutical and/or biologicals not generally provided during the clinic visit must be billed to DMAP through the pharmacy program. Refer to OAR 410 Division 121, Pharmaceutical Services;

(c) Targeted case management (TCM) services. Refer to OAR 410 Division 121, Pharmaceutical. Refer to OAR 410 Division 138, TCM for specific information.

(8) Client contact with more than one health professional for the same diagnosis or multiple encounters with the same health professional that take place on the same day and at a single location constitute a single encounter. For exceptions to this rule, refer to OAR 410-147-0140 for reporting multiple encounters.

(9) Providers are advised to include all services that can appropriately be reported using a procedure code on the claim and bill as instructed in the appropriate DMAP program rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the Client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Provider rules. Refer to OARs 410-120-1280 Billing and 410-147-0040 ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes,

(10) FQHC and RHC services that may meet the criteria of a valid encounter are. (Refer to individual program administrative rules for service limitations.):

(a) Medical (OAR 410 Division 130);

(b) Diagnostic: DMAP covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the Prioritized List of Health Services. Once a diagnosis is established for a service, treatment or item that falls below the funding line, DMAP will not cover any other services related to the diagnosis;

(c) Tobacco Cessation (OAR 410-147-0220);

(d) Dental - Refer to OAR 410-147-0125, Table 147-0120-1, and OAR 410 Division 123;

(e) Vision (OAR 410 Division 140);

(f) Physical Therapy (OAR 410 Division 131);

(g) Occupational Therapy (OAR 410 Division 131);

(h) Podiatry (OAR 410 Division 130);

(i) Mental Health (OAR 309 Division 16);

(j) Alcohol, Chemical Dependency, and Addiction services (OAR 415 Divisions 50 and 51). Requires a letter or licensure of approval by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(k) Maternity Case Management (OAR 410-147-0200);

(l) Speech (OAR 410 Division 129);

(m) Hearing (OAR 410 Division 129);

(n) DMAP considers a home visit for assessment, diagnosis, treatment or Maternity Case Management (MCM) as an encounter. DMAP does not consider home visits for MCM as Home Health Services;

(o) Professional services provided in a hospital setting; and

(p) Other Title XIX or XXI services as allowed under Oregon's Medicaid State Plan Amendment and DMAP Administrative Rules.

(11) The following practitioners are recognized by DMAP:

(a) Doctors of medicine, osteopathy and naturopathy;

(b) Licensed Physician Assistants;

(c) Dentists;

(d) Dental Hygienists who hold a Limited Access Permit (LAP) — may provide dental hygiene services without the supervision of a dentist in certain settings. See the section on Limited Access Permits, ORS 680.200 and OAR 818-035-0065 through 818-035-0100 for more information;

(e) Pharmacists;

(f) Nurse Practitioners;

(g) Nurse Midwives;

(h) Other specialized nurse practitioners;

(i) Registered nurses — may accept and implement orders within the scope of their license for client care and treatment under the supervision of a licensed health care professional recognized by DMAP in this section and who is authorized to independently diagnose and treat according to OAR 851 Division 45);

(j) Psychiatrists;

(k) Licensed Clinical Social Workers;

(l) Clinical psychologists;

(m) Acupuncturists (refer to OAR 410 Division 130 for service coverage and limitations); and

(n) Other health care professionals providing services within their scope of practice and working under the supervision requirements of:

(i) Their individual provider's certification or license; or

(ii) A clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320(3) and (5).

(12) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound clients (limited to areas in which the Secretary has determined that there is a shortage of home health agencies — Code of Federal Regulations 42 § 405.2417), and any other ambulatory services covered by DMAP are also reimbursable as permitted within the clinic's scope of services (see OAR 410-147-0020).

(13) FQHCs and RHCs may furnish services that are reimbursed outside of the PPS all-inclusive encounter rate and according to the physician fee schedule. These services include:

(a) Administrative medical examinations and report services (See OAR 410 Division 150);

(b) Death with Dignity services (See OAR 410-130-0670);

(c) Services provided to Citizen/Alien-Waived Emergency Medical (CAWEM) clients. (See OAR 410-120-1210, 461-135-1070 and 410-130-0240);

(d) Services provided to Qualified Medicare Beneficiary (QMB) only clients. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information is located in the FQHC and RHC Supplemental Information billing guide;

(14) OAR 410-120-1210 describes the OHP benefit packages and delivery system. Most OHP clients have prepaid health services, contracted for by the Department of Human Services (DHS) through enrollment in a Prepaid Health Plan (PHP). Non-PHP-enrolled clients, receive services on an "open card" or "fee-for-service" (FFS) basis.

(a) DMAP is responsible for making payment for services provided to open card clients. The provider will bill DMAP the clinic's encounter rate for Medicaid-covered services provided to these clients according to their OHP benefit package. Refer to 410-147-0360, Encounter Rate Determination.

(b) A PHP is responsible to provide, arrange and make reimbursement arrangements for covered services for their DMAP members. Refer to OAR 410-120-0250, and 410 Division 141, OHP Administrative Rules governing PHPs. The provider must bill the PHP directly for services provided to an enrolled client. See also OAR 410-147-0080, Prepaid Health Plans, and 410-147-0460, PHP Supplemental Payment. Clinics must not bill DMAP

for PHP-covered services provided to eligible OHP clients enrolled in PHPs. Exceptions include:

(i) Family planning services provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060); and

(ii) HIV/AIDS prevention provided to a PHP-enrolled client when the clinic does not have a contract with the PHP, and if the PHP denies payment (see OAR 410-147-0060).

(15) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances DMAP will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before billing DMAP. Refer to OAR 410-120-1140 Verification of Eligibility.

(16) When a Provider receives a payment from any source prior to the submission of a claim to DMAP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See OARs 410-120-1280 Billing and 410-120-1340 Payment.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 13-1993, f. & cert. ef. 71-1-93; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0390; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0150; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0125

OHP Standard Emergency Dental Benefit

(1) Clients with the OHP Standard benefit package have a limited dental benefit. The intent of the OHP Standard Emergency Dental benefit is to provide services requiring immediate treatment and is not intended to restore teeth. Services are limited to the treatment of conditions listed in Oregon Administrative Rule (OAR) 410-123-1670(3).

(2) Hospital Dentistry is not a covered benefit for the OHP Standard population, except for clients specified in OAR 410-123-1670(4).

(3) Dental services for the OHP standard population are limited to those procedures listed in OAR 410-123-1260, Table 123-1260-1.

(4) Any limitations or prior authorization requirements for services listed in OARs 410-123-1160 and 410-123-1260 will also apply to services in the OHP Standard benefit when provided by an FQHC or RHC.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0140

Multiple Encounters

(1) An encounter is defined in OAR 410-147-0120.

(2) The following services may be considered as multiple encounters when two or more service encounters are provided on the same date of service with distinctly different diagnoses (Refer to OAR 410-147-0120 and individual program rules listed below for specific service requirements and limitations):

(a) Medical (Section (4) of this rule, and OAR 410 Division 130);

(b) Dental (OAR 410-147-0125, Table 147-0120-1, and 410 Division 123);

(c) Mental Health (OAR 309 Division 016). If a client is also seen for a medical office visit and receives a mental health diagnosis, then the client contacts are a single encounter;

(d) Addiction and Alcohol and Chemical Dependency (OAR 415 Divisions 50 and 51). If a client is also seen for a medical office visit and receives an addiction diagnosis, then the client contacts are a single encounter;

(e) Ophthalmologic services — fitting and dispensing of eyeglasses are included in the encounter when the practitioner performs a vision examination. (OAR 410 Division 140);

(f) Maternity Case Management MCM (OAR 410-147-0200);

(g) Physical or occupational therapy (PT/OT) — If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter (OAR 410 Division 131); and

(h) Immunizations — if no other medical office visit occurs on the same date of service.

(3) Division of Medical Assistance Programs (DMAP) expects that multiple encounters will occur on an infrequent basis.

(4) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and that share the same or like diagnoses constitute a single encounter, except when one of the following conditions exist:

(a) After the first Medical service encounter, the patient suffers a distinctly different illness or injury requiring additional diagnosis or treatment. More than one office visit with a medical professional within a 24-hour period and receiving distinctly different diagnoses may be reported as two encounters. This does not imply that if a client is seen at a single office visit with multiple problems that the provider can bill for multiple encounters;

(b) The patient has two or more encounters as described in Section (2) of this rule.

(5) A mental health encounter and an addiction and alcohol and chemical dependency encounter provided to the same client on the same date of service will only count as multiple encounters when provided by two separate health professionals and each encounter has a distinctly different diagnosis.

(6) Similar services, even when provided by two different health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(a) A well child check and an immunization;

(b) A well child check and fluoride varnish application in a medical setting;

(c) A mental health and addiction encounter with similar diagnoses;

(d) A prenatal visit and a delivery procedure;

(e) A cesarean delivery and surgical assist;

(f) Any time a client receives only a partial service with one provider and partial service from another provider, this would be considered a single encounter.

(7) A clinic may not develop clinic procedures that routinely involve multiple encounters for a single date of service. A recipient may obtain medical, dental or other health services from any provider approved by DMAP, and/or contracts with the recipient's PHP, if the FQHC/RHC is not the recipient's primary care manager.

(8) Clinics may not "unbundle" services that are normally rendered during a single visit for the purpose of generating multiple encounters:

(a) Clinics are prohibited from asking the patient to make repeated or multiple visits to complete what is considered a reasonable and typical office visit, unless it is medically necessary to do so;

(b) Medical necessity must be clearly documented in the patient's record.

Stat. Auth.: ORS 409.05, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0520; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0155; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0160

Modifiers

(1) The Division of Medical Assistance Programs (DMAP) uses HIPAA compliant modifiers for many services.

(2) The following conditions require the use of a modifier for all codes:

(a) Family Planning Service — FP, Refer to OAR 410-130-0585 Family Planning Services

(b) Vaccine for Children — SL or 26, Refer to OAR 410-130-0255(4)

(3) When billing for services that are reimbursed outside a clinic's encounter rate, a clinic must use the required modifier(s) listed in the individual program Administrative Rules.

(a) Enhanced Care Services (including extended care) — HK, Refer to OAR 410-147-0120;

(b) Assist surgeon for cesarean deliveries for Citizen Alien Waived Emergency Medical (CAWEM) clients — 80, 81, 82 or AS.

Stat. Auth.: ORS 409.050, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0180
Vaccines for Children (VFC) Program

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the administration of vaccines to eligible clients.

(2) The VFC program supplies federally purchased free vaccines for immunizing eligible client's ages 0 through 18 at no cost to participating health care providers. For more information on how to enroll in the VFC program, contact the Department of Human Services Immunization Program. Refer to the FQHC and RHC Supplemental Information for instructions.

Stat. Auth.: ORS 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0540; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0160; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0200
Maternity Case Management Services

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for Maternity Case Management (MCM) services.

(2) MCM service is optional coverage for Prepaid Health Plans (PHPs). Before providing MCM services to a client enrolled in an PHP, determine if the PHP covers MCM services:

(a) If the PHP does not cover MCM services, the provider can bill DMAP directly per the clinic's PPS encounter rate. Prior authorization is not required if the PHP does not provide coverage for MCM services;

(b) If the PHP does cover MCM services, the provider needs to request the necessary authorizations from the PHP.

(3) Clients' records must clearly document all MCM services provided including all mandatory topics. Refer to OAR 410-130-0595, Maternity Case Management (MCM) for specific requirements.

(4) The primary purpose of the MCM program is to optimize pregnancy outcomes, including the reduction of low birth weight babies. MCM services are intended to target pregnant women early during the prenatal period and can only be initiated when the client is pregnant.

(a) MCM services cannot be initiated the day of delivery, during postpartum or for newborn evaluation;

(b) Clients are not eligible for MCM services if the provider has not completed the MCM initial evaluation the day before delivery;

(c) No other MCM service can be performed until an initial assessment has been completed.

(5) Multiple MCM contacts in a single day do not qualify as multiple encounters.

(6) A medical/prenatal visit encounter and an MCM encounter can qualify as two separate encounters when furnished on the same day only when the MCM service is:

(a) The initial evaluation to receive MCM service; or

(b) A nutritional counseling MCM service provided after the initial evaluation visit. See Section (7)(c) of this rule for limitations.

(7) MCM Services limitations:

(a) DMAP reimburses the initial evaluation one time per pregnancy per provider;

(b) Providers may bill DMAP for case management visits four times per pregnancy. In addition, if a client is identified as high risk; the practitioner may bill six additional case management visits;

(c) DMAP reimburses Nutritional Counseling one time per pregnancy if a client meets the criteria in OAR 410-130-0595(14); and

(d) DMAP reimburses a Home/Environmental Assessment one time per pregnancy, and is included in the total number of case management visits in Section (7)(b) of this rule.

(8) A client may only participate in a single case management program. DMAP does not allow multiple case management billings. This includes Maternity Case Management (MCM), and any Targeted Case Management (TCM) Program outlined in OAR 410 Division 138.

Stat. Auth.: ORS 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0560; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0180; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0220
Tobacco Cessation

(1) The Division of Medical Assistance Programs (DMAP) will reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for tobacco cessation services under the encounter rate.

(2) Refer to OAR 410-130-0190 for specific requirements and treatment limitations.

(3) Tobacco Cessation, a specific DMAP prevention program, does not qualify as a separate encounter when a medical, dental, mental health or addiction service encounter occurs on the same date of service.

Stat. Auth.: ORS 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01;OMAP 19-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0580; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0200; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0320
Federally Qualified Health Center (FQHC)/Rural Health Clinics (RHC) Enrollment

(1) This rule outlines the Division of Medical Assistance Programs (DMAP) enrollment requirements for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Refer also to OARs governing provider enrollment 410-120-1260 and 407-0120-0320.

(a) For outpatient health programs or facilities operated by an American Indian tribe under the Indian Self-Determination Act (Public Law 93-638), providers should refer to the program rules for American Indian/Alaska Native (AI/AN) Services, OAR 410 Division 146, for enrollment details;

(b) An FQHC or RHC that operates a retail pharmacy, provides durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), or provides targeted case management (TCM) services, must enroll separately as a pharmacy, DMEPOS and/or TCM provider. Refer to OAR 410 Division 121, Pharmaceutical; 410 Division 122, DMEPOS; and 410 Division 138, TCM for specific information.

(c) A county Community Mental Health Program (CMHP) furnishing Extended Care services under contract with DHS Addictions and Mental Health Division should refer to OAR 309-032-0720 through 0830 and 309-035-0100 through 0600 for licensure requirements and 309-016-0000 through 0450 for reimbursement requirements.

(2) To enroll with DMAP as an FQHC, a health center must comply with one of the following:

(a) Receive Public Health Service (PHS) grant funds under the authority of Section 330;

(b) Have received FQHC Look-Alike designation from the Centers for Medicare and Medicaid Services (CMS), based on the recommendation of the Health Resources and Services Administration (HRSA)/Bureau of Primary Health Care (BPHC); or

(c) Be an Urban Indian Health Program (UIHP) clinic (under Title V of the Indian Health Care Improvement Act, Public Law 94-437). In the Omnibus Reconciliation Act (OBRA) of 1993, Title V programs were added to the list of specific programs automatically eligible for FQHC designation.

(3) Eligible FQHCs who want to enroll with DMAP as an FQHC, and receive reimbursement under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed DHS provider enrollment forms with attachments as required in OARs 407-0120-0300 through -0320;

(b) National Provider Identifier (NPI) number and associated taxonomy code(s) obtained for the FQHC with the provider enrollment form. OAR 407-0120-0320(10);

(c) Completed Cost Statement(s) (DMAP 3027):

(A) One each for medical, dental and mental health (including addiction, alcohol and chemical dependency). See also OAR 410-147-0360;

(B) One for each FQHC-designated site, unless specifically exempted in writing by DMAP to file a consolidated cost report. See also OAR 410-147-0340 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)/Provider Numbers;

(d) Completed copy of the grant proposal submitted to HRSA/BPHC detailing the clinic's service and geographic scope;

(e) Copy of the HRSA Notice of Grant Award Authorization for Public Health Services Funds under Section 330, or a copy of the letter from CMS designating the facility as a "Look Alike" FQHC;

(f) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports;

(g) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations";

(h) Depreciation schedules;

(i) Overhead cost allocation schedule;

(j) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220, Certificates of Approval for Mental Health Services; 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(k) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(l) A list of all Prepaid Health Plan (PHP) contracts;

(m) A list including names and NPI numbers of individual practitioners enrolled with DMAP and contracted with or employed by the FQHC; and

(n) A list including business names, addresses and facility NPI numbers for all DMAP-enrolled clinics affiliated or owned by the FQHC including any clinics that do not have FQHC status.

(4) For enrollment with DMAP as an RHC, a clinic must:

(a) Be designated by CMS as an RHC.

(b) Maintain Medicare certification and be in compliance with all Medicare requirements for certification.

(5) Eligible RHCs who want to enroll with DMAP as an RHC, and be eligible for payment under the Prospective Payment System (PPS) encounter rate methodology, must submit the following information:

(a) Completed DHS provider enrollment forms with attachments as required in OARs 407-0120-0300 through -0320;

(b) National Provider Identifier (NPI) number and any associated taxonomy codes obtained for the RHC with the provider enrollment form. OAR 407-0120-0320(10);

(c) Copy of Medicare's letter certifying the clinic as an RHC;

(d) Medicare Cost Report for RHC or completed Cost Statement(s) (DMAP 3027). See also OAR 410-147-0360. Complete a cost statement for each RHC-designated site, unless specifically exempted in writing by DMAP to file a consolidated cost report. See also OAR 410-147-0340:

(A) DMAP will accept an uncertified Medicare Cost Report;

(B) If the clinic's Medicare Cost Report, provided to DMAP, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. DMAP will include these costs when determining the PPS encounter rate;

(C) An RHC can submit the Cost Statement (DMAP 3027) as a substitute to the Medicare Cost Report.

(e) A copy of the clinic's trial balance. See OAR 410-147-0500, Total Encounters for Cost Reports (only if completing Cost Statement DMAP 3027);

(f) Audited financial statements. Refer to OAR 410-120-1380 Compliance with Federal and State Statutes, and Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations" (only if completing Cost Statement DMAP 3027);

(g) Depreciation schedules (only if completing Cost Statement DMAP 3027);

(h) Overhead cost allocation schedules (only if completing Cost Statement DMAP 3027);

(i) A copy of the clinic's Addictions and Mental Health Division (AMH) certification for a program of mental health services if someone other than a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker or psychiatric nurse practitioner is providing mental health services. Refer to OAR 309-012-0130 through 309-012-0220, Certificates of Approval for Mental Health Services; 309-032-0525 through 309-032-0605, Standards for Adult Mental Health Services; 309-032-0950 through 309-032-1080, Standards for Community Treatment Services for Children; and 309-039-0500 through 309-039-0580, Standards for the Approval of Providers of Non-Inpatient Mental Health Treatment Services;

(j) A copy of the clinic's AMH letter or licensure of approval if providing Addiction, Alcohol and Chemical Dependency services. Refer to OAR 415 Division 12, Standards for Approval/Licensure of Alcohol and other Abuse Programs;

(k) A list of all Prepaid Health Plan (PHP) contracts;

(l) A list including names and NPI numbers of individual practitioners enrolled with DMAP and contracted with or employed by the RHC; and

(m) A list including business names, addresses and facility NPI numbers for all DMAP-enrolled clinics affiliated or owned by the RHC including any clinics that do not have RHC status..

(6) The FQHC/RHC Program Manager, upon receipt of the required items as listed in Section (3) of this rule for FQHCs and Section (5) of this rule for RHCs, will review all documents for compliance with program rules, completeness and accuracy.

(7) DMAP prohibits an established, enrolled FQHC or RHC that adds or opens a new clinic site from submitting claims for services rendered at the new site under their FQHC or RHC DMAP enrollment, and according to the PPS encounter rate, prior to DMAP's acknowledgment. An FQHC or RHC is required to immediately submit to the attention of the FQHC/RHC Program Manager, DMAP:

(a) For FQHCs only, a copy of the recent HRSA Notice of Grant Award including the new site under the main FQHC's scope;

(b) For RHCs only, a copy of Medicare's letter certifying the new clinic as an RHC;

(c) A recent list of all Prepaid Health Plan (PHP) contracts; and

(d) A recent list of names and NPI numbers for all individual practitioners enrolled with DMAP and contracted with or employed by the new FQHC or RHC site.

(8) If an established and enrolled RHC or FQHC changes ownership, the new owner must submit:

(a) Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated; or in writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership. Refer to OAR 410-147-360(13) for more information;

(b) Notice of a change in tax identification number;

(c) A recent list of all Prepaid Health Plan (PHP) contracts;

(d) A recent list of names and NPI numbers for all individual practitioners enrolled with DMAP and contracted with or employed by the FQHC or RHC; and

(f) A recent list including business names, addresses, NPI numbers and associated taxonomy codes for all DMAP-enrolled clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status.

(9) FQHCs that are involved with a sub-recipient must provide documentation. Sub-recipient contracts with an FQHC must enroll as an FQHC and submit the same required documentation as outlined under the enrollment sections of this rule.

Stat. Auth.: ORS 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0010; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0340

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)/Provider Numbers

(1) Pursuant to NPI requirements in 45 CFR Part 162 and in accordance with OAR 407-0120-0320(10) providers are required to use a National Provider Identifier number, and in specific situations associated taxonomy code(s), when billing DMAP.

(2) A Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) will register the NPI number and associated taxonomy code, obtained for the FQHC or RHC at the time of enrollment. Multiple sites are not separately enrolled, unless each site has a different tax identification number.

(3) The Division of Medical Assistance Programs (DMAP) may grant exception to section (2) of this rule upon written request to DMAP — Attn: FQHC/RHC Program Manager. The request must include a detailed explanation describing the:

(a) Need for separate enrollment of an additional site(s); and

(b) Mechanisms in place to assure no duplication of billings.

(4) If DMAP finds evidence of duplicate or inappropriate billing resulting from provider misuse under multiple enrollments, DMAP may terminate the exception upon written notice to the clinic.

(5) Once a clinic enrolls as a FQHC or RHC, DMAP may terminate enrollment of individual practitioners associated with the FQHC or RHC effective the FQHC or RHC's enrollment date. Associated" refers to a practitioner who is either subcontracted or employed by the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain individual active enrollment with DMAP under one of the two situations:

(a) The practitioner maintains a private practice; or

(b) The practitioner is also employed by a non-FQHC or RHC site.

(6) The FQHC/RHC or practitioner must submit a written request for exemption, including why individual enrollment should not be terminated to DMAP — Attn: FQHC/RHC Program Manager.

(7) If DMAP grants an exception to section (2) of this rule, DMAP will separately enroll each clinic site. When granted multiple provider enrollments, clinics must register:

(a) A separate NPI number for each clinic; or

(b) One NPI number and separate taxonomy codes for each clinic.

(8) If an FQHC or RHC has several clinic sites and one or more of the clinics are not designated as an FQHC or RHC, the non-FQHC or non-RHC (each individual clinic) must:

(a) Enroll as a billing provider; and

(b) Each practitioner must individually enroll.

(9) Upon enrollment and each October thereafter, FQHCs and RHCs must submit to DMAP:

(a) A list including names and NPI numbers of individual practitioners associated with the FQHC/RHC; and

(b) A list including business names, addresses and facility NPI numbers for all DMAP-enrolled clinics affiliated or owned by the FQHC or RHC including any clinics that do not have FQHC or RHC status

(10) An FQHC or RHC that operates a retail pharmacy, provides durable medical equipment (DME), prosthetics, orthotics, and supplies (DMEPOS), must enroll separately as a pharmacy and/or DMEPOS provider. Refer to OAR 410 Division 121, Pharmaceutical and OAR 410 Division 122, DMEPOS; for specific information. These services are not bill under FQHC or RHC enrollment.

(11) DMAP will coincide registration of a clinic's NPI number and associated taxonomy codes(s) if applicable, effective the date of enrollment with DMAP as an FQHC or RHC, and after the encounter rate is established.

(12) Prepaid Health Plans (PHP) are required to report all PHP encounters using the FQHC/RHC's NPI and associated taxononmy code(s), if required, and not individual practitioner NPI numbers and taxonomy codes.

Stat. Auth.: ORS 409.050, 409.110, 414.065
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0360
Encounter Rate Determination

(1) The Division of Medical Assistance Programs (DMAP) will coincide enrollment of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) with the calculation of a clinic's Prospective Payment System (PPS) encounter rate:

(a) DMAP will enroll a clinic as an FQHC or RHC effective the date DMAP determines the clinic's PPS encounter rate. The encounter rate may be used to bill for services provided on or after the coinciding effective dates of enrollment as an FQHC or RHC with DMAP and determination of the clinic's encounter rate.

(b) Consistent with OAR 410-120-1260, Provider Enrollment, only enrolled providers can submit claims to DMAP for providing specific care, item(s), or service(s) to DMAP clients. A clinic or individual provider needs to bill fee-for-service for services provided prior to enrollment as an FQHC or RHC with DMAP, according to applicable service program's enrollment and billing Oregon Administrative Rules (OARs).

(2) To determine the PPS encounter rate(s), an FQHC must submit all financial documents listed in OAR 410-147-0320 for each Medical, Dental and Mental Health (including Addiction, Alcohol and Chemical Dependency) Services.

(a) Effective October 1, 2004, for FQHCs only, DMAP will calculate three separate PPS encounter rates for clinics newly enrolling as an FQHC with DMAP:

(i) Medical;

(ii) Dental; and

(iii) Mental Health, to include addiction, alcohol and chemical dependency services.

(b) FQHCs enrolled with DMAP prior to October 1, 2004, with a single PPS medical encounter rate, will have a separate encounter rate calculated if the clinic adds a service category listed in either Section (2)(a)(ii) or (iii) of this rule. Refer also to Section (16) of this rule.

(3) To determine the PPS encounter rate, a RHC must submit all financial documents listed in OAR 410-147-0320.

(a) DMAP will accept an uncertified Medicare Cost Report;

(b) If the clinic's Medicare Cost Report, provided to DMAP, does not include all covered Medicaid costs provided by the clinic, the clinic must submit additional cost information. DMAP will include these costs when determining the PPS encounter rate.

(c) DMAP will remove the Medicare productivity screen and any other Medicare payment caps from the RHC's Medicare encounter rate;

(d) An RHC can submit the DMAP cost statement form 3027 as a substitute to the Medicare Cost Report.

(4) FQHCs or RHCs that have an additional clinic site(s) under the main FQHC or RHC designation, must file the required financial documentation for each clinic site unless specifically exempted in writing by DMAP. If exempted from this requirement by DMAP, an FQHC or RHC may file a consolidated cost report. See OAR 410-147-0340 regarding separate enrollment for multiple sites.

(5) FQHCs and RHCs cannot include costs associated with non-FQHC or non-RHC designated sites in the cost report.

(6) FQHCs and RHCs cannot include costs associated with non-covered Medicaid services. DMAP does not allow the inclusion of indirect or direct costs for non-covered Medicaid services in the clinic's cost report/statement as allowed expenses. Refer to OAR 410-120-1200 Excluded Services and Limitations.

(7) An out-of-state FQHC or RHC will only include expenses associated with Medicaid covered services provided at clinic sites serving DMAP clients when completing the Cost Statement (DMAP 3027). For RHCs only, the Medicare Cost Report can only include financial documents for Medicaid-covered services provided at clinic sites that see DMAP clients. Do not include costs associated with non-FQHC or RHC designated sites, or clinic sites that do not serve DMAP clients in the Cost Statements (DMAP 3027) or Medicare Cost Reports for RHCs.

(8) At any time, if DMAP determines that the costs provided by the clinic for calculating the PPS encounter rate(s) were inflated, DMAP may:

(a) Request corrected cost reports and any other financial documents in order to review and adjust the encounter rate(s); and

(b) Impose sanctions as defined in OARs 410-120-1400 Provider Sanctions, 410-120-1460 Type and Conditions of Sanctions; and 407-120-360 Consequences of Non-Compliance and Provider Sanctions.

(9) Effective January 1, 2001, DMAP determines FQHC and RHC encounter rates in compliance with 42 USC 1396a(bb). In general, the PPS encounter rate is calculated by dividing total costs of Medicaid covered services furnished by the FQHC/RHC during fiscal years 1999 and 2000 by the total number of clinic encounters during the two fiscal years.

(10) Clinics existing in 1999 and 2000, and enrolled with DMAP as a FQHC or RHC as of January 1, 2001, receive payment from DMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness.

(11) Clinics first qualifying as an FQHC or RHC after fiscal year 2000, will receive payment from DMAP for services rendered to Medicaid-eligible OHP clients per an all-inclusive PPS encounter rate (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the clinic for furnishing such services during the fiscal year the clinic first qualifies as an FQHC or RHC. Coinciding with enrollment as an FQHC or RHC with DMAP, a clinic will have a PPS encounter rate:

(a) Established by reference to payments to other clinics located in the same or adjacent areas, and of similar caseload; or

(b) In the absence of such clinic, through cost reporting methods based on tests of reasonableness.

(12) Beginning in fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the PPS encounter rate(s) payment amount to which the clinic was entitled under Section 42 USC 1396a(bb) in the previous fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI).

(13) For established, enrolled clinics with a change of ownership, the new owner can submit:

(a) A Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership for review by DMAP to

determine if a new PPS encounter rate will be calculated as otherwise described in this rule; or

(b) In writing, a letter advising adoption of the PPS encounter rate calculated under the former ownership, including notice if there is a change to the clinic's tax identification number;

(c) Failure to submit a cost statement (DMAP 3027) or Medicare Cost Report within 30 days of the change of ownership, will forfeit the opportunity for calculation of a PPS encounter rate(s) at a later date. The PPS encounter rate(s) calculated under the former ownership will be reassigned to the new ownership.

(14) The Centers for Medicare and Medicaid Services (CMS) defines a change in scope of services as one that affects the type, intensity, duration, and amount of services. Clinics must submit a request for change in scope to DMAP for review.

(15) DMAP may establish a separate PPS encounter rate if a FQHC adds Dental or Mental Health (including addiction, and alcohol and chemical dependency) services. A separate PPS encounter rate will be calculated by DMAP for the added service element if:

(a) Costs associated with the added service element were not included on the original cost statements for the initial PPS encounter rate determination;

(b) The addition of the service element has been approved by the Health Resources and Services Administration (HRSA) and is included in the notice of grant award issued by HRSA;

(c) The FQHC is certified by the Addictions and Mental Health Division (AMH) to provide mental health services (if mental health services are provided by un-licensed providers), or has a letter or licensure of approval by Addictions and Mental Health Division (AMH) former Office of Mental Health and Addictions Services (OMHAS) to provide addiction, and alcohol and chemical dependency services;

(i) Certification by AMH of an FQHC's outpatient mental health program is required if mental health services are provided by non-licensed providers. Refer to OAR 410-147-0320(3)(i) and (5)(h) for certification requirements

(iii) A letter of licensure or approval by AMH is required for FQHCs providing addiction, alcohol and chemical dependency services. Refer to OAR 410-147-0320 (3)(j) and (5)(i);

(16) If an FQHC meets the criteria as outlined in Section (15) of this rule for the addition of Dental or Mental Health (including addiction, and alcohol and chemical dependency) services, after the initial encounter rate determination, DMAP will determine the PPS encounter rate for the newly added service element using the date the scope change was approved by HRSA. For example: the clinic submitted 1999 & 2000 cost reports. In 2001 the clinic added a dental clinic. The cost report would be from 2001 (the most appropriate months) with the MEI adjusted for 2002, 2003 and 2004.

(17) When an FQHC shares the same space for multiple services, then DMAP will use square footage to determine the percent of the indirect cost associated with each encounter rate.

(18) A clinic may be exempt from this requirement if an FQHC has minimal utilization for a particular service such as "Look Alike" clinics and is located in an isolated area. Submit an exemption request with appropriate documentation to the DMAP FQHC Program Manager for consideration.

Stat. Auth.: ORS 409.050, 409.110, 414.065
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0460
Prepaid Health Plan Supplemental Payments

(1) Effective January 1, 2001, the Division of Medical Assistance Programs (DMAP) is required by 42 USC 1396a(bb), to make supplemental payments to eligible Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) that contract with Prepaid Health Plans (PHP).

(2) The PHP Supplemental Payment represents the difference, if any, between the payment received by the FQHC/RHC from the PHP(s) for treating the PHP enrollee and the payment to which the FQHC/RHC would be entitled if they had billed DMAP directly for these encounters according to the clinic's Medicaid Prospective Payment System (PPS) encounter rate. Refer to OAR 410-147-0360.

(3) In accordance with federal regulations the Provider must take all reasonable measures to ensure that in most instances Medicaid will be the payer of last resort. Providers must make reasonable efforts to obtain payment first from other resources before submitting claims to the PHP. Refer to OAR 410-147-0120(14).

(4) When any other coverage is known to the provider, the provider must bill the other resource(s) prior to billing the PHP. When a Provider receives a payment from any source prior to the submission of a claim to the PHP, the amount of the payment must be shown as a credit on the claim in the appropriate field. See also OAR 410-120-1280 Billing and 410-120-1340 Payment.

(5) Supplemental payment by DMAP for encounters submitted by FQHC/RHCs for purposes of this rule is reduced by any and all payments received by the FQHC/RHC from outside resources, including Medicare, private insurance or any other coverage. Therefore, FQHC/RHCs are required to report all payments received on the Managed Care Data Submission Worksheet, including:

(a) Medicaid PHPs;

(b) Medicare Advantage Managed Care Organizations (MCO);

(c) Medicare, including Medicare MCO supplemental payments; and

(d) Any Third Party Resource(s) (TPR).

(6) DMAP will calculate the PHP Supplemental Payment in the aggregate of the difference between total payments received by the FQHC/RHC, to include payments as listed in Section (5) of this rule and the payment to which the FQHC/RHC would have been eligible to claim as an encounter if they had billed DMAP directly per their PPS encounter rate.

(7) Effective July 1, 2006, FQHC/RHCs must submit their clinic's data beginning with dates of service January 1, 2006 and after, using the Managed Care Data Submission Template developed by DMAP to report all PHP encounter and payment activity.

(8) To facilitate DMAP processing PHP supplemental payments, the FQHC or RHC must submit the following:

(a) To PHPs:

(A) Claims within the required timelines outlined in the contract with the PHP and in OAR 410-141-0420, Oregon Health Plan Prepaid Health Plan Billing Payment Under the Oregon Health Plan;

(B) The NPI number and associated taxonomy code, registered by the FQHC or RHC clinic with DMAP must be used when submitting all claims to the PHPs;

(b) To DMAP:

(A) Report total payments for all services submitted to the PHP:

(i) Including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and

(ii) Excluding any bonus or incentive payments;

(B) Report total payments for each category listed in the "Amounts Received During the Settlement Period" section of the Managed Care Data Submission Template Coversheet;

(C) Payments are to be reported at the detail line level on the Managed Care Data Submission Template Worksheet, except for capitated payments, or per member per month and risk pool payments received from the PHP;

(D) The total number of actual encounters. An encounter represents all services for a like service element (Medical, Dental, Mental Health, or Alcohol and Chemical Dependency) provided to an individual client on a single date of service. The total number of encounters is not the total number of clients assigned to the FQHC or RHC or the total detail lines submitted on the Managed Care Data Submission Template Worksheet;

(E) All individual NPI numbers and taxonomy codes assigned to practitioners associated with the FQHC or RHC. A practitioner associated with an FQHC or RHC can only retain individual active enrollment with DMAP in limited situations. Refer to OAR 410-147-0340(3).

(F) A current list of all PHP contracts. An updated list of all PHP contracts must be submitted annually to DMAP no later than October 31 of each year.

(9) PHP Supplemental Payment process:

(a) DMAP will process PHP Supplemental Payments on a quarterly basis:

(A) Quarterly processing of PHP Supplemental Payments includes a final reconciliation for the reported time period;

(B) For an FQHC or RHC approved by DMAP to participate in a pilot project, PHP Supplemental Payments will be processed at the discretion of DMAP in collaboration with health centers;

(b) Upon processing a clinic's data and the PHP Supplemental Payment, DMAP will:

(A) Send a check to the clinic for PHP Supplemental Payment calculated from clinic data DMAP was able to process;

(B) Provide a cover letter and summary of the payment calculation; and

(C) Return data that is incomplete, unmatched, or cannot otherwise be processed by DMAP;

(c) The FQHC or RHC is responsible for reviewing the data DMAP was unable to process for accuracy and completeness. The clinic has 30 days, from the date of DMAP's cover letter under Section (9)(b) of this rule, to make any corrections to the data and resubmit to DMAP for processing. Documentation supporting any and all changes must accompany the resubmitted data. A request for extension must be received by DMAP prior to expiration of the 30 days, and must:

(A) Be requested in writing;

(B) Accompanied by a cover letter fully explaining the reason for the late submission; and

(C) Provide an anticipated date for providing DMAP the clinic's resubmitted data and supporting documentation;

(d) Within 30 days of DMAP's receipt of the re-submitted data, DMAP will:

(A) Review the data and issue a check for all encounters DMAP 7verifies to be valid; and

(B) For quarterly data submissions, send a letter outlining the final quarterly settlement including any other pertinent information to accompany the check;

(e) The FQHC or RHC should submit data to DMAP within the timelines provided by DMAP.

(10) Clinics must carefully review in a timely fashion the data that DMAP was unable to process and returns to the FQHC or RHC. If clinics do not bring any incomplete, inaccurate or missing data to DMAP's attention within the time frames outlined, DMAP will not process an adjustment.

(11) DMAP encourages FQHCs and RHCs to request PHP Supplemental Payment in a timely manner.

(12) Clinics must exclude from a clinic's data submission for PHP supplemental payment, clinic services provided to a PHP-enrolled client when the clinic does not have a contract or agreement with the PHP. This may not apply to family planning services, or HIV/ AIDS prevention services. Family Planning and HIV/AIDS prevention services provided to a PHP-enrolled client when a clinic does not have a contract or agreement with the PHP:

(a) Must be reported in the clinic's data submission for PHP Supplemental Payment if the clinic receives payment from the PHP;

(b) Cannot be reported in the clinic's data submission for PHP Supplemental Payment if the clinic is denied payment by the PHP. If the PHP denies payment to the clinic, the clinic can bill these services directly to DMAP. (See also OAR 410-147-0060).

(13) If a PHP denies payment to an FQHC or RHC for all services, items and supplies provided to a client on a single date of service and meeting the definition of an "encounter" as defined in OAR 410-147-0120, for the reason that all services, items and supplies are non-covered by the plan, DMAP is not required to make a supplemental payment to the clinic. The following examples are excluded from the provision of this rule:

(a) Encounters that will later be billed to the PHP as a covered global procedure (e.g. Obstetrics Global Encounter);

(b) Had payment received by Medicare, and any other third party resource not have exceeded the payment the PHP would have made, the PHP would have made payment;

(c) At least one of the detail lines reported for all services, items and supplies provided to a client on a single date of service and represents an "encounter," has a reported payment amount by the PHP.

(14) If an FQHC or RHC has been denied payment by a PHP because the clinic does not have a contract or agreement with the PHP, DMAP is not required to make a supplemental payment to the clinic. DMAP is only required to make a PHP supplement payment when the FQHC or RHC has a contract with a PHP.

(15) DMAP will not reimburse some Medicaid covered services that are only reimbursed by PHPs, and are not reimbursed by DMAP. DMAP will not make PHP supplemental payment for these services, as DMAP does not reimburse these services when billed directly to DMAP.

(16) It is the responsibility of the FQHC or RHC to refer PHP-enrolled clients back to their PHP if the FQHC or RHC does not have a contract with the PHP, and the service to be provided is not family planning or HIV/AIDS prevention. The Provider assumes full financial risk in serving a person not confirmed by DMAP as eligible on the date(s) of service. See OAR 410-120-1140. It is the responsibility of the Provider to verify:

(a) That the individual receiving medical services is eligible on the date of service for the service provided; and

(b) Whether a client is enrolled with a PHP or receives services on an "open card" or "fee-for-service" basis.

Stat. Auth.: ORS 409.050, 409.110, 414.065
Stat. Implemented: ORS 414.065
Hist.: OMAP 63-2002, f. & cert. ef. 10-1-02; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0480
Cost Statement (DMAP 3027) Instructions

(1) The Division of Medical Assistance Programs (DMAP) requires Federally Qualified Health Centers (FQHC) to submit Cost Statements (DMAP 3027).

(2) Rural Health Clinics (RHC) can choose to submit either their Medicare Cost Report or the Cost Statement (DMAP 3027). If the RHC files a Medicare Cost Report, DMAP may request additional information.

(3) DMAP reimburses some services, items and supplies fee-for-service, outside of a FQHC or RHC's Prospective Payment System (PPS) encounter rate. For this reason, clinics must exclude the costs for the following items from the cost statement:

(a) Contraceptive supplies and contraceptive medications. Refer to OAR 410-147-0280;

(b) Pharmacy. Requires separate enrollment, refer to OAR 410 Division 121, Pharmaceutical Services Program Rulebook for specific information;

(c) Durable Medical Equipment and Supplies. Requires separate enrollment, refer to OAR 410 Division 122, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); and

(d) Targeted Case Management (TCM) services. Requires separate enrollment, refer to OAR 410-147-0610, and 410 Division 138, Targeted Case Management for specific information.

(4) Payment for services provided by FQHCs and RHCs is in accordance with 42 USC 1396a(bb). In general, a Prospective Payment System (PPS) encounter rate is calculated on a per visit basis that is equal to the average of reasonable and allowable costs incurred by a clinic for furnishing services included in the State Plan under Title XIX and XXI of the Social Security Act. The rate is calculated by dividing the total costs incurred by an FQHC or RHC for furnishing services by the total number of clinic encounters as defined in OAR 410-147-0500. A clinic must submit a Cost Statement (DMAP 3027) to DMAP:

(a) For established clinics during an adjustment to the clinic's rate based on a change in scope of clinic services. Refer to OAR 410-147-0360;

(b) For new clinics. Refer also to OAR 410-147-0360; or

(c) If there is a change of ownership, the new owner can submit the Cost Statement (DMAP 3027) or Medicare Cost Report within 30 days from the date of change of ownership to have a new PPS encounter rate calculated. See also OAR 410-147-0320(8).

(5) The Cost Statement (DMAP 3027) must include all documents required by OAR 410-147-0320.

(6) Each section must be completed if applicable.

(7) Page 1 — Statistical Information:

(a) Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, legacy DMAP provider number, current NPI numbers and associated taxonomy code(s); the name of the persons or organizations having legal ownership of the FQHC or RHC; and all provider and health care practitioners as defined on the DMAP 3027 Cost Statement.

(b) The Cost Statement (DMAP 3027) must be prepared, signed and dated by both the FQHC or RHC accountant and an authorized responsible officer.

(8) Page 2 — Part A — FQHC or RHC Practitioner Staff and Visits:

(a) FTE Personnel: List the total number of staff by position;

(b) Encounters: List the number of on-site and off-site encounters by staff. Refer also to OAR 410-147-0500, Total Encounters for Cost Reports. Exclude the following types of encounters from your total encounters:

(A) Outstationed Outreach Workers;

(B) Administration; and

(C) Support staff, or any staff members who do not meet the criteria of OAR 410-147-0120(6) or the qualification or certification requirements under a clinic's mental health certification or alcohol and other drug program approval or licensure by the Addictions and Mental Health Division (AMH). Refer to OAR 410-147-0320.

(9) Pages 3-4 — Reclassification and Adjustment of Trial Balance of Expenses:

(a) Record the expenses for covered health care costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs:

(A) Covered health care (program) costs include all necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper

costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. Whether DMAP allows the costs is subject to the regulations prescribing the treatment of specific items under the Medicaid program. Refer also to OAR 410-147-0020 Professional Services. Covered health care (program) and direct health care costs include but are not limited to:

(i) Personnel costs, including Medical record and medical receptionist costs;

(ii) Administrative costs;

(iii) Employee pension plan costs;

(iv) Normal standby costs;

(v) Medical practitioner salaries; and

(vi) Malpractice insurance costs;

(B) Non-reimbursable program costs are costs that are not related to patient care and which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs that are not necessary include costs that usually are not common or accepted occurrences in the field of the provider's activity. Non-reimbursable program costs include, but are not limited to:

(i) Women, Infants and Children (WIC);

(ii) Community Services/Housing Projects. Refer to OAR 410-120-1200;

(iii) Environmental external maintenance costs (e.g. landscaping, pesticide application);

(iv) Research;

(v) Public Education; and

(vi) Outside services;

(C) Allowable overhead costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. Below are examples of overhead costs:

(i) Administrative costs;

(ii) Billing department expenses;

(iii) Audit costs;

(iv) Reasonable data processing expenses (not including computers, software or databases not used solely for patient care or clinic administration purposes);

(v) Space costs (rent and utilities); and

(vi) Liability insurance costs;

(D) Non-reimbursable overhead costs:

(i) Entertainment;

(ii) Fines and penalties;

(iii) Fundraising;

(iv) Goodwill;

(v) Gifts and contributions;

(vi) Political contributions;

(vii) Bad debts;

(viii) Other interest expense;

(ix) Advertising;

(x) Membership dues for public relations purposes, including country or fraternal club memberships;

(xi) Cost of personal use of motor vehicles;

(xii) Cost of travel incurred in connection with non-patient care related purposes; and

(xiii) Costs applicable to services, facilities, and supplies furnished by a related organization (Related Party Transactions) in excess of the lower of cost to the related organization, or the price of comparable service as rendered by a non-related entity. Refer to OAR 410-147-0540;

(b) Attach expense documentation from financial accounting records and an explanation for allocations, and allocation method used;

(c) Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC Administrative rules on allowable costs. A schedule of any reported reclassification of trial balance expense, whether an increase or decrease, must include:

(A) A reference to the line number on either page 3 or 4;

(B) A description of the reclassification or adjustment;

(C) The amount of the debit or credit; and

(D) The total for each debit and credit;

(d) Net expenses must equal the combined reclassified trial balance taking into account the adjustment amount on each detail line;

(e) Enter the totals from each column in the "Total" fields.

(10) Page 5 — Determinations — Determination of Overhead Applicable to FQHC and RHC Services:

(a) Parts A and B: Enter all totals from the previous pages of the Cost Statement (DMAP 3027) as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate;

(b) Part C: If applicable, complete by entering the wages for Outstationed Outreach Workers on line C1, divide the wages by the number of billable DMAP encounters to determine the rate per encounter. See also OAR 410-147-0400.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0400; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0540
Related Party Transactions

(1) A "related party" is an individual or organization that is associated or affiliated with, or has control of, or is controlled by the Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) furnishing the services, facilities, or supplies:

(a) "Common ownership" exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider;

(b) "Control" exists if an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

(2) Division of Medical Assistance Programs (DMAP) allows costs applicable to services, facilities, and supplies furnished to the FQHC or RHC by a related party at the lower of cost, excluding profits and markups to the related party, or charge to the clinic. Such costs are allowable in accordance with 42 CFR 413.17, to the extent that they:

(a) Relate to Title XIX and Title XXI client care;

(b) Are reasonable, ordinary, and necessary; and

(c) Are not in excess of those costs incurred by a prudent cost-conscious buyer.

(3) The intent is to treat the costs incurred by the related party as if they were incurred by the FQHC/RHC itself.

(4) Clinics must disclose a related party who is separately enrolled as a provider with DMAP and furnish the provider's NPI and associated taxonomy code(s).

(5) Documentation of costs to related parties shall be made available at the time of an audit or as requested by DMAP. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(6) DMAP will allow rental expense paid to related individuals or organizations for facilities or equipment to the extent the rental does not exceed the related organization's cost of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of the FQHC and RHC Administrative Rules.

(7) If all of these conditions are not met, none of the costs of the related party transaction can be reported as reimbursable costs on the FQHC or RHC's cost statement report.

Stat. Auth.: ORS 184.750, 184.770, 409.010 & 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 13-1993, f. & cert. ef. 7-1-93; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0280; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0560
Sanctions

(1) Providers are directed to Division of Medical Assistance Programs' (DMAP) General Rules OARs 410-120-1400 Provider Sanctions and 410-120-1460 Type and Conditions of Sanctions; and Department of Human Services Administrative Services Division and Director's Office OAR 407-120-360 Consequences of Non-Compliance and Provider Sanctions.

(2) OARs 410-120-1510 and 407-120-0380 govern fraud and abuse. The Department is authorized to take the actions necessary to investigate and respond to substantiated allegations of fraud and abuse, including but not limited to suspending or terminating the provider from participation in the medical assistance programs

Stat. Auth.: ORS 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 13-1993, f. & cert. ef. 71-1-93; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0395; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0610
Targeted Case Management (TCM)

(1) Targeted Case Management (TCM) services are provided and reimbursed through a separate program requiring enrollment as a TCM provider.

(2) Refer to OAR 410 Division 138, Targeted Case Management, for specific requirements.

(3) If an FQHC or RHC is participating in a TCM program, the clinic must notify the Division of Medical Assistance Programs (DMAP) in writing and must include a description of the TCM program. With the exception of maternity case management (MCM) services authorized by OAR 410-147-0200, costs for TCM services cannot be included in a clinic's cost statement and TCM services are prohibited from being billed directly to DMAP or a PHP under the FQHC or RHC's enrollment under OAR 410 Division 147.

(4) A client may only participate in a single TCM program. DMAP does not allow multiple TCM billings. This includes Maternity Case Management (MCM).

Stat. Auth.: ORS 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

410-147-0620
Medicare/Medical Assistance Program Claims

(1) If a client has both Medicare and Medicaid coverage under the Oregon Health Plan (OHP), coordinated by the Division of Medical Assistance Programs (DMAP), providers must bill Medicare first. Refer to OARs 407-120-0340 Claim and PHP Encounter Submission and 410-120-1280 Billing.

(2) All claims submitted by Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC) to DMAP for clients who have both Medicare and DMAP coverage must be billed on a CMS-1500 claim form or by 837P transmission. See also Billing for Medicare/Medicaid Clients in the FQHC and RHC Supplemental Information.

(3) If an out-of-state Medicare carrier or intermediary was billed, you must bill DMAP using a CMS-1500 claim form or 837P transmission, but only after that carrier has made payment determination.

(4) When billing on a CMS-1500 claim form or 837P transmission for a client with both Medicare and DMAP coverage:

(a) Bill all services provided to an OHP beneficiary;

(b) Bill the clinic's encounter rate; and

(c) Enter the total Medicare payment received in the "Amount Paid" field or use the appropriate Third Party Resources (TPR) explanation. Refer to CMS-1500 or 837P detailed billing instructions.

(5) Claims for Qualified Medicare Beneficiary (QMB)-only clients must be billed on CMS-1500 claim form or 837P transmission. Refer to OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System. Specific billing information and instructions are located in the FQHC and RHC Supplemental Information billing guide:

(a) The total charged amount must equal the total Medicare allowed/covered charges. FQHCs and RHCs are not to bill their encounter rate for services provided to Qualified Medicare Beneficiary (QMB)-only clients;

(b) FQHC and RHCs must bill each service, treatment or item provided to a QMB-only beneficiary on the CMS-1500 claim form or 837P transmission identical to how Medicare was billed.

(c) FQHCs and RHCs must apply any reductions and/or adjustments by Medicare to the Medicare payment, such that the difference between the Medicare allowed/covered amount and the amount paid by Medicare as reported on the claim equals only the Medicare coinsurance and/or deductible;

(d) For claims to process payment correctly, FQHCs and RHCs billing multiple services need to apply the total charge calculated, according to section (a) above, to the first detail line and zero charge all subsequent lines. The billed charge at the detail line level must equal the total charge.

Stat. Auth.: ORS 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0040; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 44-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08

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Rule Caption: Relative Value Units weights used for CPT reimbursement.
Adm. Order No.: DMAP 35-2008
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 11-1-2008
Rules Amended: 410-120-1340
Subject: The General Rules program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to clients. DMAP amended rule 410-120-1340 to follow the standards for payment methods subsequent to the yearly revisions to the Relative Value Units (RVU) weights made by Centers of Medicare and Medicaid (CMS). This rule is amended to specify which RVUs will be utilized for the calendar year 2009 and include a COLA to the RVU conversion factor of 3.5%. Text is revised to improve readability and take care of necessary "housekeeping" corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-120-1340
Payment

(1) The Division of Medical Assistance Programs (DMAP) will make payment only to the enrolled Provider who actually performs the service or to the Provider's enrolled Billing Provider for covered services rendered to eligible Clients. Any contracted Billing Agent or Billing Service submitting claims on behalf of a Provider but not receiving payment in the name of or on behalf of the Provider does not meet the requirements for Billing Provider enrollment. If electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 407-120-0100 through 407-120-0200. DMAP may require that payment for services be made only after review by DMAP.

(2) DMAP or the Department of Human Services (DHS) office that is administering the program under which the billed services or items are provided sets Fee-for-Service (FFS) payment rates.

(3) All FFS payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the DMAP maximum allowable amount or the reimbursement specified in the individual program Provider rules:

(a) Amount billed may not exceed the Provider's Usual Charge (see definitions);

(b) DMAP's maximum allowable rate setting process uses the following methodology. The rates are updated periodically and posted on the DMAP web site at http://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml:

(A) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight and reflecting services not typically performed in a facility, DMAP will convert to the 2008 Transitional Non-Facility Total RVU weights published in the Federal Register, Vol. 73, January 15, 2008, to be effective for dates of services beginning January 1, 2009. For CPT/HCPCS codes for professional services typically performed in a facility, the Transitional Facility RVU weight Totals will be adopted:

(i) The conversion factor for labor and delivery (59400-59622) is $41.61;

(ii) CPT codes 92340-92342 and 92352-92353 remain at a flat rate of $26.81;

(iii) All remaining RVU weight based CPT/HCPCS codes have a conversion factor of $27.82;

(B) Surgical assist reimburses at 20% of the surgical rate;

(C) The base rate for anesthesia services 00100-01996 is $24.19 and is based on per unit of service;

(D) Clinical lab codes are priced based upon the Centers for Medicare and Medicaid Service (CMS) mandates. Other Non-RVU weight based Lab vary by code are generally between 62% to 97% of Medicare's rates;

(E) All approved Ambulatory Surgical Center (ASC) procedures are reimbursed at 80% of Medicare's fee schedule;

(F) Physician administered drugs, billed under a HCPCS code, are based on Medicare's Average Sale Price (ASP). When no ASP rate is listed the rate will be based upon Average Wholesale Price (AWP). Pricing information for AWP is provided by First Data Bank. These rates may change periodically based on drug costs;

(G) All procedures used for vision materials and supplies are based on contracted rates which include acquisition cost plus shipping and handling;

(c) Individual Provider rules may specify reimbursement rates for particular services or items.

(4) DMAP reimburses Inpatient Hospital service under the DRG methodology, unless specified otherwise in the DMAP Hospital services administrative rules (chapter 410 division 125). Reimbursement for services, including claims paid at DRG rates, will not exceed any Upper Limits established by federal regulation.

(5) DMAP reimburses all out-of-state Hospital services at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 Division 125) unless the Hospital has a contract or Service Agreement with DMAP to provide highly specialized services.

(6) Payment rates for in-home services provided through DHS Seniors and People with Disabilities Division (SPD) will not be greater than the current DMAP rate for Nursing Facility payment.

(7) DHS sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate that is:

(a) Consistent with similar services provided in the State of Oregon; and

(b) The lesser of the rate paid to the most similar facility licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) The rate established by SPD for out-of-state Nursing Facilities.

(8) DMAP will not make payment on claims that have been assigned, sold, or otherwise transferred or when the Billing Provider, Billing Agent or Billing Service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a Provider for accounts receivable.

(9) DMAP will not make a separate payment or copayment to a Nursing Facility or other Provider for services included in the Nursing Facility's All-Inclusive Rate. The following services are not included in the All-Inclusive Rate (OAR 411-070-0085) and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services administrative rules (chapter 410 division 121) and Home Enteral/Parenteral Nutrition and IV Services administrative rules, (chapter 410 division 148);

(b) Physical Therapy, Speech Therapy, and Occupational Therapy provided by a non-employee of the Nursing Facility within the appropriate program administrative rules, (chapter 410 division 131 and 129);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment and Medical Supplies administrative rules, (chapter 410 division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services administrative rules, (chapter410 division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services administrative rules, (chapter 410 division 130);

(f) Medical services provided by Physician or other Provider of medical services, such as radiology and Laboratory, as outlined in the Medical-Surgical Services Provider rules, (chapter 410 division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies administrative rules, (chapter 410 division 122).

(10) DMAP reimburses Hospice services on a per diem basis dependent upon the level of care being provided. A separate payment will not be made for services included in the core package of services as outlined in OAR 410 Division 142.

(11) Payment for DMAP Clients with Medicare and full Medicaid:

(a) DMAP limits payment to the Medicaid allowed amount less the Medicare payment up to the Medicare co-insurance and deductible, whichever is less. DMAP payment cannot exceed the co-insurance and deductible amounts due;

(b) DMAP pays the DMAP allowable rate for DMAP covered services that are not covered by Medicare.

(12) For Clients with Third-Party Resources (TPR), DMAP pays the DMAP allowed rate less the TPR payment but not to exceed the billed amount.

(13) DMAP payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For DMAP such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding the DMAP allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain Payment Authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual Provider rules.

(14) Payment by DMAP does not limit DHS or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050 & 409.110

Stats. Implemented: ORS 414.019, 414.025, 414.033, 414.065, 414.095, 414.705, 414.727, 414.728, 414.742 & 414.743

Hist.: PWC 683, f. 7-19-74, ef. 8-11-784; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; Renumbered from 461-013-0061; PWC 833, f. 3-18-77, ef. 4-1-77; Renumbered from 461-013-0061; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060, AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 50-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0081, 461-013-0085, 461-013-0175 & 461-013-0180; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0040, 410-120-0220, 410-120-0200, 410-120-0240 & 410-120-0320; HR 2-1994, f. & cert. ef. 2-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 24-2007, f. 12-11-07 cert. ef. 1-1-08; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 35-2008, f. 12-11-08, cert. ef. 1-1-09

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Rule Caption: Semi-annual Practitioner Managed Prescription (PMPDP) Plan Drug list (PDL) ; pricing calculations; vaccinations; Federal Upper Limits; and nursing homes.
Adm. Order No.: DMAP 36-2008
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 11-1-2008
Rules Amended: 410-121-0000, 410-121-0030, 410-121-0032, 410-121-0060, 410-121-0185, 410-121-0300, 410-121-0625
Rules Repealed: 410-121-0140
Subject: The Pharmaceutical Services program rules govern the Division of Medical Assistance Programs' (DMAP) payments for services provided to certain clients. DMAP amended rules listed above to clarify current policies and procedures and as follows:

410-121-0000: to add text from OAR 410-121-0140, Definition of Terms;

410-121-0030: to add certain drugs to the PMPDP PDL and to reflect net cost of drugs;

410-121-0032: to reflect net cost of drugs;

410-121-0060: to correct Pharmacy Benefits Manger (PBM);

410-121-0140: text removed and placed into OAR 410-121-0000, Foreword and Definition of Terms;

410-121-0185: to make DMAP rules congruent with Board of Pharmacy rules on vaccinations, and to update a Board of Pharmacy rule number reference in the rule;

410-121-0300: to update the reference for Centers for Medicare and Medicaid (CMS) Transmittals and updates to Transmittals for the Federal Upper Limits (FUL) for prescription drugs.

410-121-0625: to require Nursing Homes to be billed for items covered under Seniors and People with Disabilities (SPD) all-inclusive-rate. Text in all rules listed may be revised to improve readability and take care of necessary "housekeeping" corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0000
Foreword and Definition of Terms

(1) The Pharmaceutical Services Oregon Administrative Rules (OARs) are designed to assist providers in preparing claims for services provided to Division of Medical Assistance Programs' (DMAP) fee-for-service clients. Providers must use Pharmaceutical OARs in conjunction with the General Rules OARs (chapter 410, division 120) for Oregon Medical Assistance Programs.

(2) Pharmaceutical services delivered through managed care plans contracted with DMAP, under the Oregon Health Plan (OHP), are subject to the policies and procedures established in the OHP Administrative Rules (chapter 410, division 141) and by the specific managed health care plans.

(3) Definition of Terms:

(a) Actual Acquisition Cost: The net amount paid per invoice line item to a supplier. This net amount does not include separately identified discounts for early payment;

(b) Average Net Price: The average of Net Price (definition below) of all drugs in an identified Plan Drug List (PDL) (definition below) class or group.

(c) Average Manufacturer's Price (AMP): The average price at which manufacturers sell medication to wholesalers and retail pharmacies, as further clarified in 42 CFR 447;

(d) Bulk Dispensing: Multiple doses of medication packaged in one container labeled as required by pertinent Federal and State laws and rules.

(e) Centers for Medicare and Medicaid Services (CMS) Basic Rebate: The quarterly payment by the manufacturer of a drug pursuant to the Manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927 (c) (3) of the Social Security act (42 U.S.C. 1396r-8(c) (1) and 42 U.S.C. 1396r-8 (c) (3)). See 410-121-0157;

(f) CMS Basic CPI Rebate: The quarterly payment by the manufacturer pursuant to the Manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with Section 1927 (c) (2) of the Social Security act (42 U.S.C. 1396r-8(c) (2)

(g) Community Based Care Living Facility: For the purposes of the Division of Medical Assistance Programs (DMAP) Pharmacy Program, a home, facility, or supervised living environment licensed or certified by the state of Oregon which provides 24 hour care, supervision, and assistance with medication administration. These include, but are not limited to:

(A) Supportive Living Facilities;

(B) 24-Hour Residential Services;

(C) Adult Foster Care;

(D) Semi-independent Living Programs;

(E) Assisted Living and Residential Care Facilities;

(F) Group Homes and other residential services for people with developmental disabilities or needing mental health treatment; and

(G) Inpatient hospice;

(h) Compounded Prescriptions:

(A) A prescription that is prepared at the time of dispensing and involves the weighting of at least one solid ingredient that must be a reimbursable item or a legend drug in a therapeutic amount;

(B) Compounded prescription is further defined to include the Oregon Board of Pharmacy definition of Compounding (see OAR 855-006-0005);

(i) Dispensing: Issuance of a prescribed quantity of an individual drug entity by a licensed pharmacist;

(j) Drug Order/Prescription:

(A) A medical practitioner's written or verbal instructions for a patient's medications; or

(B) A medical practitioner's written order on a medical chart for a client in a nursing facility;

(k) Durable Medical Equipment and supplies (DME): Equipment and supplies as defined in OAR 410-122-0010, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies;

(l) Estimated Acquisition Cost (EAC): The estimated cost at which the pharmacy can obtain the product listed in OAR 410-121-0155;

(m) Intermediate Care Facility: A facility providing regular health-related care and services to individuals at a level above room and board, but less than hospital or skilled nursing levels as defined in ORS 442.015;

(n) Long Term Care Facility: Includes skilled nursing facilities and intermediate care facilities with the exclusions found in ORS 443.400 to 443.455;

(o) Maintenance medication: Drugs that have a common indication for treatment of a chronic disease and the therapeutic duration is expected to exceed one year. This is determined by a First DataBank drug code maintenance indicator of "Y" or "1";

(p) Net Price: The amount a drug costs DHS and calculated using the following formula. "Estimated Acquisition Cost — CMS Basic Rebate — CMS CPI Rebate — State Supplemental Rebate";

(q) Managed Access Program (MAP): The Managed Access Program (MAP) is a system of determining, through a series of therapeutic and clinical protocols, which drugs require authorizations prior to dispensing:

(A) OAR 410-121-0040 lists the drugs or categories of drugs requiring prior authorization (PA);

(B) The practitioner, or practitioner's licensed medical personnel listed in OAR 410-121-0060, may request a PA;

(r) Nursing Facility: An establishment that is licensed and certified by the DHS Seniors and People with Disabilities Division (SPD) as a Nursing Facility;

(s) Plan Drug List: The PDL consists of prescription drugs in selected classes that DHS, in consultation with the Health Resources Commission (HRC), has determined represent effective drug(s) available at the best possible price. (See details for the DMAP PMPD PDL in OAR 410-121-0030);

(t) Point-of-Sale (POS): A computerized, claims submission process for retail pharmacies that provides on-line, real-time claims adjudication;

(u) Prescription Splitting: Any one or a combination of the following actions:

(A) Reducing the quantity of a drug prescribed by a licensed practitioner for prescriptions not greater than 34 days (see OAR 410-121-0146);

(B) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing fee for the quantity billed;

(C) Separating the ingredients of a prescribed drug and billing the agency for separate individual ingredients, with the exception of compounded medications (see OAR 410-121-0146); or

(D) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice;

(v) State Supplemental Rebate: The amount paid quarterly by the Manufacturer to DHS for utilization under the DHS Medicaid program pursuant to a Supplemental Rebate Agreement;

(w) Unit Dose: A sealed, single unit container of medication, so designed that the contents are administered to the patient as a single dose, direct from the container, and dispensed following the rules for unit dose dispensing system established by the Oregon Board of Pharmacy.

[ED NOTE: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0030

Practitioner-Managed Prescription Drug Plan (PMPDP)

For the purpose of reviewing this rule the following definitions apply: (These definitions are also found in OAR 410-121-0000, Foreword and Definitions of Terms): Net Price: The amount a drug costs DHS and calculated using the following formula: Estimated Acquisition Cost minus CMS Basic Rebate minus CMS CPI Rebate minus State Supplemental Rebate. Average Net Price: The average of Net Price of all drugs in an identified Plan Drug List (PDL) class or group.

(1) The Practitioner-Managed Prescription Drug Plan (PMPDP) is a plan that ensures that fee for service clients of the Oregon Health Plan will have access to the most effective prescription drugs appropriate for their clinical conditions at the best possible price:

(a) Licensed health care practitioners (informed by the latest peer reviewed research), make decisions concerning the clinical effectiveness of the prescription drugs;

(b) The licensed health care practitioners also consider the health condition of a client or characteristics of a client, including the client's gender, race or ethnicity.

(2) PMPDP Plan Drug List (PDL):

(a) The PDL is the primary tool that the Department of Human Services (DHS) has developed to inform licensed health care practitioners about the results of the latest peer-reviewed research and cost effectiveness of prescription drugs;

(b) The PDL consists of prescription drugs in selected classes that DHS, in consultation with the Health Resources Commission (HRC), has determined represent effective drug(s) available at the best possible price;

(c) For each selected drug class, the PDL will identify the drug(s) in the class that DHS determines to be the most effective drug(s) and determine the Net Price for each drug and Average Net Price of the class;

(d) The PDL will include drugs in the class that are Medicaid reimbursable and which the Food and Drug Administration (FDA) has determined to be safe and effective if the relative cost is less than the Average Net Price. If pharmaceutical manufacturers enter into supplemental rebate agreements with DHS that reduce the cost of their drug below that of the Average Net Price for the class, DHS, in consultation with the HRC recommendations, may include their drug on the PDL;

(e) A copy of the current PDL is available on the web at www.dhs.state.or.us/policy/healthplan/guides/pharmacy/.

(3) PMPDP PDL Selection Process:

(a) DHS will utilize the recommendations made by the HRC, which result from an evidence-based evaluation process, as the basis for identifying the most effective drug(s) within a selected drug class;

(b) DHS will determine the drug(s) identified in (3) (a) that is (are) available for the best possible price and will consider any input from the

HRC about other FDA-approved drug(s) in the same class that are available for a lesser relative price. DHS will determine relative price using the methodology described in subsection (4);

(c) DHS will review drug classes and selected drug(s) for the drug classes periodically:

(A) Review will occur more frequently at the discretion of DHS if new safety information or the release of new drugs in a class or other information makes a review advisable;

(B) DHS will not add new drugs to the PDL until they have been reviewed by the HRC;

(C) DHS will make all changes or revisions to the PDL, using the rulemaking process and will publish the changes on the DHS Pharmaceutical Services provider rules Web page.

(4) Relative cost and best possible price determination:

(a) DHS will determine the relative cost of all drugs in each selected class that are Medicaid reimbursable and that the FDA has determined to be safe and effective;

(b) DHS may also consider dosing issues, patterns of use and compliance issues. DHS will weigh these factors with any advice provided by the HRC in reaching a final decision;

(c) DHS will determine the Average Net Price for each PDL drug class. ;

(e). DHS will include drugs on the PDL based on all of the above and with a Net Price under the Average Net Price.

(5) Regardless of the PDL, pharmacy providers shall dispense prescriptions in the generic form, unless the practitioner requests otherwise, subject to the regulations outlined in OAR 410-121-0155. Table 121-0030-1, PMPDP PDL.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 25-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 31-2002, f. & cert. ef. 8-1-02; OMAP 36-2002, f. 8-30-02, cert. ef. 9-1-02; OMAP 29-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 35-2003, f. & cert. ef. 5-1-03; OMAP 47-2003, f. & cert. ef. 7-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 70-2003(Temp), f. 9-15-03, cert. ef. 10-1-03 thru 3-15-04; OMAP 82-2003, f. 10-31-03, cert. ef. 11-1-03; OMAP 9-2004, f. 2-27-04, cert. ef. 3-1-04; OMAP 29-2004, f. 4-23-04 cert. ef. 5-1-04; OMAP 34-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 45-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 81-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 89-2004, f. 11-24-04 cert. ef. 12-1-04; OMAP 19-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 32-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 58-2005, f. 10-27-05, cert. ef. 11-1-05; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 32-2006, f. 8-31-06, cert. ef. 9-1-06; OMAP 48-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 4-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0032

Supplemental Rebate Agreements

(1) Supplemental Rebate Agreements are negotiated for specific drug products between the Division of Medical Assistance Programs (DMAP) and pharmaceutical manufacturers. Manufacturers may submit Supplemental Rebate offers for consideration to include their drug(s) on the Practitioner's-Managed Prescription Drug Plan (PMPDP) Plan Drug List (PDL), OAR 410-121-0030:

(a) Manufacturers must submit Supplemental Rebate Agreements on the agreement template approved by the Centers for Medicare and Medicaid Services (CMS). This template is available on the Department of Human Services Web site;

(b) "Supplemental Rebates" are DMAP and CMS approved discounts paid by manufacturers per unit of drug. These rebates are authorized by the Social Security Act section 42 USC 1396r-8(a)(1) and are in addition to federal rebates mandated by the Omnibus Budget Rehabilitation Act (OBRA 90) and the federal rebate program;

(c) "Net Price" is the ingredient reimbursement amount minus the CMS Basic Rebate and CMS Consumer Price Index (CPI) Rebate minus the Supplemental Rebate;

(d) "CMS Basic Rebate" is the quarterly payment by a manufacturer pursuant to the manufacturer's CMS Medicaid Drug Rebate Agreement made in accordance with the Social Security Act, section 1927(c)(3), 42 USC 1396r-8(c)(1), and 42 USC1396r-8(c)(3);

(e) "CMS CPI Rebate" is the quarterly payment by the manufacturer pursuant to the manufacturer's CMS Medicaid Drug Rebate Agreement, made in accordance with 42 USC 1396r-8(c)

(2) Manufacturers may offer Supplemental Rebates by submitting the completed template to DMAP:

(a) Manufacturers may be allowed to submit Supplemental Rebate offers for drugs recommended for inclusion on the PDL by the Health Resources Commission;

(b) Drugs may be considered for addition to the appropriate PDL class based on the net cost to DHS.

(3) Manufacturers may submit a Supplemental Rebate Agreement offer by:

(a) Obtaining the CMS-approved template from the DHS website, and;

(b) Submitting the completed Supplemental Rebate Agreement with attachment B listing the drugs offered to DMAP. The manufacturers may submit up to three separate attachment B drug lists with the Supplemental Rebate Agreement offer.

(4) Acceptance of the offer:

(a) DMAP may notify the manufacturer of the acceptance of the offer(s);

(b) Supplemental Agreements will be executed after signed by all parties, approved by CMS if required, and added to the PMPDP Plan Drug List by the Administrative rule process.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 97-2004, f. 12-30-04, cert. ef. 1-1-05; DMAP 16-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0060

How to Get Prior Authorization for Drugs

(1) A prescriber electing to order a drug requiring PA may have any licensed medical personnel in their office call the Managed Access Program (MAP) Help Desk to request the PA. The PA request may also be transmitted to the MAP Help Desk by FAX using the request form shown in the Pharmaceutical Services Supplemental Information on the Department of Human Services website.

(2) PA approval:

(a) If the PA request is approved, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(A) PA approvals are given for a specific date of service and for specific NDC numbers or products.

(B) PA approvals do not guarantee eligibility or reimbursement.

(b) It is the pharmacist's responsibility to check whether the drugs are covered, whether the client is eligible, and to note restrictions such as date ranges and quantities before dispensing any medications that require PA.

(c) The pharmacy must also check whether the client's prescribed medications are covered by a managed care plan because an enrollment may have taken place after PA was received. If the client is enrolled in a managed care plan and the pharmacy receiving the PA is not a participating pharmacy provider in the managed care plan's network, the pharmacy must inform the client that it is not a participating provider in the managed care plan's network and must also recommend that the client contact his or her managed care plan for a list of pharmacies participating in its network.

(d) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy provider, if consistent with all other applicable administrative rules. There is no need for a PA number.

(3) If the PA request has been denied, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information will be available.

(4) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from the Pharmacy Benefits Manager (PBM) when the client is eligible for covered fee-for-service drug prescriptions.

(a) Clients who do not have a PA pending may receive an emergency dispensing for a 96-hour supply.

(b) Clients who do have a PA pending may receive an emergency dispensing up to a seven-day supply.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065

Stats. Implemented: ORS 414.065

Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90, Renumbered from 461-016-0180; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 2-1995, f. & cert. ef. 2-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 20-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 16-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 34-2008, f. 11-26-08, cert. ef. 12-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0185

Pharmacy Based Immunization Delivery

(1) A pharmacist may administer vaccines to persons who are over the age of eighteen and may administer as provided pursuant to ORS 689.205 and The Board of Pharmacy Administrative rule 855-019-0270.

(2) For Medicaid recipients age 0-18, vaccination serums are free under the federal Vaccinations for Children (VFC) Program and providers must be enrolled in the VFC program. DMAP will not reimburse the providers the cost of a privately purchased vaccination.

(3) Providers use either the CMS-1500 or the Point Of Sale claims processing system to bill for the administration of immunization:

(a) When using the CMS-1500 billing form:

(A) Use the appropriate CPT-code (90471 and 90472) for the administration plus the appropriate immunization code(s) 90476-90749:

(B) An ICD-9 diagnosis must be shown in field 21 of the CMS-1500, and;

(C) The diagnosis code must be shown to the highest degree of specificity.

(b) Providers using the Point-of-Sale system, use the National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed. The administration fee for this service will be equivalent to those under 90471–90472.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 7-2002, f. & cert. ef. 4-1-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; OMAP 9-2005, f. 3-9-05, cert. ef. 4-1-05; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0300
CMS Federal Upper Limits for Drug Payments

(1) The Centers for Medicare and Medicaid Services (CMS) Federal Upper Limits for Drug Payments listing of multiple source drugs meets the criteria set forth in 42 CFR 447.332 and 1927(e) of the Act as amended by OBRA 1993 and the DRA 2005.

(2) Payments for multiple source drugs must not exceed, in the aggregate, payment levels determined by applying to each drug entity a reasonable dispensing fee (established by the State and specified in the State Plan), plus an amount based on the limit per unit. CMS has determined the amount based on the limit per unit to be equal to 250 percent of the Average Manufacturer's Price (AMP). CMS will post the AMP to a Website available to the public on a quarterly basis.

(3) The FUL drug listing is published in the State Medicaid Manual, Part 6, Payment for Services, Addendum A. The most current Transmittals and subsequent changes are posted to the CMS website http://www.cms.hhs.gov/Reimbursement/05_FederalUpperLimits.asp#TopOfPage.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 3-1990(Temp), f. & cert. ef. 2-23-90; HR 13-1990, f. & cert. ef. 4-20-90, Renumbered from 461-016-0330; HR 20-1990, f. & cert. ef. 7-9-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 45-1990, f. & cert. ef. 12-28-90; HR 10-1991, f. & cert. ef. 2-19-91; HR 37-1991, f. & cert. ef. 9-16-91; HR 13-1992, f. & cert. ef. 6-1-92; HR 28-1992, f. & cert. ef. 9-1-92; HR 35-1992(Temp), f. & cert. ef. 12-1-92; HR 1-1993(Temp), f. & cert. ef. 1-25-93; HR 3-1993, f. & cert. ef. 2-22-93; HR 5-1993(Temp), f. 3-10-93, cert. ef. 3-22-93; HR 8-1993(Temp), f. & cert. ef. 4-1-93; HR 11-1993, f. 4-22-93, cert. ef. 4-26-93; HR 15-1993(Temp), f. & cert. ef. 7-2-93; HR 20-1993, f. & cert. ef. 9-1-93; HR 25-1993(Temp), f. & cert. ef. 10-1-93; HR 14-1994, f. & cert. ef. 3-1-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; HR 14-1995, f. 6-29-95, cert. ef. 7-1-95; HR 23-1995, f. 12-29-95, cert. ef. 1-1-96; HR 22-1997, f. & cert. ef. 10-1-97; HR 27-1997, f. & cert. ef. 12-1-97; OMAP 2-1998, f. 1-30-98, cert. ef. 2-1-98; OMAP 43-1998(Temp), f. & cert. ef. 11-20-98 thru 5-1-99; OMAP 5-1999, f. & cert. ef. 2-26-99; OMAP 42-2000(Temp), f. & cert. ef. 12-15-00 thru 5-1-01; OMAP 1-2001(Temp), f. & cert. ef. 2-1-01 thru 6-1-01; OMAP 2-2001(Temp), f. 2-14-01, cert. ef. 2-15-01 thru 7-1-01; OMAP 18-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 23-2001(Temp), f. & cert. ef. 4-16-01 thru 8-1-01; OMAP 26-2001(Temp), f. & cert. ef. 6-6-01 thru 1-2-02; OMAP 51-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-15-01; OMAP 58-2001, f. 11-30-01, cert. ef. 12-1-01; OMAP 67-2001(Temp), f. 12-28-01, cert. ef. 1-1-02 thru 5-15-02; OMAP 3-2002(Temp), f. & cert. ef. 2-15-02 thru 6-15-02; OMAP 5-2002(Temp) f. & cert. ef. 3-5-02 thru 6-15-02; OMAP 19-2002(Temp), f. & cert. ef. 4-22-02 thru 9-15-02; OMAP 29-2002(Temp), f. 7-15-02, cert. ef. 8-1-02 thru 1-1-03; OMAP 71-2002(Temp), f. & cert. ef. 12-1-02 thru 5-15-03; OMAP 10-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 11-2003(Temp), f. 2-28-03, cert. ef. 3-1-03 thru 8-15-03; OMAP 41-2003, f. & cert. ef. 5-29-03; OMAP 51-2003, f. & cert. ef. 8-5-03; OMAP 54-2003(Temp), f. & cert. ef. 8-15-03 thru 1-15-03; OMAP 75-2003, f. & cert. ef. 10-1-03; OMAP 83-2003(Temp), f. 11-25-03, cert. ef. 12-1-03 thru 4-15-04; OMAP 2-2004, f. 1-23-04, cert. ef. 2-1-04; OMAP 32-2004(Temp), f. & cert. ef. 5-14-04 thru 10-15-04; OMAP 43-2004, f. 6-24-04 cert. ef. 7-1-04; OMAP 93-2004(Temp), f. & cert. ef. 12-10-04 thru 5-15-05; OMAP 2-2005, f. 1-31-05, cert. ef. 2-1-05; OMAP 23-2005(Temp), f. & cert. ef. 4-1-05 thru 9-1-05; OMAP 29-2005, f. & cert. ef. 6-6-05; OMAP 56-2005, f. 10-25-05, cert. ef. 11-1-05; OMAP 59-2005(Temp), f. 11-8-05, cert. ef. 11-12-05 thru 5-1-06; OMAP 68-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 8-2006(Temp), f. 3-29-06, cert. ef. 4-1-06 thru 9-15-06; OMAP 13-2006, f. 5-26-06, cert. ef. 6-1-06; OMAP 50-2006, f. 12-28-06, cert. ef. 1-1-07; DMAP 26-2007, f. 12-11-07, cert. ef. 1-1-08; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

410-121-0625
Items Covered in the All-Inclusive Rate for Nursing Facilities

(1) The all-inclusive rate for nursing facilities includes but is not limited to various drug products and OTC items. DMAP requires that nursing facilities be billed for these items.

(2) The all-inclusive list is available for downloading in the Division of Medical Assistance Programs Web page on the Department of Human Services website.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110 & 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0920; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04; DMAP 36-2008, f. 12-11-08, cert. ef. 1-1-09

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Subject: The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to certain clients. DMAP adopted and amended rules as follows:

Adoptions: 410-122-0211 Cough Stimulating Device: Establishes conditions of coverage.

Amendments: 410-122-0182 Legend: Clarifies "months rented" language.

410-122-0200 Pulse Oximeter for Home Use: Revises conditions of coverage.

410-122-0203 Oxygen and Oxygen Equipment: In Table 0203 corrects "16R" to "36R" (An item with a "36R" designation means payment for the equipment is considered capped.)

410-122-0204 Nebulizers: Adds that when billing for quantities of supplies greater than those described in rule as the usual maximum amounts, there must be clear documentation in the client's medical records corroborating the medical appropriateness of the current use.

410-122-0330 Power-Operated Vehicle: Removes requirement that date of face-to-face evaluation be written on the prescription (duplication in rule, already required on the evaluation report).

410-122-0340 Wheelchair Options/Accessories: Adds E2208 (wheelchair accessory, cylinder tank carrier, each). This code is currently covered. Adds E2209 (accessory, arm trough, with or without hand support, each). This code is currently covered. Adds E2300 (power w/c accessory, power seat elevation system) as an exclusion of coverage. Elevator systems codes currently are excluded from coverage. Adds E2392 (power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each). This code is currently covered. Removes K0106 (arm trough) from rule (obsolete code).

410-122-0365 Standing and Positioning Aids: Adds E0641 (standing frame system, multi-position, any size including pediatric, with or without wheels) and E0642 (standing frame system, mobile (dynamic stander), any size including pediatric. These codes are currently covered.

410-122-0560 Urological Supplies: Adds coverage criteria to allow for one sterile catheter for each intermittent catheterization. Clarifies conditions of coverage. Corrects descriptions of A4326 (male external catheter with integral collection chamber, any type, each) and A5105 (urinary suspensory with leg bag, with or without tube, each) These codes are currently covered.

410-122-0580 Bath Supplies: Removes asterisk following description of E0162. Removes text following description of E0240. Revises coverage criteria for rehab shower commode chair.

410-122-0630 Incontinent Supplies: Removes prior authorization requirements for incontinent supplies.

410-122-0655 External Breast Prostheses: Adds that an external breast prosthesis of a different type may be covered if there is a change in the client's medical condition necessitating a different type of item.

Text is revised to improve readability and make necessary "housekeeping" corrections.

Rules Coordinator: Darlene Nelson—(503) 945-6927

410-122-0182
Legend

(1) The Division of Medical Assistance Programs (DMAP) uses abbreviations in the tables within this division.

(2) This rule explains the meaning of these abbreviations.

(3) PA — Prior authorization (PA): "PA" indicates that PA is required, even if the client has private insurance. See OAR 410-122-0040 for more information about PA requirements.

(4) PC — Purchase: "PC" indicates that purchase of this item is covered for payment by DMAP.

(5) RT — Rent: "RT" indicates that the rental of this item is covered for payment by DMAP.

(6) MR — Months Rented:

(a) "13" — Indicates up to 13 months of continuous rental, when DMAP fee schedule purchase price is met for the item, when the usual purchase price is reached or the actual charge is met (whichever is lowest), the equipment is considered paid for and owned by the client. The provider must then transfer title of the equipment to the client;

(b) "36" — Beginning with the first rental month, indicates that after 36 months of rental), payment for the equipment is considered capped. After 36 months of rental payments, the provider that furnishes oxygen equipment during the 36-month rental period must continue to furnish this same equipment after the 36-month period rental period;

(c) For any other rental situation, when DMAP fee schedule purchase price is met for the item, when the usual purchase price is reached or the actual charge is met (whichever is lowest), the equipment is considered paid for and owned by the client. The provider must then transfer title of the equipment to the client.

(7) RP — Repair: "RP" indicates that repair of this item is covered for payment by DMAP.

(8) NF — Nursing Facility: "NF" indicates that this procedure code is covered for payment by DMAP when the client is a resident of a nursing facility.

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0200
Pulse Oximeter for Home Use

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a tamper-proof pulse oximeter for home use when all of the following criteria are met:

(A) The client has frequently fluctuating oxygen saturation levels that are clinically significant;

(B) Measurements are integral in dictating acute therapeutic intervention;

(C) The absence of readily available saturation measurements represents an immediate and demonstrated health risk;

(D) The client has a caregiver trained to provide whatever care is needed to reverse the low oxygen saturation level ordered by the physician;

(b) Some examples of when a home pulse oximeter may be covered include the following:

(A) When weaning a client from home oxygen or a ventilator;

(B) When a change in the client's physical condition requires an adjustment in the liter flow of their home oxygen needs;

(C) To determine appropriate home oxygen liter flow for ambulation, exercise, or sleep;

(D) To monitor a client on mechanical ventilation at home;

(E) To periodically re-assess the need for long-term oxygen in the home;

(F) Infants with chronic lung disease (e.g., bronchopulmonary dysplasia);

(G) Premature infants on active therapy for apnea;

(H) When a client exhibits a certain unstable illness and has compromised or potentially compromised respiratory status;

(I) When evidence-based clinical practice guidelines support the need;

(c) Home pulse oximetry for indications other than those listed above may be covered on a case-by-case basis upon medical review by DMAP's Policy Unit;

(d) The durable medical equipment prosthetics, orthotics and supplies (DMEPOS) provider is responsible to ensure the following services for home pulse oximetry rental are provided:

(A) For purchase or rental of a pulse oximeter for home use:

(i) Training regarding the use and care of the equipment and care of the client as it relates to the equipment, including progressive intervention and cardiopulmonary resuscitation (CPR) training prior to use of the equipment by the client; and

(ii) A follow-up home visit within the first 30 days of equipment setup to ensure a CPR/emergency area has been designated; and

(B) For rental of a pulse oximeter for home use:

(i) Monthly telephone follow-up and support to ensure caregivers are using the equipment as ordered by the physician; and

(ii) 24-hour/7 day a week respiratory therapist on-call availability for troubleshooting, exchanging of malfunctioning equipment, etc.;

(iii) The allowable rental fee includes all equipment, supplies, services, including all probes, routine maintenance and necessary training for the effective use of the pulse oximeter;

(e) DMAP may cover probes for a client-owned covered oximeter:

(A) DMAP will reimburse for the least costly alternative for payment of probes, whether disposable or reusable, which meets the medical need of the client;

(B) A reusable probe must be used when it is the least costly alternative rather than a disposable probe, unless the client's medical records clearly substantiates why a reusable probe is contraindicated;

(C) Disposable probes (oxisensors) may be reused on the same client as long as the adhesive attaches without slippage;

(f) The use of home pulse oximetry for indications considered experimental and investigational, including the following, are not covered:

(A) Asthma management;

(B) When used alone as a screening/testing technique for suspected obstructive sleep apnea;

(C) Routine use (e.g., client with chronic, stable cardiopulmonary condition).

(2) Documentation Requirements:

(a) Submit the following documentation for prior authorization (PA) review:

(A) An order from the treating physician that clearly specifies the medical appropriateness for home pulse oximetry testing;

(B) Documentation of signs/symptoms/medical condition exhibited by the client, that require continuous pulse oximetry monitoring as identified by the need for oxygen titration, frequent suctioning or ventilator adjustments, etc.;

(C) Plan of treatment that identifies a trained caregiver is available to perform the testing, document the frequency and the results and implement the appropriate therapeutic intervention, when necessary;

(D) For probes for a client-owned oximeter, documentation that probes requested are the least costly alternative;

(E) Other medical records that corroborate conditions for coverage are met as specified in this rule;

(b) History and physical exam and progress notes must be available for review by DMAP, upon request.

(3) Procedure Codes:

(a) A4606 — Oxygen probe for use with client-owned oximeter device, replacement:

(A) PA required;

(B) DMAP will purchase;

(b) E0445 — Oximeter device for measuring blood oxygen levels non-invasively:

(A) PA required;

(B) DMAP will purchase or rent on a monthly basis;

(C) DMAP will repair a client-owned, covered pulse oximeter when cost effective;

(D) Item considered purchased after seven months of rent;

(E) Quantity (units) is one on a given date of service.

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994,. f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 32-1999, f. & cert. ef. 10-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0203
Oxygen and Oxygen Equipment

(1) Indications and limitations:

(a) For all the sleep oximetry criteria described in section (1) (c-e) of this rule, the five minutes do not have to be continuous:

(A) When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake,

during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria are met;

(B) If an ABG test at rest/awake is non-qualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result will determine coverage;

(b) The Division of Medical Assistance Programs (DMAP) may cover home oxygen therapy services for children under age 19 when the treating practitioner has determined it to be medically appropriate;

(c) DMAP may cover home oxygen therapy services for clients who are:

(A) Adults 19 years of age and older if the following conditions are met:

(i) The treating practitioner has determined that the client has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy; and

(ii) The client's blood gas study meets the criteria stated below; and

(iii) A physician or qualified provider or supplier of laboratory services performed the qualifying blood gas study; and

(iv) The qualifying blood gas study was obtained under the following conditions:

(I) If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date; or

(II) If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the client is in a chronic stable state, that is, not during a period of acute illness or an exacerbation of their underlying disease;

(v) Alternative treatment measures have been tried or considered and deemed clinically ineffective;

(B) Clients residing in a nursing facility only when continuous oxygen is required that exceeds 1000 liters in a 24-hour period. See OAR 410-120-1340 and 411-070-0085;

(d) Group I coverage duration and indications:

(A) DMAP limits initial Group I coverage to 12 months or the practitioner-specified length of need, whichever is shorter. See documentation requirements for information on recertification;

(B) Criteria for Group I include any of the following:

(i) An arterial partial pressure of oxygen (PO2) at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake); or

(ii) An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least five minutes taken during sleep for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake; or

(iii) A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis); or

(iv) An arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a client who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air;

(e) Group II coverage duration and indications:

(A) Initial coverage limited to three months or the practitioner-specified length of need, whichever is shorter. See documentation requirements for information on recertification;

(B) Criteria include presence of PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least five minutes, or during exercise (as described under Group I criteria); and any of the following:

(i) Dependent edema suggesting congestive heart failure; or

(ii) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or

(iii) Erythrocythemia with a hematocrit greater than 56 percent.

(f) Group III indications include a presumption of non-coverage and are considered precautionary, not therapeutic, in nature. Criteria include arterial PO2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent;

(g) DMAP does not cover oxygen therapy and related services, equipment or supplies for any of the following:

(A) Angina pectoris in the absence of hypoxemia;

(B) Dyspnea without cor pulmonale or evidence of hypoxemia;

(C) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia;

(D) Terminal illnesses that do not affect the respiratory system;

(E) Humidifiers (E0550, E0555 and E0560) with rented oxygen equipment. All accessories, such as humidifiers necessary for the effective use of oxygen equipment, are included in the monthly rental payment;

(F) Group III clients;

(G) Emergency or stand-by oxygen systems, including oxygen as needed (i.e., PRN), since they are precautionary and not therapeutic in nature;

(H) Topical hyperbaric oxygen chambers (A4575);

(I) Oxygen for topical use;

(J) Back-up equipment, since it is part of the all-inclusive rate;

(K) Travel oxygen:

(i) Clients traveling outside the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider's service area must make their own arrangements for oxygen;

(ii) DMAP will only pay one DMEPOS provider for oxygen during any one rental month;

(iii) The traveling client is responsible to pay for oxygen furnished by an airline, not the DMEPOS provider.

(2) Guidelines for testing and certification:

(a) Testing specifications:

(A) The term blood gas study in this policy refers to either an ABG test or an oximetry test:

(i) An ABG is the direct measurement of the PO2 on a sample of arterial blood;

(ii) The PO2 is reported as mm Hg;

(iii) An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger;

(iv) The saturation is reported as a percent;

(B) The qualifying blood gas study must be performed by a qualified provider (a laboratory, physician, etc.);

(i) DMAP does not consider a DMEPOS provider a qualified provider or a qualified laboratory for purposes of this policy;

(ii) DMAP will not accept blood gas studies either performed by, or paid for, by a DMEPOS provider;

(iii) This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests;

(C) For sleep oximetry studies, the tester must provide the client a tamper-proof oximeter that has the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value;

(D) When oxygen services are based on an oxygen study obtained during exercise, DMAP requires documentation of three oxygen studies in the client's medical record:

(i) Testing at rest without oxygen; and

(ii) Testing during exercise without oxygen; and

(iii) Testing during exercise with oxygen applied, to demonstrate the improvement of the hypoxemia.

(E) The qualifying test value (i.e., testing during exercise without oxygen) on the Certificate of Medical Necessity (CMN). The other results do not have to be routinely submitted but must be available to DMAP on request;

(F) The qualifying blood gas study may be performed while the client is on oxygen, as long as the reported blood gas values meet the Group I or Group II criteria.

(b) Certification:

(A) On the CMN, the blood gas study obtained must be the most recent study prior to the initial date, indicated in Section A of the CMN, and this study must be obtained within 30 days prior to that initial date;

(B) There is an exception for clients who were on oxygen prior to enrollment with DMAP. For those clients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent test obtained prior to enrollment with DMAP;

(C) For clients initially meeting Group I criteria:

(i) The tester must report the most recent blood gas study prior to the 13th month of therapy on the recertification CMN;

(ii) If the estimated length of need on the initial CMN is less than lifetime and the practitioner wants to extend coverage, a repeat blood gas study

must be performed within 30 days prior to the date of the revised certification;

(D) For clients initially meeting Group II criteria:

(i) On the recertification CMN, the tester must report the most recent blood gas study that was performed between the 61st and 90th day following the date of the initial certification CMN;

(ii) If a tester does not obtain a qualifying test between the 61st and 90th day of home oxygen therapy, but the client continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, DMAP will resume coverage beginning with the date of that test;

(iii) If the estimated length of need on the initial CMN is less than lifetime and the practitioner wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the revised certification;

(E) On any revised CMN, the tester must report the most recent blood gas study performed prior to the revision date;

(F) DMAP may request a repeat blood gas study at any time;

(G) The treating practitioner must see and evaluate the client:

(i) Within 30 days prior to the date of initial certification;

(ii) Within 90 days prior to the date of any recertification;

(iii) If the treating practitioner fails to see and reevaluate the client within 90 days prior to recertification, but subsequently evaluates and determines the client meets the blood gas study criteria, DMAP will cover the dates of service between the scheduled recertification date and the practitioner visit date.

(3) Portable oxygen system coverage:

(a) A portable oxygen system may be covered if the client is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is not covered;

(b) If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. (See the exception in Section (4) of this rule);

(c) If a portable oxygen system is covered, the DMEPOS provider must provide whatever quantity of oxygen the client uses;

(d) DMAP's reimbursement is the same, regardless of the quantity of oxygen dispensed;

(e) Code K0738 (portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flow meter, humidifier, cannula or mask, and tubing) is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.

(4) Liter flow greater than 4 liters per minute (LPM):

(a) DMAP will pay for a higher allowance of a flow rate of greater than 4 LPM only if:

(A) Basic oxygen coverage criteria have been met; and

(B) The client meets Group I or II criteria; and

(C) A blood gas study is performed while client is on 4 LPM oxygen;

(b) DMAP will limit payment to the standard fee schedule allowance if the provider requests a flow rate greater than 4 LPM when the coverage criterion for the higher allowance is not met;

(c) If a client qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen:

(A) DMAP will pay for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both;

(B) In this situation, if both a stationary system and a portable system are requested for the same rental month, DMAP will not cover the portable oxygen system.

(5) Oxygen contents:

(a) The DMAP allowance for rented oxygen systems includes oxygen contents;

(b) Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a client-owned stationary gaseous or liquid system respectively;

(c) Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

(A) The client owns a concentrator and rents or owns a portable system; or

(B) The client rents or owns a portable system and has no stationary system (concentrator, gaseous, or liquid);

(C) If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased.

(6) Oxygen accessory items:

(a) The DMAP allowance for rented systems includes, but is not limited to, the following accessories:

(A) Transtracheal catheters (A4608);

(B) Cannulas (A4615);

(C) Tubing (A4616);

(D) Mouthpieces (A4617);

(E) Face tent (A4619);

(F) Masks (A4620, A7525);

(G) Oxygen tent (E0455);

(H) Humidifiers (E0550, E0555, E0560);

(I) Nebulizer for humidification (E0580);

(J) Regulators (E1353);

(K) Stand/rack (E1355);

(b) The DMEPOS provider must provide any accessory ordered by the practitioner;

(c) Accessories are separately payable only when they are used with a client-owned system that was purchased prior to June 1, 1989. DMAP does not cover accessories used with a client-owned system that was purchased on or after June 1, 1989;

(7) Billing for miscellaneous oxygen items:

(a) DMAP only covers rented oxygen systems (E0424, E0431, E0434, E0439, E1390RR, E1405 RR, E1406RR, E1392RR);

(b) For gaseous or liquid oxygen systems or contents, report one unit of service for one month rental. Do not report in cubic feet or pounds;

(c) Use the appropriate modifier if the prescribed flow rate is less than 1 LPM (QE) or greater than 4 LPM (QF or QG). DMAP only accepts these modifiers with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). Do not use these modifiers with codes for portable systems or oxygen contents;

(d) Use Code E1391 (oxygen concentrator, dual delivery port) in situations in which two clients are both using the same concentrator. In this situation, this code must only be requested for one of the clients;

(e) For E1405 and E1406 (oxygen and water vapor enriching systems) , products must be coded as published by the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services;(f) Code E1392 describes a portable oxygen concentrator system. Use E1392 when billing DMAP for the portable equipment add-on fee for clients using lightweight oxygen concentrators that can function as both the client's stationary equipment and portable equipment. A portable concentrator:

(A) Weighs less than 10 pounds;

(B) Is capable of delivering 85 percent or greater oxygen concentration; and

(C) Is capable of providing at least two hours of remote portability at a 2 LPM order equivalency;

(g) Contact the PDAC for guidance on the correct coding of these items.

(8) Documentation Requirements: The DMEPOS provider must have the following documentation on file which supports conditions of coverage as specified in this rule are met:

(a) Medical records that reflect the need for the oxygen care provided include records from:

(A) Physician's or practitioner's office;

(B) Hospital;

(C) Nursing home;

(D) Home health agency;

(E) Other health care professionals;

(F) Test reports;

(b) The treating practitioner's signed and dated orders for each item billed. When the DMEPOS provider bills DMAP before the provider receives a signed and dated order, the provider must submit the claim with an EY modifier added to each affected HCPCS code. In the following situations, a new order must be obtained and kept on file by the DMEPOS provider, but neither a new CMN nor a repeat blood gas study are required:

(A) Prescribed maximum flow rate changes but remains within one of the following categories:

(i) Less than 1 LPM;

(ii) 1-4 LPM;

(iii) Greater than 4 LPM;

(B) Change from one type of system to another (i.e., concentrator, liquid, gaseous);

(c) A completed, signed, dated CMN from the treating practitioner;

(A) The CMN may substitute for a written order if it is sufficiently detailed;

(B) The CMN for home oxygen is CMS form 484. Section B (order information) of the CMN must be completed by the physician or the practitioner, not the DMEPOS provider. The DMEPOS provider may use Section C to record written confirmation of other details of the oxygen order, or the practitioner can enter other details directly, such as means of deliver (e.g., cannula, mask, etc.) and the specifics of varying oxygen flow rates or non-continuous use of oxygen;

(C) The ABG PO2 must be reported on the CMN if both an ABG and oximetry test were performed the same day under the condition reported on the CMN (that is, at rest, awake, during exercise, or during sleep);

(D) A completed sleep study documenting the qualifying desaturation for clients who qualify for oxygen coverage based only on a sleep oximetry study. The saturation value reported in Question 1(b) of the Oxygen CMN must be the lowest value (not related to artifact) during the five-minute qualifying period reported on the sleep study;

(E) The blood gas study reported on the initial CMN must be the most recent study obtained prior to the initial date and this study must be obtained within 30 days prior to that initial date;

(i) There is an exception for clients who were on oxygen in a Medicare Health Maintenance Organization (HMO) and who transition to fee-for-service Medicare;

(ii) For those clients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent test obtained while in the HMO;

(F) The DMEPOS provider must submit to DMAP an initial CMN in the situations described below. The initial date refers to the dates reported in Section A of the CMN;

(i) With the first claim to DMAP for home oxygen, even if the client was on oxygen prior to becoming eligible for DMAP coverage, or oxygen was initially covered by a Medicare HMO;

(ii) When the first CMN did not meet coverage criteria and the client was subsequently retested and meets coverage criteria, the initial date on the new CMN is the date of the subsequent, qualifying blood gas study;

(iii) When a change occurs in the client's condition that caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. This indication does not apply if there was just a break in billing because the client was in a hospital, nursing facility, hospice or Medicare HMO, but the client continued to need oxygen during that time;

(iv) When a Group I client with length of need less than or equal to 12 months was not retested prior to Revised Certification/ Recertification, but a qualifying study was subsequently performed. The initial date on this new CMN is the date of the subsequent, qualifying blood gas study;

(v) When a Group II client did not have a qualifying, repeat blood gas study between the 61st and 90th days of coverage, but a qualifying study was subsequently performed. The initial date on the new CMN is the date of the subsequent, qualifying blood gas study;

(vi) When a change of provider occurs due to an acquisition and the previous provider did not file a recertification when it was due or the requirements for recertification were not met when it was due. The initial date on this new CMN is the date of the subsequent qualifying blood gas study;

(G) The DMEPOS provider must submit to DMAP a recertification CMN in the following circumstances. The initial date refers to the dates reported in Section A of the CMN:

(i) For Group I oxygen test results, 12 months after the initial certification (i.e., with the 13th month's claim). The blood gas reported study must be the most recent study performed prior to the 13th month of therapy;

(ii) If a Group I client with a lifetime length of need was not seen and evaluated by the practitioner within 90 days prior to the 12-month recertification, but was subsequently seen, the date on the recertification CMN must be the date of the practitioner visit;

(iii) For Group II oxygen test results, three months after the initial certification (i.e., with the fourth month's claim). The reported blood gas study must be the most recent study performed between the 61st and 90th day following the initial date;

(iv) If there was a change of provider due to an acquisition and the previous DMEPOS provider did not file a recertification when it was due, but all the requirements for the recertification were met when it was due, the provider would file a recertification CMN with the recertification date being 12 months (for a Group I initial CMN) or three months (for a Group II initial CMN) after the initial date;

(v) In other situations at the discretion of DMAP. The blood gas study must be the most recent study that was performed within 30 days prior to the recertification date;

(H) The DMEPOS provider must submit to DMAP a revised CMN in the following circumstances. Submission of a revised CMN does not change the recertification schedule specified elsewhere. The initial date refers to the dates reported in Section A of the CMN:

(i) When the prescribed maximum flow rate changes from one of the following categories to another:

(I) Less than 1 LPM;

(II) 1-4 LPM;

(III) Greater than 4 LPM;

(IV) If the change is from category (a) or (b) to category (c), a repeat blood gas study with the client on 4 LPM must be performed within 30 days prior to the start of the greater than 4 LPM flow;

(ii) When a portable oxygen system is added subsequent to initial certification of a stationary system. In this situation, DMAP does not require a repeat blood gas study, unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the client is at rest (awake) or during exercise within 30 days prior to the revised date;

(iii) When a stationary system is added subsequent to initial certification of a portable system. In this situation, DMAP does not require a repeat blood gas study;

(iv) When the length of need expires, if the practitioner specified less than lifetime length of need on the most recent CMN. In this situation, a blood gas study must be performed within 30 days prior to the revised date;

(v) When there is a new treating practitioner, but the oxygen order is the same. In this situation, DMAP does not require a repeat blood gas study. Note: In this situation, the revised CMN does not have to be submitted with the claim but must be kept on file by the provider;

(vi) If there is a new provider, that provider must be able to provide DMAP with a CMN on request. That CMN would not necessarily be an initial CMN or the first CMN for that client. If the provider obtains a new CMN, it would be considered a revised CMN;

(vii) If the indications for a revised CMN are met at the same time that a recertification CMN is due, file the CMN as a recertification CMN.

(9) **Table 122-0203** — Oxygen and Oxygen Equipment.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0204
Nebulizer

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) Equipment:

(A) Small Volume Nebulizer:

(i) A small volume nebulizer and related compressor may be covered to administer inhalation drugs based on evidence-based clinical practice guidelines;

(ii) The physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, the MDI was not sufficient for the administration of needed inhalation drugs.

(B) Large Volume Nebulizer:

(i) A large volume nebulizer (A7017), related compressor (E0565 or E0572), and water or saline (A4217 or A7018) may be covered when it is medically appropriate to deliver humidity to a client with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent;

(ii) Combination code E0585 will be covered for the same indications as in (1)(a)(B)(i);

(C) The Division of Medical Assistance Programs (DMAP) will consider other uses of compressors/generators individually on a case by case basis, to determine their medical appropriateness, such as a battery powered compressor (E0571);

(b) Accessories:

(A) A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and should not be separately billed when used for clients with rented home oxygen equipment;

(B) DMAP does not cover use of a large volume nebulizer, related compressor/generator, and water or saline when used predominately to provide room humidification;

(C) A non-disposable unfilled nebulizer (A7017 or E0585) filled with water or saline (A4217 or A7018) by the client/caregiver is an acceptable alternative to the large volume nebulizer when used as indicated in (1)(a)(B)(i) of this rule;

(D) Kits and concentrates for use in cleaning respiratory equipment are not covered;

(E) Accessories are separately payable if the related aerosol compressor and the individual accessories are medically appropriate. The following table lists each covered compressor/ generator and its covered accessories. Other compressor/generator/accessory combinations are not covered;

(F) Compressor/Generator (Related Accessories): E0565 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7017, A7525, E1372); E0570 (A7003, A7004, A7005, A7006, A7013, A7015, A7525); E0571 (A7003, A7004, A7005, A7006, A7013, A7015, A7525) ; E0572 (A7006, A7014); E0585 (A4619, A7006, A7010, A7011, A7012, A7013, A7014, A7015, A7525);

(G) This array of accessories represents all possible combinations but it may not be appropriate to bill any or all of them for one device;

(H) Table 122-0204-1 lists the usual maximum frequency of replacement for accessories. DMAP will not cover claims for more than the usual maximum replacement amount unless the request has been prior approved by DMAP before dispensing. The provider must submit requests for more than the usual maximum replacement amount to DMAP for review.

(2) Coding Guidelines:

(a) Accessories:

(A) Code A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece and mouthpiece. In addition, code A7006 includes a filter;

(B) Code A7004 includes only the lid, jar and baffles;

(C) Code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer;

(D) Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing;

(E) Code A7017 is billed for a durable, bottle type nebulizer when it is used with a E0572 compressor or a separately billed E0565 compressor;

(F) Code A7017 would not be separately billed when an E0585 system was also being billed. Code E0580 (Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as A7017, but should only be billed when this type of nebulizer is used with a client-owned oxygen system.

(b) Equipment:

(A) In this policy, the actual equipment (i.e., electrical device) will generally be referred to as a compressor (when nebulization of liquid is achieved by means of air flow). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor in order to achieve a functioning delivery system for aerosol therapy;

(B) Code E0565 describes an aerosol compressor, which can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation;

(C) A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered;

(D) A portable compressor (E0571) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option;

(E) A light duty adjustable pressure compressor (E0572) is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow of 6-8 L/m, but is capable only of intermittent operation.

(3) Documentation Requirements:

(a) When billing for an item in Table 122-0204, medical records must corroborate that all criteria in this rule are met;

(b) When billing for quantities of supplies greater than those described in Table 122-0204-1 as the usual maximum amounts, there must be clear documentation in the client's medical records corroborating the medical appropriateness of the current use.

(c) When a battery powered compressor (E0571) is dispensed, supporting documentation which justifies the medical appropriateness must be on file with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider;

(d) The DMEPOS provider must maintain these medical records and make them available to DMAP on request.

(4) **Table 122-0204-1**.

(5) **Table 122-0204-2.**

[ED. NOTE: Table referenced is available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0211

Cough Stimulating Device

(1) Indications and Limitations of Coverage and Medical Appropriateness:

The Division of Medical Assistance Programs (DMAP) may cover a cough stimulating device, alternating positive and negative airway pressure for a client who meets the following criteria:

(a) The client has been diagnosed with a neuromuscular disease as identified by one of the following diagnosis codes:

(A) 138 — Late effects of acute poliomyelitis;

(B) 277.00 — 277.09 — Cystic fibrosis;

(C) 335.0 — 335.9 — Werdnig-Hoffmann disease — anterior horn cell disease unspecified;

(D) 340 — 344.09 — Multiple sclerosis — quadriplegia and quadriparesis;

(E) 358.00 — 359.9 — Myoneural disorders;

(F) 519.4 — Disorders of diaphragm;

(G) 805.00 - 806.39 — Fracture of vertebral column, cervical or dorsal (thoracic);

(H) 907.2 — Late effect of spinal cord injury;

(I) 907.3 — Late effect of injury to nerve root(s), spinal plexus(es) and other nerves of trunk;

(J) 952.00 — 952.19 — Spinal cord injury without evidence of spinal bone injury, cervical or dorsal, (thoracic); and

(b) Standard treatment such as chest physiotherapy (e.g., chest percussion and postural drainage, etc.) has been tried and documentation supports why these modalities were not successful in adequately mobilizing retained secretions; or

(c) Standard treatment such as chest physiotherapy (e.g., chest percussion and postural drainage, etc.) is contraindicated and documentation supports why these modalities were ruled out; and

(d) The condition is causing a significant impairment of chest wall or diaphragmatic movement, such that it results in an inability to clear retained secretions.

(2) Procedure Code:

(a) E0482 (cough stimulating device, alternating positive and negative airway pressure) — prior authorization required;

(b) DMAP will purchase or rent on a monthly basis (limited to the lowest cost alternative);

(c) E0482 is considered purchased after no more than 10 months of rent;

(d) The fee includes all equipment, supplies, services, routine maintenance and necessary training for the effective use of the device.

(3) Documentation Requirements: Submit specific documentation from the treating practitioner which supports coverage criteria in this rule are met and may include, but is not limited to, evidence of any of the following:

(a) Poor, ineffective cough;

(b) Compromised respiratory muscles from muscular dystrophies or scoliosis;

(c) Diaphragmatic paralysis;

(d) Frequent hospitalizations or emergency department/urgent care visits due to pneumonias.

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0330

Power-Operated Vehicle

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover a power-operated vehicle (POV) when all of the following criteria are met:

(A) The client has a mobility limitation that significantly impairs their ability to accomplish mobility-related activities of daily living (MRADLs) ; places the client at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL; or the client is unable to sustain safely the performance of MRADLs throughout the course of a regular day. See OAR 410-122-0010 Definitions for complete definition of MRADLs;

(B) An appropriately fitted cane or walker cannot resolve the client's mobility limitation;

(C) The client does not have sufficient upper extremity function to self-propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day:

(i) Assessment of upper extremity function should consider limitations of strength, endurance, range of motion, or coordination, presence of pain, and deformity or absence of one or both upper extremities;

(ii) An optimally-configured manual wheelchair features an appropriate wheelbase, device weight, seating options, and other appropriate nonpowered accessories;

(D) The client has sufficient strength, postural stability, or other physical or mental capabilities needed to safely operate a POV in the home;

(E) The client's home provides adequate maneuvering space, maneuvering surfaces, and access between rooms for the operation of the POV being requested;

(F) Use of a POV will significantly improve the client's ability to move within the home to the areas customarily used for their MRADLs to allow completion of these activities within a reasonable time frame;

(G) The client is willing to use the requested POV in the home, and the client will use it on a regular basis in the home;

(H) DMAP does not cover services or upgrades that primarily allow performance of leisure or recreational activities. Such services include but are not limited to backup POVs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if the POV meets the same need, custom colors, and wheelchair gloves;

(b) For a POV to be covered, the treating physician or nurse practitioner must conduct a face-to-face examination of the client before writing the order:

(A) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider must receive a written report of this examination within 45 days after the face-to-face examination and prior to delivery of the device.

(B) When this examination is performed during a hospital or nursing facility stay, the DMEPOS provider must receive the report of the examination within 45 days after date of discharge;

(C) The physician or nurse practitioner may refer the client to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. This person may not be an employee of the DMEPOS provider or have any direct or indirect financial relationship, agreement or contract with the DMEPOS provider. When the DMEPOS provider is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination:

(i) If the client was referred to the PT/OT before being seen by the physician or nurse practitioner, then once the physician or nurse practitioner has received and reviewed the written report of this examination, the physician or nurse practitioner must see the client and perform any additional examination that is needed. The physician's or nurse practitioner's report of the visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician or nurse practitioner must provide the DMEPOS provider with a copy of both examinations within 45 days of the face-to-face examination with the physician or nurse practitioner;

(ii) If the physician or nurse practitioner examined the client before referring the client to a PT/OT, then again in person after receiving the report of the PT/OT examination, the 45-day period begins on the date of that second physician or nurse practitioner visit. However, it is also acceptable for the physician or nurse practitioner to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician or nurse practitioner must send a copy of the note from his/her initial visit to evaluate the client plus the annotated, signed, and dated copy of the PT/OT examination to the DMEPOS provider. The 45-day period begins when the physician or nurse practitioner signs and dates the PT/OT examination;

(iii) If the POV is a replacement of a similar item that was previously covered by DMAP or when only POV accessories are being ordered and all other coverage criteria in this rule are met, a face-to-face examination is not required;

(c) DMAP may authorize a new POV when a client's existing POV is no longer medically appropriate; or repair and/or modifications to the POV exceed replacement costs;

(d) If a client has a medically appropriate POV regardless of payer, DMAP will not reimburse for another POV;

(e) The cost of the POV includes all options and accessories that are provided at the time of initial purchase, including but not limited to batteries, battery chargers, seating systems, etc.;

(f) Reimbursement for the POV includes all labor charges involved in the assembly of the POV and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, pick-up and delivery for repairs/modifications, education and on-going assistance with use of the POV;

(g) If a client-owned POV meets coverage criteria, medically appropriate replacement items, including but not limited to batteries, may be covered;

(h) If a POV is covered, a manual or power wheelchair provided at the same time or subsequently will usually be denied as not medically appropriate;

(i) DMAP will cover one month's rental of a POV if a client-owned POV is being repaired;

(j) The following services are not covered:

(A) POV for use only outside the home; and

(B) POV for a nursing facility client.

(2) Coding Guidelines:

(a) Codes K0800 — K0802 are used only for POVs that can be operated inside the home;

(b) Codes K0800 — K0802 are not used for a manual wheelchair with an add-on tiller control power pack;

(c) A replacement item, including but not limited to replacement batteries, should be requested using the specific wheelchair option or accessory code if one exists (see 410-122-0340, Wheelchairs Options/Accessories). If a specific code does not exist, use code K0108 (wheelchair component or accessory, not otherwise specified);

(d) For guidance on correct coding, DMEPOS providers should contact the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services. See 410-122-0180 Healthcare Common Procedure Coding System (HCPCS) Level II Coding for more information.

(3) Documentation Requirements: Submit all of the following documentation with the prior authorization (PA) request:

(a) A copy of the written report of the face-to-face examination of the client by the physician or nurse practitioner:

(A) The report must include information related to the following:

(i) This client's mobility limitation and how it interferes with the performance of activities of daily living;

(ii) Why a cane or walker can't meet this client's mobility needs in the home;

(iii) Why a manual wheelchair can't meet this client's mobility needs in the home;

(iv) This client's physical and mental abilities to operate a POV (scooter) safely in the home:

(I) Besides a mobility limitation, if other conditions exist that limit a client's ability to participate in MRADLs, how these conditions will be ameliorated or compensated;

(II) How these other conditions will be ameliorated or compensated sufficiently such that the additional provision of mobility assistive equipment (MAE) will be reasonably expected to significantly improve the client's ability to perform or obtain assistance to participate in MRADLs in the home.

(B) The face-to-face examination should provide pertinent information about the following elements, but may include other details. Only relevant elements need to be addressed:

(i) Symptoms;

(ii) Related diagnoses;

(iii) History:

(I) How long the condition has been present;

(II) Clinical progression;

(III) Interventions that have been tried and the results;

(IV) Past use of walker, manual wheelchair, POV, or power wheelchair and the results;

(iv) Physical exam:

(I) Weight;

(II) Impairment of strength, range of motion, sensation, or coordination of arms and legs;

(III) Presence of abnormal tone or deformity of arms, legs or trunk;

(IV) Neck, trunk, and pelvic posture and flexibility;

(V) Sitting and standing balance;

(v) Functional assessment — any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person:

(I) Transferring between a bed, chair, and power mobility device;

(II) Walking around their home — to bathroom, kitchen, living room, etc. — provide information on distance walked, speed, and balance;

(C) Although a client who qualifies for coverage of a POV may use that device outside the home, because DMAP's coverage of a POV is determined solely by the client's mobility needs within the home, the examination must clearly distinguish the client's abilities and needs within the home from any additional needs for use outside the home;

(b) The physician's or nurse practitioner's written order, received by the DMEPOS provider within 30 days after the physician's or nurse practitioner's face-to-face examination, which includes all of the following elements:

(A) Client's name;

(B) Description of the item that is ordered. This may be general — e.g., "POV" or "power mobility device" — or may be more specific:

(i) If this order does not identify the specific type of POV that is being requested, the DMEPOS provider must clarify this by obtaining another written order which lists the specific POV that is being ordered and any options and accessories requested;

(ii) The items on this order may be entered by the DMEPOS provider. This subsequent order must be signed and dated by the treating physician or nurse practitioner, received by the DMEPOS provider and submitted to the authorizing authority, but does not have to be received within 45 days following the face-to-face examination.

(C) Most significant ICD-9 diagnosis code that relates specifically to the need for the POV;

(D) Length of need;

(E) Physician's or nurse practitioner's signature;

(F) Date of physician's or nurse practitioner's signature;

(c) For all requested equipment and accessories, include the manufacturer's name, product name, model number, standard features, specifications, dimensions and options;

(d) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable;

(e) A written evaluation of the client's living quarters, performed by the DMEPOS provider. This assessment must support that the client's home can accommodate and allow for the effective use of a POV, including, but is not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps), electrical service, etc; and

(f) All HCPCS to be billed on this claim (both codes that require authorization and those that do not require authorization); and

(g) Any additional documentation that supports indications of coverage are met as specified in this rule;

(h) The above documentation must be kept on file by the DMEPOS provider;

(i) Documentation that the coverage criteria have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to DMAP on request.

(4) Billing:

(a) Procedure Codes:

(A) K0800 Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds — PA;

(B) K0801 Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds — PA;

(C) K0802 Power operated vehicle, group 1 very heavy duty, patient weight capacity, 451 to 600 pounds — PA;

(b) DMAP will purchase, rent and repair;

(c) Item considered purchased after 13 months of rent.

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 15-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0340

Wheelchair Options/Accessories

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover options and accessories for covered wheelchairs when the following criteria are met:

(A) The client has a wheelchair that meets DMAP coverage criteria; and

(B) The client requires the options/accessories to accomplish their mobility-related activities of daily living (MRADLs) in the home. See 410-122-0010 Definitions for definition of MRADLs;

(b) DMAP does not cover options/accessories whose primary benefit is allowing the client to perform leisure or recreational activities;

(c) Arm of Chair:

(A) Adjustable arm height option (E0973, K0017, K0018, K0020) may be covered when the client:

(i) Requires an arm height that is different than what is available using nonadjustable arms; and

(ii) Spends at least two hours per day in the wheelchair;

(B) An arm trough (E2209) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements;

(d) Foot rest/Leg rest:

(A) Elevating leg rests (E0990, K0046, K0047, K0053, K0195) may be covered when:

(i) The client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or

(ii) The client has significant edema of the lower extremities that requires having an elevating leg rest; or

(iii) The client meets the criteria for and has a reclining back on the wheelchair;

(B) Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per leg rest;

(C) Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests;

(e) Nonstandard Seat Frame Dimensions:

(A) For all adult wheelchairs, DMAP includes payment for seat widths and/or seat depths of 15-19 inches in the payment for the base code. These seat dimensions must not be separately billed;

(B) Codes E2201-E2204 and E2340-E2343 describe seat widths and/or depths of 20 inches or more for manual or power wheelchairs;

(C) A nonstandard seat width and/or depth (E2201-E2204 and E2340-E2343) is covered only if the patient's dimensions justify the need;

(f) Rear Wheels for Manual Wheelchairs: Code K0064 (flat free insert) is used to describe either:

(A) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or

(B) Non-removable foam material in a foam filled rubber tire;

(C) K0064 is not used for a solid self-skinning polyurethane tire;

(g) Batteries/Chargers:

(A) Up to two batteries (E2360-E2365) at any one time are allowed if required for a power wheelchair;

(B) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base;

(h) Seating:

(A) DMAP may cover a general use seat cushion and a general-use wheelchair back-cushion for a client whose wheelchair that meets DMAP coverage criteria;

(B) A skin protection seat cushion may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets DMAP coverage criteria; and

(ii) The client has either of the following:

(I) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or

(II) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis), post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease;

(C) A positioning seat cushion, positioning back cushion, and positioning accessory (E0955-E0957, E0960) may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets DMAP coverage criteria; and

(ii) The client has any significant postural asymmetries due to one of the diagnoses listed in criterion (h)(B)(ii)(II) or to one of the following diagnoses: monoplegia of the lower limb; hemiplegia due to stroke, traumatic brain injury, or other etiology; muscular dystrophy; torsion dystonias; spinocerebellar disease;

(D) A combination skin protection and positioning seat cushion may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion;

(E) Separate payment is allowed for a seat cushion solid support base (E2618) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161) or lightweight power wheelchair. There is no separate payment when this is used with other types of power wheelchairs because those wheelchairs include a solid support base;

(F) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion;

(G) There is no separate payment for mounting hardware for a seat or back cushion;

(H) There is no separate payment for a headrest (E0955, E0966) on a captain's seat on a power wheelchair;

(I) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient:

(i) Basic materials include liquid foam or a block of foam and sheets of fabric or liquid coating material:

(I) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately;

(II) The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface;

(ii) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, CAD-CAM technology, or detailed measurements of the patient used to create a configured cushion:

(I) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated;

(II) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion;

(iii) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617;

(J) A custom fabricated seat cushion may be covered if criteria (i) and (iii) are met. A custom fabricated back cushion may be covered if criteria (ii) and (iii) are met:

(i) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;

(ii) Client meets all of the criteria for a prefabricated positioning back cushion;

(iii) There is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs;

(K) A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification as published by the Pricing, Data Analysis and Coding (PDAC) Contractor by the Centers for Medicare and Medicaid Services; or which does not meet the criteria stated in this rule is not covered;

(L) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest;

(M) The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion;

(N) A solid insert (E0992) is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support and is included in the allowance for a seat cushion;

(O) A solid support base for a seat cushion is a rigid piece of plastic or other material that is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2618 for this solid support base;

(i) DMAP will only cover accessories billed under the following codes when PDAC has made written confirmation of use of the code for the specific product(s) being billed: E2601-E2608, E2611-E2616, E2620, E2621; E2609 and E2617 (brand-name products), K0108 (for wheelchair cushions):

(A) Information concerning the documentation that must be submitted to PDAC for a Coding Verification Request can be found on the PDAC Web site or by contacting PDAC;

(B) A Product Classification List with products that have received a coding verification can be found on the PDAC Web site;

(j) Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(k) Power seating systems:

(A) A power-tilt seating system (E1002):

(i) Includes all the following:

(I) A solid seat platform and a solid back; any frame width and depth;

(II) Detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swingaway detachable leg rests;

(IV) Fixed or flip-up footplates;

(V) Motor and related electronics with or without variable speed programmability;

(VI) Switch control that is independent of the power wheelchair drive control interface;

(VII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability for the supplier to adjust the seat to back angle;

(IV) Ability to support patient weight of at least 250 pounds.

(B) A power recline seating system (E1003-E1005):

(i) Includes all the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth;

(III) Detachable or flip-up fixed height or adjustable height arm rests;

(IV) Fixed or swingaway detachable leg rests;

(V) Fixed or flip-up footplates;

(VI) A motor and related electronics with or without variable speed programmability;

(VII) A switch control that is independent of the power wheelchair drive control interface;

(VIII) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to recline to greater than or equal to 150 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability to support patient weight of at least 250 pounds.

(C) A power tilt and recline seating system (E1006-E1008):

(i) Includes the following:

(I) A solid seat platform and a solid back;

(II) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests;

(III) Fixed or swing-away detachable leg rests; fixed or flip-up footplates;

(IV) Two motors and related electronics with or without variable speed programmability;

(V) Switch control that is independent of the power wheelchair drive control interface;

(VI) Any hardware that is needed to attach the seating system to the wheelchair base;

(ii) It does not include a headrest;

(iii) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Ability to recline to greater than or equal to 150 degrees from horizontal;

(III) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

(D) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises, a mechanical linkage between the two panels allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(E) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises, a separate motor controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(F) A power leg elevation feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s);

(l) Codes E2310 and E2311 (Power Wheelchair Accessory):

(A) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or non-proportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing;

(B) Include a function selection switch that allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected;

(C) When the wheelchair drive function is selected the indicator feature may also show the direction that is selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface;

(D) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present);

(E) When a switch is medically appropriate and a client has adequate hand motor skills, a switch would be considered the least costly alternative;

(F) E2310 or E2311 may be considered for coverage when a client does not have hand motor skills or presents with cognitive deficits, contractures or limitation of movement patterns that prevents operation of a switch;

(G) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick);

(H) If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it is not covered.

(m) Power Wheelchair Drive Control Systems:

(A) The term interface in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc;

(B) A proportional interface is one in which the direction and amount of movement by the client controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick;

(C) A non-proportional interface is one that involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a non-proportional interface is a sip-and-puff mechanism;

(D) The term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface) and convert that input into power output to the motor and gears in the power wheelchair base;

(E) A switch is an electronic device that turns power to a particular function either "on" or "off". The external component of a switch may be either mechanical or non-mechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of non-mechanical switches include, but are not limited to, proximity, infrared, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component;

(F) A stop switch allows for an emergency stop when a wheelchair with a non-proportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch is sometimes referred to as a kill switch;

(G) A direction change switch allows the client to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time;

(H) A function selection switch allows the client to determine what operation is being controlled by the interface at any particular time. Operations may include, but are not limited to, drive forward, drive backward, tilt forward, recline backward, etc.;

(I) An integrated proportional joystick and controller is an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair;

(J) The interfaces described by codes E2320-E2322, E2325, and E2327-E2330 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking;

(K) A remote joystick (E2320, E2321) is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. These codes include remote joysticks that are used for hand control as well as joysticks that are used for chin control. Code E2320 includes any type of proportional remote joystick stick including, but not limited to standard, mini-proportional, compact, and short throw remote joysticks;

(L) When code E2320 or E2321 is used for a chin control interface, the chin cup is billed separately with code E2324;

(M) Code E2320 also describes a touchpad that is an interface similar to the pad-type mouse found on portable computers;

(N) Code E2322 describes a system of 3-5 mechanical switches that are activated by the client touching the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch, if provided, are included in the allowance for the code;

(O) Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick – e.g., U shape or T shape – or that have some other nonstandard feature – e.g., flexible shaft;

(P) A sip and puff interface (E2325) is a non-proportional interface in which the client holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit that is described by code E2326;

(Q) A proportional, mechanical head control interface (E2327) is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the client's head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code;

(R) A proportional, electronic head control interface (E2328) is one in which a client's head movements are sensed by a box placed behind the client's head. The direction and amount of movement of the client's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the client's arm or leg control the direction and speed of the wheelchair;

(S) A non-proportional, contact switch head control interface (E2329) is one in which a client activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(T) A non-proportional, proximity switch head control interface (E2330) is one in which a client activates one of three switches placed around the back and sides of their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(U) Code E2399 (not otherwise classified interface) is appropriately used in the following situations:

(i) An integrated proportional joystick and controller box are being replaced due to damage; or

(ii) The item being replaced is a remote joystick box only (without the controller); or

(iii) The item being replaced is another type of interface, e.g. sip and puff, head control without the controller); or

(iv) The item being replaced is the controller box only (without the remote joystick or other type of interface); or

(v) There is no specific E code that describes the type of drive control interface system that is provided. In this situation, E2399 would be used at the time of initial issue or if the item was being provided as a replacement;

(V) The KC modifier (replacement of special power wheelchair interface):

(i) Is used in the following situations:

(I) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface — e.g., remote joystick, head control, sip and puff, etc.; or

(II) The client has a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage;

(ii) The KC modifier is never used at the time of initial issue of a wheelchair;

(iii) The KC modifier specifically states replacement, therefore, the RP modifier is not required. The KC modifier is not used when billing code E2399;

(n) Other Power Wheelchair Accessories: An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface may be covered if the client has a covered speech generating device. (See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services.);

(o) Miscellaneous Accessories:

(A) Anti-rollback device (E0974) is covered if the client propels himself/herself and needs the device because of ramps;

(B) A safety belt/pelvic strap (E0978) is covered if the client has weak upper body muscles, upper body instability or muscle spasticity that requires use of this item for proper positioning;

(C) A shoulder harness/straps or chest strap (E0960) and a safety belt/pelvic strap (E0978) are covered only to treat a client's medical symptoms:

(i) A medical symptom is defined as an indication or characteristic of a physical or psychological condition;

(ii) E0960 and E0978 are not covered when intended for use as a physical restraint or for purposes intended for discipline or convenience of others;

(D) One example (not all-inclusive) of a covered indication for swing-away, retractable, or removable hardware (E1028) would be to move the component out of the way so that a client could perform a slide transfer to a chair or bed;

(E) A fully reclining back option (E1226) is covered if the client spends at least 2 hours per day in the wheelchair and has one or more of the following conditions/needs:

(i) Quadriplegia;

(ii) Fixed hip angle;

(iii) Trunk or lower extremity casts/braces that require the reclining back feature for positioning;

(iv) Excess extensor tone of the trunk muscles; and/or

(v) The need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(2) Documentation Requirements: Submit documentation that supports coverage criteria in this rule are met and the specified information as follows with the prior authorization (PA) request:

(a) When code K0108 is billed, a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical appropriateness for the item;

(b) Options/accessories for individual consideration might include documentation on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment;

(c) For a custom-fabricated seat cushion:

(A) A comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a DMEPOS provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs, and;

(B) Diagnostic reports that support the medical condition;

(C) Dated and clear photographs;

(D) Body contour measurements;

(d) Documentation that the coverage criteria in this rule have been met must be present in the client's medical record. This documentation and any additional medical information from the DMEPOS provider must be made available to DMAP on request.

(3) **Table 122-0340**.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 25-2006, f. 6-14-06, cert. ef. 7-1-06; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0365

Standing and Positioning Aids

(1) Indications and coverage: If a client has one aid that meets his/her medical needs, regardless of who obtained it, the Division of Medical Assistance Programs (DMAP) will not provide another aid of same or similar function.

(2) Documentation to be submitted for prior authorization (PA) and kept on file by the Durable Medical Equipment (DME) provider:

(a) Documentation of medical appropriateness, which has been reviewed and signed by the prescribing practitioner;

(b) The care plan outlining positioning and treatment regime, and all DME currently available for use by the client;

(c) The physician's order;

(d) The documentation for customized positioner must include objective evidence that commercially available positioners are not appropriate;

(e) Each item requested must be itemized with description of product, make, model number, and manufacturers suggested retail price (MSRP);

(f) Submit Positioner Justification form (DMAP 3155) or reasonable facsimile, with recommendation for most appropriate equipment. This must be submitted by physical therapist, occupational therapist, or prescribing practitioner when requesting a PA;

(3) Gait Belts:

(a) Covered when:

(A) The client weighs 60 lbs. or more; and

(B) The care provider is trained in the proper use; and

(C) The client can walk independently, but needs:

(i) A minor correction of ambulation; or

(ii) Needs minimal or standby assistance to walk alone; or

(iii) Requires assistance with transfer;

(b) Use code E0700.

(4) Standing frame systems, prone standers, supine standers or boards and accessories for standing frames are covered when:

(a) The client has been sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and,

(b) The client is following a therapy program initially established by a physical or occupational therapist; and

(c) The home is able to accommodate the equipment; and

(d) The weight of the client does not exceed manufacturer's weight capacity; and

(e) The client has demonstrated an ability to utilize the standing aid independently or with caregiver; and

(f) The client has demonstrated compliance with other programs; and

(g) The client has demonstrated a successful trial period in a monitored setting; and

(h) The client does not have access to equipment from another source.

(5) Sidelyers and custom positioners must meet the following criteria in addition to the criteria in Table 122-0365:

(a) The client must be sequentially evaluated by a physical or occupational therapist to make certain the client can tolerate and obtain medical benefit; and

(b) The client must be following a therapy program initially established by a physical or occupational therapist; and,

(c) The home must be able to accommodate the equipment; and

(d) The caregiver and/or family are capable of using the equipment appropriately.

(6) Criteria for Specific Accessories:

(a) A back support may be covered when a client:

(A) Needs for balance, stability, or positioning assistance; or

(B) Has extensor tone of the trunk muscles; or

(C) Needs for support while being raised or while completely standing;

(b) A tall back may be covered when:

(A) The client is over 5'11" tall; and

(B) The client has no trunk control and needs additional support; or

(C) The client has more involved need for assistance with balance, stability, or positioning;

(c) Hip guides may be covered when a client:

(A) Lacks motor control and/or strength to center hips; or

(B) Has asymmetrical tone which causes hips to pull to one side; or

(C) Has spasticity; or

(D) Has low tone or high tone; or

(E) Need for balance, stability, or positioning assistance;

(d) A shoulder retractor or harness may be covered when:

(A) Erect posture cannot be maintained without support due to lack of motor control or strength; or

(B) Has kyphosis; or

(C) Presents strong flexor tone;

(e) Lateral supports may be covered when a client:

(A) Lacks trunk control to maintain lateral stability; or

(B) Has scoliosis which requires support; or

(C) Needs a guide to find midline;

(f) A headrest may be covered when a client:

(A) Lacks head control and cannot hold head up without support; or

(B) Has strong extensor thrust pattern that requires inhibition;

(g) Independent adjustable knee pads may be covered when a client:

(A) Has severe leg length discrepancy; or

(B) Has contractures in one leg greater than the other;

(h) An actuator handle extension may be covered when a client:

(A) Has no caregiver; and

(B) Is able to transfer independently into standing frame; and

(C) Has limited range of motion in arm and/or shoulder and cannot reach actuator in some positions;

(i) Arm troughs may be covered when a client:

(A) Has increased tone which pulls arms backward so hands cannot come to midline; or

(B) Has poor tone, strength, or control is so poor that causes arms to hang out to side and backward, causing pain and risking injury; or

(C) Needs for posture;

(j) A tray may be covered when proper positioning cannot be accomplished by other accessories;

(k) Abductors may be covered to reduce tone for proper alignment and weight bearing;

(l) Sandals (shoe holders) may be covered when a client:

(A) Has dorsiflexion of the foot or feet; or

(B) Has planar flexion of the foot or feet or

(C) Has eversion of the foot or feet; or

(D) Needs for safety.

(7) **Table 122-0365**.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 17-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0560

Urological Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover the following urinary catheters, external urinary collection devices, and medically appropriate related supplies when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention;

(b) Indwelling Catheters (A4311 – A4316, A4338 – A4346):

(A) No more than one catheter per month for routine catheter maintenance;

(B) Non-routine catheter changes when documentation substantiates medical appropriateness, such as for the following indications:

(i) Catheter is accidentally removed (e.g., pulled out by client);

(ii) Catheter malfunctions (e.g., balloon does not stay inflated, hole in catheter);

(iii) Catheter is obstructed by encrustation, mucous plug, or blood clot;

(iv) History of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change frequency of more than once per month;

(C) A specialty indwelling catheter (A4340) or an all silicone catheter (A4344, A4312, or A4315) when documentation in the client's medical record supports the medical appropriateness for that catheter rather than a straight Foley type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex);

(D) A three way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) only if continuous catheter irrigation is medically appropriate;

(c) Catheter Insertion Tray (A4310-A4316, A4353, and A4354):

(A) Only one insertion tray per episode of indwelling catheter insertion;

(B) One intermittent catheter with insertion supplies (A4353) per episode of medically appropriate sterile intermittent catheterization;

(d) Urinary Drainage Collection System (A4314-A4316, A4354, A4357, A4358, A5102, and A5112):

(A) For routine changes of the urinary drainage collection system as noted in Table 122-0560-1;

(B) Additional charges for medically appropriate non-routine changes when the documentation substantiates the medical appropriateness (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection);

(C) A vinyl leg bag (A4358) or a latex leg bag (A5112) only for clients who are ambulatory or are chair or wheelchair bound.

(e) Intermittent Irrigation of Indwelling Catheters:

(A) Supplies for the intermittent irrigation of an indwelling catheter when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter;

(B) Routine intermittent irrigations of a catheter are not covered;

(C) Routine irrigations are defined as those performed at predetermined intervals;

(D) Covered supplies for medically appropriate non-routine irrigation of a catheter include either an irrigation tray (A4320) or an irrigation syringe (A4322), and sterile water/saline (A4217);

(f) Continuous Irrigation of Indwelling Catheters:

(A) Supplies for continuous irrigation of a catheter when there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically appropriate catheter changes;

(B) Continuous irrigation as a primary preventative measure (i.e., no history of obstruction) is not covered;

(C) Documentation must substantiate the medical appropriateness of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation;

(D) The records must also indicate the rate of solution administration and the duration of need;

(E) Covered supplies for medically appropriate continuous bladder irrigation include a three-way Foley catheter (A4313, A4316, and A4346), irrigation tubing set (A4355), and sterile water/saline (A4217):

(i) DMAP may cover one irrigation tubing set per day for continuous catheter irrigation;

(ii) Continuous irrigation is considered a temporary measure and may only be covered for up to 14 days.

(g) Intermittent Catheterization: Intermittent catheter supplies when basic coverage criteria are met and the client or caregiver can perform the procedure:

(A) For each episode of covered catheterization, one catheter (A4351, A4352) and an individual packet of lubricant (A4332); or

(B) One sterile intermittent catheter kit (A4353) when the client requires catheterization and meets one of the following criteria (i-iv):

(i) The client is immunosuppressed. Examples of immunosuppressed clients include (but are not limited) clients who are:

(I) On a regimen of immunosuppressive drugs post-transplant;

(II) On cancer chemotherapy;

(III) Have AIDS;

(IV) Have a drug-induced state such as chronic oral corticosteroid use.

(ii) The client has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization;

(iii) The client is a pregnant, spinal cord-injured female with neurogenic bladder (for duration of pregnancy only);

(iv) The client has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant (A4332), twice within the 12 month period prior to the initiation of sterile intermittent catheter kits. A urinary tract infection means a urine culture with greater than 10,000 colony form-

ing units of a urinary pathogen; and documentation in the client's medical records of concurrent presence of one or more of the following signs, symptoms or laboratory findings:

(I) Fever (oral temperature greater than 38º C);

(II) Systemic leukocytosis;

(III) Change in urinary urgency, frequency, or incontinence;

(IV) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation);

(V) Physical signs of prostatitis, epididymitis, orchitis;

(VI) Increased muscle spasms;

(VII) Pyuria (greater than five white blood cells [WBCs] per high-powered field);

(B) The kit code (A4353) must be used for billing even if the components are packaged separately rather than together as a kit;

(h) Coude (Curved) Tip Catheters:

(A) Use of a Coude (curved) tip catheter (A4352) in female clients is rarely medically appropriate;

(B) For any client, when a Coude tip catheter is dispensed and billed, there must be specific documentation in the client's medical record why a Coude tip catheter is required rather than a straight tip catheter;

(i) External Catheters/Urinary Collection Devices:

(A) Male external catheters (condom-type) or female external urinary collection devices for clients who have permanent urinary incontinence when used as an alternative to an indwelling catheter;

(B) Coverage for male external catheters (A4349) is limited to 35 per month; Greater utilization of these devices must be accompanied by documentation of medical appropriateness;

(C) Male external catheters (condom-type) or female external urinary collection devices are not covered for clients who also use an indwelling catheter;

(D) DMAP may cover specialty type male external catheters such as those that inflate or that include a faceplate (A4326) or extended wear catheter systems (A4348) only when documentation substantiates the medical appropriateness for such a catheter;

(E) Coverage of female external urinary collection devices is limited to one metal cup (A4327) per week or one pouch (A4328) per day;

(j) Miscellaneous Supplies:

(A) Appliance cleaner (A5131): One unit of service (16 oz) per month when used to clean the inside of certain urinary collecting appliances (A5102, A5112);

(B) One external urethral clamp or compression device (A4356) every three months or sooner if the rubber/foam casing deteriorates;

(C) Adhesive catheter anchoring devices (A4333, three per week) and catheter leg straps (A4334, one per month) for indwelling urethral catheters;

(D) A catheter/tube anchoring device (A5200) separately payable when it is used to anchor a covered suprapubic tube or nephrostomy tube;

(E) Non-Sterile Gloves:

(i) Up to 200 pairs of non-sterile gloves (A4927) per month only when the client or caregiver is performing intermittent catheterizations;

(ii) DMAP will not pay for more than 200 pairs of non-sterile gloves (A4927) per month;

(k) The following services are not covered:

(A) Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250);

(B) Catheter care kits (A9270);

(C) Adhesive remover (A4365, A4455);

(D) Catheter clamp or plug (A9270);

(E) Disposable underpads, all sizes, diapers or incontinence garments, any type, disposable or reusable unless authorized under 410-122-0630 Incontinent Supplies;

(F) Drainage bag holder or stand (A9270);

(G) Urinary suspensory without leg bag (A4359);

(H) Measuring container (A9270);

(I) Urinary drainage tray (A9270);

(J) Gauze pads (A6216-A6218) and other dressings;

(K) Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270);

(L) Irrigation supplies that are used for care of the skin or perineum of incontinent clients;

(M) Syringes, trays, sterile saline, or water used for routine irrigation.

(2) Guidelines:

(a) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical records, including the judgment of the attending treating practitioner, indicate the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met;

(b) A urinary intermittent catheter with insertion supplies (A4353) is a kit, which includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use;

(c) Adhesive strips or tape used with male external catheters are included in the allowance for the code and are not separately payable;

(d) Catheter insertion trays (A4310-A4316, A4353, and A4354) that contain component parts of the urinary collection system, (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts may be allowed only per the stated criteria in each section of the policy;

(e) Extension tubing (A4331) may be covered for use with a latex urinary leg bag (A5112) and is included in the allowance for codes A4314, A4315, A4316, A4354, A4357, A4358, and A5105 and A4331 cannot be separately billed with these codes;

(f) Use A4333 when used to anchor an indwelling urethral catheter;

(g) Use code A5105 when billing for a urinary suspensory with leg bag;

(h) Replacement leg straps (A5113, A5114) are used with a urinary leg bag (A4358, A5105, or A5112). These codes are not used for a leg strap for an indwelling catheter;

(i) A4326 is a male external catheter with an integrated collection chamber that does not require the use of an additional leg bag.

(3) Documentation Requirements:

(a) For services requiring prior authorization (PA), submit documentation which supports coverage criteria as specified in this rule are met;

(b) Intermittent Catheterization:

(A) The practitioner's order must indicate the actual number of times intermittent catheterization is performed per day;

(B) The client's medical records must support the number of times per day intermittent catheterization is performed;

(c) When requesting quantities of supplies greater than the maximum units specified in this rule, submit documentation supporting the medical appropriateness for the higher utilization to the appropriate authorization authority for prior authorization (PA);

(d) Documentation, which supports condition of coverage requirements for codes billed in this rule, must be kept on file by the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider and made available to DMAP on request;

(e) A client's medical records must support the justification for supplies billed to DMAP.

(4) **Table 122-0560-1**, Maximum Quantity of Supplies.

(5) **Table 122-0560-2**.

(6) **Table 122-0560-3**, Procedure Codes.

[ED. NOTE: Tables referenced rule are available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0580

Bath Supplies

(1) Indications and Limitations of Coverage and Medical Appropriateness

(a) The Division of Medical Assistance Programs (DMAP) may cover bath supplies when medically appropriate and cost-effective including a rehab shower/commode chair when all of the following criteria are met:

(A) Client is unable to use a standard shower chair/bench due to a musculoskeletal condition;

(B) Client has positioning, trunk stability or neck support needs that a standard shower chair/bench cannot provide;

(C) The home (shower) can accommodate a rehab/shower chair;

(D) Less costly alternatives have been considered or tried and ruled out;

(E) The rehab shower/commode chair meets the following specifications and standard features as a minimum:

(i) Constructed specifically for use as a rehab shower/commode chair (corrosive resistant);

(ii) Swing-away or detachable arms;

(iii) Removable commode pan holder and pan;

(iv) Adjustable removable footrests;

(v) Wheellock system;

(F) The rehab shower/commode chair must be supplied by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider that employs a Rehabilitation Engineering and Assistive Technology Society of North America (RESNA)-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the rehab shower/commode chair selection for the client;

(b) Verification of the healthcare common procedure coding system (HCPCS) code assignment by the Pricing, Data Analysis and Coding (PDAC) Contractor is not required for a rehab shower/commode chair;

(c) Use E1399 for a rehab shower/commode chair.

(2) Documentation Requirements:

(a) The practitioner's order and medical justification for the equipment must be kept on file by the DMEPOS provider. The client's medical records must contain information which supports the medical appropriateness of the item ordered;

(b) For a rehab shower/commode chair, submit documentation which supports conditions of coverage in this rule are met.

(3) **Table 122-0580** Bath Supplies.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 47-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0630

Incontinent Supplies

(1) The Division of Medical Assistance Programs (DMAP) may cover incontinent supplies for urinary or fecal incontinence as follows:

(a) Category I Incontinent Supplies — For up to 220 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity;

(b) Category II Underpads:

(A) Disposable underpads (T4541 and T4542): For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month;

(B) Reusable/washable underpads: (T4537 and T4540) For up to eight units (any combination of T4537 and T4540) in a 12 month period;

(C) Category II Underpads are separately payable only with Category I Incontinent Supplies;

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months.

(c) Category III Washable Protective Underwear:

(A) For up to 12 units in a 12 month period;

(B) Category III Washable Protective Underwear are not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months;

(d) The following services require prior authorization (PA):

(A) A4335 (Incontinence supply; miscellaneous); and

(B) Quantity of supplies greater than the amounts listed in this rule as the maximum monthly utilization (e.g., more than 220 units/month of Category I Incontinent Supplies).

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description.

(4) Documentation requirements:

(a) The client's medical records must support the medical appropriateness for the services provided or being requested by the DMEPOS provider, including, but not limited to:

(A) For all categories, the medical reason and condition causing the incontinence; and

(B) When a client is using urological or ostomy supplies at the same time as codes specified in this rule, information which clearly corroborates the overall quantity of supplies needed to meet bladder and bowel management is medically appropriate.

(b) For services requiring PA, submit documentation as specified in (4)(a)(A) and (B);

(c) The durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider is required to keep supporting documentation on file and make available to DMAP on request.

(5) Quantity specification:

(a) For PA and reimbursement purposes, a unit count for Category I — III codes is considered as single or individual piece of an item and not as multiple quantity;

(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) must be specified in the unit column on the PA request. See table 122-0630-2;

(c) For gloves (Category IV Miscellaneous), 100 gloves equal one unit.

(9) **Table 122-0630-1**.

(10) **Table 122-0630-2**.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 64-2001, f. 12-28-01, cert.ef. 1-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05; OMAP 35-2006, f. 9-15-06, cert. ef. 10-1-06; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

410-122-0655

External Breast Prostheses

(1) Indications and Limitations of Coverage and Medical Appropriateness:

(a) The Division of Medical Assistance Programs (DMAP) may cover an external breast prosthesis for a client who has had a mastectomy;

(b) An external breast prosthesis garment, with mastectomy form (L8015) may be covered for use in the postoperative period prior to a permanent breast prosthesis or as an alternative to a mastectomy bra and breast prosthesis;

(c) An external breast prosthesis of a different type may be covered if there is a change in the client's medical condition necessitating a different type of item;

(d) DMAP will pay for only one breast prosthesis per side for the useful lifetime of the prosthesis;

(e) DMAP will pay for a breast prosthesis for a client residing in a nursing facility;

(f) Two prostheses, one per side, are allowed for a client who has had bilateral mastectomies;

(g) More than one external breast prosthesis per side is not covered;

(h) An external breast prosthesis of the same type may be replaced if it is lost or is irreparably damaged (this does not include ordinary wear and tear);

(i) An external breast prosthesis of a different type may be covered if there is a change in the client's medical condition necessitating a different type of item;

(j) Replacement sooner than the useful lifetime because of ordinary wear and tear is not covered.

(2) Guidelines:

(a) Use code A4280 when billing for an adhesive skin support that attaches an external breast prosthesis directly to the chest wall;

(b) L8000 is limited to a maximum of four units every 12 months;

(c) Code L8015 describes a camisole type undergarment with polyester fill used post mastectomy;

(d) The right (RT) and left (LT) modifiers must be used with these codes. When the same code for two breast prostheses are billed for both breasts on the same date, the items (RT and LT) must be entered on the same line of the claim form using the RTLT modifier and two units of service;

(e) The useful lifetime expectancy for silicone breast prostheses is two years;

(f) For fabric, foam, or fiber filled breast prostheses, the useful lifetime expectancy is six months. Requirements:

(a) For services that do not require prior authorization (PA), the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider must have documentation on file which supports conditions of coverage as specified in this rule are met;

(b) For services that require PA, the DMEPOS provider must submit documentation for review which supports conditions of coverage as specified in this rule are met;

(c) Medical records must be made available to DMAP on request.

(4) **Table 122-0655** (Procedure Codes): The procedure codes in this table may be covered for purchase.

Stat. Auth.: ORS 409.010, 409.050, 409.110, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; Renumbered from 410-122-0255, DMAP 12-2007, f. 6-29-07, cert. ef. 7-1-07; DMAP 37-2008, f. 12-11-08, cert. ef. 1-1-09

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Rule Caption: January 1, 2009 rule changes.
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Subject: The Dental Services program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to certain clients. DMAP amended 410-123-1260 to increase coverage limitations of preventive dental care for children due to revisions of the Health Services Commission's guidelines. The table is removed as unnecessary text. This and new information are now in tables in the DMAP Dental Supplemental Information document and referenced in rule. DMAP amended other rules listed above to clarify current policies and procedures to ensure these rules are not open to interpretation by the provider or outside parties and to help eliminate confusion possibly resulting in non-compliance. DMAP clarified rules to help facilitate provider compliance with federal requirements, service coverage and limitations, and billing requirements. Text is revised to improve readability and take care of necessary "housekeeping" corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-123-1085
Client Copayments for Oregon Health Plus Dental Benefit

(1) Co-payments for Oregon Health Plan (OHP) clients may be required for certain services under the OHP Plus Benefit package. The co-payment is paid directly to the provider.

(2) Clients receiving benefits under the OHP Standard Benefit package are exempt from co-payments.

(3) Clients enrolled in a dental care organization are exempt from co-payments for any services paid for by their plan.

(4) Refer to OAR 410-120-1230 (Division of Medical Assistance Programs, General Rules) for specific information regarding client co-payments.

Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 76-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1160
Prior Authorization

(1) Prior authorization (PA) for services and supplies listed in the Dental Services administrative rules are intended for clients who are not enrolled in a Dental Care Organization (DCO). Contact the client's DCO for their policy governing PA requirements.

(2) Covered services requiring PA from the Division of Medical Assistance Programs (DMAP) for clients receiving dental benefits under fee-for-service (FFS) are:

(a) Crowns (porcelain fused to metal, resin with metal);

(b) Complete dentures;

(c) Immediate dentures;

(d) Partial dentures;

(e) Denture repairs; and

(f) Orthodontics (when covered pursuant to OAR 410-123-1260).

(3) Hospital dentistry — Refer to OAR 410-123-1490 for PA for routine (non-emergency) dental services performed in an Ambulatory Surgical Center (ASC), outpatient or inpatient setting. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(4) Life-threatening emergencies — PA for outpatient or inpatient services is not required for any life-threatening emergencies. The client's clinical record must document any appropriate clinical information that supports the need for the hospitalization.

(5) Oral surgical services — PA is required for oral surgical services performed in an (ASC, outpatient or inpatient hospital setting and related anesthesia. Refer to OAR 410-123-1260(15) and the current Medical Surgical Services administrative rules (OAR 410-130-0200) for information.

(6) Maxillofacial surgeries — PA may be required for some maxillofacial surgeries. Refer to the current Medical Surgical Services administrative rules for information (OAR 410-130-0200).

(7) DMAP will provide PA for services when:

(a) The prognosis is favorable;

(b) The treatment is practical;

(c) The services are dentally appropriate; and

(d) A lesser-cost procedure would not achieve the same ultimate results.

(8) PA does not guarantee eligibility or reimbursement. It is the responsibility of the provider to check the client's eligibility on the date of service.

(9) Treatment justification: DMAP may request the treating dentist to submit appropriate radiographs or other clinical information that justifies the treatment:

(a) When radiographs are required they must be:

(A) Readable copies;

(B) Mounted or loose;

(C) In an envelope, stapled to the PA form;

(D) Clearly labeled with the dentist's name and address and the client's name; and

(E) If digital x-ray, they must be of photo quality;

(b) Do not submit radiographs unless it is required by the Dental Services administrative rules or they are requested during the PA process.

(10) Providers must request PA from the DMAP Dental Program Coordinator in writing, on an ADA form, listing the specific services requested. Telephone calls requesting PA will not be accepted.

(11) Upon approval of the request for payment, DMAP will enter a nine-digit PA number on the requesting form and return the form to the treating provider. Claims cannot be paid without this PA number.

(12) DMAP will issue a decision on PA requests within 30 days of receipt of the request.

(13) For certain services and billings, DMAP will seek a general practice consultant or an oral surgery consultant for professional review before PA. DMAP will deny PA if the consultant decides that the clinical information furnished does not support the treatment of services.

(14) PA for clients receiving services through a DCO for services other than hospital dentistry:

(a) Contact the client's DCO for PA requirements for individual services and/or supplies listed in the Dental Services administrative rules. DCOs may not have the same PA requirements for dental services as listed in this administrative rule;

(b) If a client is enrolled in a Fully Capitated Health Plan (FCHP) or in a Physician Care Organization (PCO) that is responsible for hospital services, the FCHP or PCO may require PA for ASC, outpatient or inpatient hospital dental services. It is the provider's responsibility to check with the FCHP or PCO for any required authorization prior to the service being rendered;

(c) If a client is enrolled in a DCO and is FFS for medical, DMAP requires PA for ASC, outpatient or inpatient hospital dental services. It is the responsibility of the provider to contact DMAP for PA prior to the service being rendered;

(d) If a client is enrolled in a DCO and is assigned to a Primary Care Manager (PCM) through FFS, the client must have a referral from the PCM prior to any hospital service being approved by DMAP.

Stat. Auth.: ORS 409.050, 414.051, 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 32-1994, f. & cert. ef. 11-1-94; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1220
Services Not Funded on the Health Services Commission's Prioritized List of Health Services

(1) Refer to the document: Covered and Non-Covered Dental Services, dated January 1, 2009, which contains all covered dental services. This rule incorporates by reference the Covered and Non-Covered Dental Services document located at website http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.htm. This document is subject to change if there are funding changes to the Health Services Commission's (HSC) List of Prioritized Services (posted on DHS' website at: http://egov.oregon.gov/DAS/OHPPR/HSC/current_prior.shtml). In the event of an alleged variation between a Division of Medical Assistance Program (DMAP)-listed code and a national code, DMAP will apply the national code in effect on the date of request or date of service.

(2) The following general categories of Dental Services are not included/funded on the HSC List and are not covered for any client. Several of these services are considered "cosmetic" in nature (i.e., done for the sake of appearance):

(a) Desensitization;

(b) Implant and implant services;

(c) Mastique or veneer procedure;

(d) Orthodontia (except when it is treatment for cleft palate with cleft lip);

(e) Overhang removal;

(f) Procedures, appliances or restorations solely for aesthetic/ cosmetic purposes;

(g) Temporomandibular Joint Dysfunction treatment; and

(h) Tooth bleaching.

Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 21-1994(Temp), f. 4-29-94, cert. ef. 5-1-94; HR 32-1994, f. & cert. ef. 11-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; HR 9-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1230
Buying-Up

(1) Buying-up as defined in OAR 410-120-0000 is prohibited.

(2) Providers are not permitted to bill and accept payment from the Division of Medical Assistance Programs (DMAP) or a managed care plan for a covered service when:

(a) A non-covered service has been provided; and

(b) Additional payment is sought or accepted from the client.

(3) If a client wants to purchase a non-covered service or item, the client must be responsible for full payment. A payment from DMAP or the managed care plan for a covered service cannot be credited toward the non-covered service and then an additional client payment sought to obtain, for example, a gold crown (not covered) instead of the stainless steel crown (covered).

Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065
Hist.: OMAP 14-1999(T), f. & cert. ef. 4-1-99 thru 9-1-99; OMAP 29-1999, f. 6-9-99, cert. ef. 6-10-99; OMAP 48-2002, f. & cert. ef. 10-1-02; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1240
The Dental Claim Invoice

(1) Providers: Refer to the Dental Services Supplemental Information for information regarding claims submissions and billing information.

(2) Providers billing dental services on paper must use the 2006 version of the American Dental Association (ADA) claim form.

(3) Submission of electronic claims directly or through an agent must comply with the DHS Electronic Data Interchange (EDI) rules. OAR 407-120-0100 et.seq.

(4) Specific information regarding Health Insurance Portability and Accountability Act (HIPAA) requirements can be found on the DMAP Web site.

(5) Providers will not include any client co-payments on the claim when billing for dental services.

Stat. Auth.: ORS 409.050, 414.065
Stats. Implemented: ORS 414.065
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 76-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 36-2005, f. & cert. ef. 8-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1260
Dental Exams, Diagnostic and Procedural Services

(1) Refer to OAR 410-123-1160 for information regarding dental services requiring prior authorization (PA) and refer to the document: Covered and Non-Covered Dental Services, dated January 1, 2009, at the website http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html for requirements to submit surgical reports as shown by "BR" (by report). This rule incorporates by reference the Covered and Non-Covered Dental Services document. Procedure codes listed in the document: Covered and Non-Covered Dental Services are subject to change by the American Dental Association (ADA) without notification.

(2) Changes to services funded on the Oregon Health Services Commission's (HSC's) Prioritized List of Health Services are effective on the date of the List change, but will not be reflected in DMAP administrative rules (Chapter 410 division 123) until they have gone through DMAP rule filing process.

(3) The client's records must include documentation to support the appropriateness of the service and level of care rendered.

(4) DMAP will not reimburse for dental services that are not dentally appropriate as defined in OAR 410-123-1060, or are for the convenience of the client or practitioner.

(5) Early and Periodic Screening, Diagnosis and Treatment (EPSDT):

(a) EPSDT provides that Medicaid eligible individuals under the age of 18 (or individuals up to age 21if determined as eligible) receive regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status. See Code of Federal Regulations (42 CFR 441, Subpart B). For dental services this includes, but is not limited to:

(A) Dental screening services for eligible EPSDT individuals; and

(B) Dental diagnosis and treatment which is indicated by screening, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health for services covered by the HSC's Prioritized List of Health Services;

(b) Providers shall perform EPSDT services for DMAP clients in accordance to the Dental Services administrative rules 410-123 and the Oregon Health Plan (OHP) — Recommended Dental Periodicity Schedule, dated January 1, 2009. This rule incorporates by reference the OHP Recommended Dental Periodicity Schedule located in the Dental Services Supplement Information at the website http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.htm.

(6) Restorative, periodontal and prosthetic treatments must be consistent with the prevailing standard of care, documentation must be included in the client's charts to support the treatment, and may be limited as follows:

(a) When prognosis is unfavorable;

(b) When treatment is impractical;

(c) A lesser-cost procedure would achieve the same ultimate result; or

(d) The treatment has specific limitations outlined in this rule.

(7) Prosthetic treatment (including porcelain fused to metal crowns) are limited until rampant progression of caries is arrested and a period of adequate oral hygiene and periodontal stability is demonstrated; periodontal health needs to be stable and supportive of a prosthetic.

(8) Exams:

(a) For children (under 19 years of age) — DMAP will reimburse exams (billed as D0120, D0145, D0150, D0160 or D0180) a maximum of twice every 12 months with the following limitations:

(A) D0150 can be reimbursed only once every 12 months when performed by the same practitioner;

(B) D0150 can be reimbursed twice every 12 months only when performed by different practitioners;

(C) D0160 or D0180 can be reimbursed only once every 12 months;

(b) For adults (19 years of age and older) — DMAP will reimburse exams (billed as D0120, D0150, D0160, or D0180) by the same practitioner once every 12 months:

(c) For each emergent episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams;

(d) Oral exams are not covered when provided by a medical practitioner unless the practitioner is an oral surgeon.

(9) Radiographs:

(a) DMAP will reimburse for routine radiographs once every 12 months;

(b) DMAP will reimburse for panoramic (D0330) or intraoral complete series (D0210) once every five years, but both cannot be done within the five-year period;

(c) Clients must be a minimum of six years old for billing code D0210. For clients under age six, radiographs may be billed separately every 12 months as follows:

(A) D0220 — once;

(B) D0230 — a maximum of five times;

(C) D0270 — a maximum of twice, or D0272 once;

(d) The minimum standards for reimbursement of intra-oral complete series are:

(A) For clients age six through 11- a minimum of 10 periapicals and two bitewings for a total of 12 films;

(B) For clients ages 12 and older - a minimum of 10 periapicals and four bitewings for a total of 14 films;

(e) If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), DMAP will reimburse for the complete series;

(f) DMAP will reimburse bitewing radiographs for routine screening once every 12 months;

(g) Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);

(h) If DMAP determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;

(i) DMAP will reimburse a maximum of six radiographs for any one emergency;

(j) The exception to these limitations is if the client is new to the office or clinic and the office or clinic was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the client's records;

(k) Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.

(10) Preventive Services:

(a) Prophylaxis:

(A) For children (under 19 years of age) — Limited to twice every 12 months;

(B) For adults (19 years of age and older) — Limited to once every 12 months:

(C) Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care'

(D) Are coded using the appropriate Current Dental Terminology (CDT) coding:

(i) D1110 (Prophylaxis — Adult) — Use for clients age 14 and up; and

(ii) D1120 (Prophylaxis — Child) — Use for clients age 0 through 13;

(b) Topical Fluoride Treatment:

(A) For children (under 19 years of age) — Limited to twice every 12 months;

(B) For adults (19 years of age and older) — Limited to once every 12 months;

(C) Additional topical fluoride treatments may be available, up to a total of 4 treatments within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following clients who:

(i) Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;

(ii) Are pregnant;

(iii) Have physical disabilities that cannot perform adequate, daily oral health care;

(iv) Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care;

(v) Are six years old or younger with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc;

(c) Topical fluoride varnish treatments by medical practitioners:

(A) Are covered as part of a medical visit for those high-risk young children that do not have access to a dental practitioner;

(B) Are limited to children six years old and younger in accordance with the limitations detailed in OAR 410-123-1260(8)(b) herein;

(C) Are billed on the CMS-1500 form, using the appropriate CDT code (D1206 – Topical Fluoride Varnish);

(D) Are billed directly to DMAP, whether the client is fee-for-service (FFS) or enrolled in a Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO);

(E) An oral screening by a medical practitioner is not a separate billable service and is included in the office visit;

(d) Sealants:

(A) Are covered for permanent molars only for children 15 or younger;

(B) Are limited to one treatment per tooth every five years except for visible evidence of clinical failure;

(e) Topical fluoride varnish and/or sealants by Dental Hygienists in limited access locations:

(A) For clients who receive services on an open-card/FFS basis:

(i) Are reimbursed by DMAP based on the physician fee schedule in accordance with the limitations detailed in OAR 410-123-1260(8)(b) and (d); and

(ii) As the CDT codebook specifies that the evaluation, diagnosis and treatment planning components of the exam are the responsibility of the dentist, DMAP does not reimburse dental exams when furnished by a Dental Hygienist (with or without a limited access permit);

(B) For clients enrolled in a DCO, it is the responsibility of the Dental Hygienist to coordinate all dental services with the client's DCO prior to providing services;

(C) Regardless of whether a client is receiving services fee-for-service or through a DCO, if provided through a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), refer to OAR 410 Division 147 for details;

(f) Space management – Removable space maintainers will not be replaced if lost or damaged.

(11) Tobacco Cessation:

(a) For dental services use CDT code D1320 on an ADA claim form when billing for tobacco cessation services when the following brief counseling is provided:

(A) Ask patients about their tobacco-use status at each visit and record information in the chart;

(B) Advise patients on their oral health conditions related to tobacco use and give direct advice to quit using tobacco;

(C) Assess the patient's current level of readiness to quit;

(D) Assist patients, for example by providing self-help cessation materials, recommending tobacco cessation therapy products through the patient's primary care physician (e.g. nicotine patches, oral medications intended for tobacco cessation treatment and gum) and encouraging the setting of a quit date; and

(E) Arrange to follow up with patients at their next office visit and provide local tobacco-use cessation resources, if needed;

(b) A maximum of 10 services is allowed within a three-month period;

(c) For medical services tobacco cessation other than dental services, follow criteria outlined in OAR 410-130-0190.

(12) Restorations — Amalgam and Composite:

(a) Payment for restorations is limited to the maximum restoration fee of four surfaces per tooth. Refer to the ADA CDT codebook for definitions of restorative procedures;

(b) All surfaces must be combined and billed one line per tooth using the appropriate code. For example, tooth #30 has a buccal amalgam and a MOD amalgam — bill MOD, B, using code D2161;

(c) Payment for an amalgam or composite restoration and a crown on the same tooth will be denied;

(d) Payment is made for a surface once in each treatment episode regardless of the number or combination of restorations;

(e) Payment for occlusal adjustment and polishing of the restoration is included in the restoration fee;

(f) Posterior composite restorations will be paid at the same rate as amalgam restorations;

(g) Replacement of posterior composite restorations is limited to once every five years.

(13) Crowns:

(a) Acrylic heat or light cured crowns (D2970) — allowed for anterior permanent teeth only;

(b) Prefabricated plastic crowns (D2932) — allowed for anterior teeth only, permanent or primary;

(c) Stainless steel crowns (D2930/D2931) — allowed for posterior teeth, permanent or primary;

(d) Permanent crowns (Resin-based composite — D2710 and porcelain fused to metal (PFM) — D2751 and D2752) — allowed only for ante-

rior permanent teeth if dentally appropriate and with the following requirements:

(A) Clients must be 16 years or older;

(B) Radiographs required; history, diagnosis, and treatment plan may be requested;

(C) Rampant caries should be arrested and a period of oral hygiene demonstrated before prosthetics (including a PFM crown) are proposed; and

(D) PFM crowns must meet the following additional requirements:

(i) Will be used only if no other restoration option will restore function. Other restoration options should be attempted first with clinical failure documented. If the dentist determines no other restoration option can be used, written documentation in the client's chart must support that finding;

(ii) Will be used only if client has documented stable periodontal status with pocket depths within 1 – 3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeter and over, documentation must be maintained in the client's chart of the dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long term prognosis;

(iii) The crown has a favorable long-term prognosis; and

(iv) If tooth to be crowned is clasp/abutment tooth in partial denture, both prognosis for crown itself and tooth's contribution to partial denture must have favorable expected long-term prognosis;

(e) Payment for preparation of the gingival tissue is included in the fee for the crown;

(f) Payment for retention pins is limited to four per tooth;

(g) Crowns are covered only when there is significant loss of clinical crown and no other restoration will restore function. The following is not covered:

(A) Endodontic therapy alone (with or without a post) is not covered;

(B) Aesthetics (cosmetics);

(h) Crown replacement is limited to once every five years per tooth and only when dentally appropriate. Exceptions to this limitation may be made for crown damage due to acute trauma, based on the following factors:

(A) Extent of crown damage;

(B) Extent of damage to other teeth or crowns;

(C) Extent of impaired mastication;

(D) Tooth is restorable without other surgical procedures; and

(E) If loss of tooth would result in coverage of removable prosthetic;

(i) Crowns are not covered in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;

(j) Crowns will be covered if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures.

(14) Endodontics:

(a) Pulp Capping:

(A) Direct and indirect pulp caps are included in the restoration fee; no additional payment will be made for clients with the OHP Plus Benefit package;

(B) Direct pulp caps are covered as a separate service for clients with the OHP Standard Benefit package because restorations are not a covered benefit under this benefit package;

(b) Endodontic Therapy:

(A) Endodontics is covered only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

(B) Retreatment is not covered for bicuspid or molars;

(C) Retreatment is limited to anterior teeth when:

(i) Crown-to-root ratio is 50:50 or better;

(ii) The tooth is restorable without other surgical procedures; or

(iii) If loss of tooth would result in the need for removable prosthodontics;

(D) Separate reimbursement for open-and-drain as a palliative procedure is not allowed when the root canal is completed on the same date of service, or if the same practitioner or dental practitioner in the same group practice completed the procedure;

(E) The client's record must include documentation to support the appropriateness of services and level of care rendered;

(F) Root canal therapy is not covered for third molars;

(G) Endodontic therapy is covered if the tooth is restorable within the OHP benefit coverage package;

(c) Endodontic therapy on permanent teeth —Apexification is limited to a maximum of five treatments on permanent teeth only.

(15) Periodontics:

(a) D4210 and D4211 — limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia;

(b) D4240, D4241, D4260 and D4261 — allowed once every three years unless there is a documented medical/dental indication;

(c) D4341 and D4342 — allowed once every two years. A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances. Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater;

(d) D4910 — limited to following periodontal therapy and allowed once every six months. For further consideration of more frequent periodontal maintenance benefits, office records must clearly reflect clinical indication, i.e., chart notes, pocket depths and radiographs;

(e) Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;

(f) Surgical procedures include six months routine postoperative care;

(g) Note: DMAP will not reimburse for procedures identified by the following codes if performed on the same date of service:

(A) D1110 (Prophylaxis — adult);

(B) D1120 (Prophylaxis — child);

(C) D4210 (Gingivectomy or gingivoplasty — four or more contiguous teeth or bounded teeth spaces per quadrant);

(D) D4211 (Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant);

(E) D4260 (Osseous surgery, including flap entry and closure — four or more contiguous teeth or bounded teeth spaces per quadrant);

(F) D4261 (Osseous surgery, including flap entry and closure — one to three contiguous teeth or bounded teeth spaces per quadrant);

(G) D4341 (Periodontal scaling and root planning — four or more teeth per quadrant);

(H) D4342 (Periodontal scaling and root planning — one to three teeth per quadrant);

(I) D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and

(J) D4910 (Periodontal maintenance).

(16) Removable Prosthodontics:

(a) Removable cast metal prosthodontics and full dentures are limited to clients 16 years or older;

(b) Adjustments to removable prosthodontics during the six-month period following delivery to clients are included in the fee;

(c) Replacement:

(A) Replacement of dentures and partials, when it cannot be made clinically serviceable by a less costly procedure (reline, rebase, repair, tooth replacement, etc.), is limited to once every five years and only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every five years, but only when dentally appropriate;

(B) The limitation of once every five years applies to the client regardless of whether the denture or partial was received while the client was on the Oregon Health Plan and regardless of DCO or FFS enrollment status. This includes clients that move from FFS to DCO, DCO to FFS, or DCO to DCO. For example: a client receives full dentures on February 1, 2007, while FFS and a year later enrolls in a DCO. The client would not be eligible for another full denture until February 2, 2012, regardless of DCO or FFS enrollment;

(C) Replacement of partial dentures with full dentures is payable five years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene will not warrant replacement;

(d) Relines:

(A) Reline of complete or partial dentures is allowed once every two years;

(B) Exceptions to this limitation may be made under the same conditions warranting replacement;

(C) Laboratory relines are not payable within five months after placement of an immediate denture;

(e) Tissue conditioning:

(A) Tissue conditioning is allowed once per denture unit in conjunction with immediate dentures;

(B) One tissue conditioning is allowed prior to new prosthetic placement;

(f) Cast partial dentures:

(A) Cast partial dentures will not be approved if stainless steel crowns are used as abutments;

(B) Cast partial dentures must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;

(C) Teeth to be replaced and teeth to be clasped are to be noted in the "remarks" section of the form;

(g) Denture rebase procedures:

(A) Rebase should only be done if a reline will not adequately solve the problem. Rebase is limited to once every three years;

(B) Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene will not warrant rebasing;

(h) Laboratory denture reline procedures — Limited to once every two years.

(17) Maxillofacial Prosthetics:

(a) For clients enrolled in managed care, maxillofacial prosthetics are to be billed using Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) coding on a CMS-1500 to the client's medical managed care organization (i.e., FCHP). Provision of maxillofacial prosthetics is included in the FCHP capitation and is not the DCO's responsibility;

(b) For fee-for-service clients, bill DMAP using CPT or HCPCS codes on a CMS-1500. Payment is based on the physician fee schedule;

(c) Refer to the document: Covered and Non-Covered Dental Services, dated January 1, 2009, which lists the maxillofacial prosthetics procedures as "medical." This rule incorporates by reference the Covered and Non-Covered Dental Services document.

(18) Oral Surgery:

(a) Oral surgical procedures that are directly related to the teeth and supporting structures that are not due to a medical condition must be billed on an ADA claim form, using CDT codes;

(b) Oral surgical services that are included in a dental plan benefit package which are performed in a dental office setting (including an oral surgeon's office):

(A) Do not require PA, and include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits;

(B) Are billed on an ADA dental claim form, using CDT codes, except when the procedures are a result of a medical condition (i.e., fractures, cancer) which must be billed using a CMS-1500 claim form with the appropriate American Medical Association (AMA) CPT procedure/ICD-9 diagnosis codes;

(C) For clients enrolled in a DCO, the DCO is responsible for payment of those services in the dental plan package;

(c) Oral surgical services performed in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting:

(A) Oral surgical services in a hospital setting and related anesthesia services require PA;

(B) If the hospital setting oral surgical procedures are directly related to the teeth and supporting structures, the procedures must be billed on an ADA claim form, using CDT codes;

(C) If the services requiring hospital dentistry are the result of a medical condition/diagnosis (i.e., fracture, cancer), use appropriate AMA CPT procedure codes/ICD-9 diagnosis codes and bill procedures on a CMS-1500 claim form;

(D) For clients enrolled in a FCHP, the facility charge and anesthesia services are the responsibility of the FCHP. For clients enrolled in a PCO, the outpatient facility charge (including ASCs) and anesthesia are the responsibility of the PCO. Refer to the current Medical Surgical Services administrative rules in OAR Chapter 410 — Division 130 for more information;

(d) All codes listed as "by report" require an operative report;

(e) DMAP covers payment for tooth reimplantation only in cases of traumatic avulsion where there are good indications of success;

(f) Biopsies collected are reimbursed by the dental plan. Reimbursement for laboratory services of biopsies must be arranged through the medical plan;

(g) Surgical excisions of soft tissue lesions (D7410 – D7415) are not covered services;

(h) Extractions — Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;

(i) Surgical extractions:

(A) Includes local anesthesia and routine post-operative care;

(B) Surgical removal of impacted teeth or removal of residual tooth roots are limited to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums;

(C) Alveoloplasty in conjunction with extractions (D7310 and D7311) are not services that are covered separately from the extraction. Alveoplasty not in conjunction with extractions (D7320) is a covered service;

(j) Refer to the document: Covered and Non-Covered Dental Services, dated January 1, 2009, which lists CDT procedure codes on the HSC's Prioritized List of Health Services that also have CPT medical codes. This rule incorporates by reference the Covered and Non-Covered Dental Services document. The procedures listed as "medical" on the table may be covered as medical procedures, the table may not be all-inclusive of every dental code that has a corresponding medical code:

(A) If billed as a medical procedure in accordance with these rules, the procedure must be billed on a CMS-1500, using CPT coding. Refer to the Medical-Surgical administrative rules for additional information (DMAP chapter 410 — division 130);

(B) If a client is enrolled in a FCHP or a PCO, it is the responsibility of the provider to contact the FCHP or the PCO for any required authorization before the service is rendered.

(19) Orthodontia:

(a) Orthodontia services and extractions are limited to eligible clients:

(A) With the ICD-9-CM diagnosis of cleft palate with cleft lip; and

(B) When orthodontia treatment began prior to 21 years of age; or

(C) When surgical corrections of cleft palate with cleft lip was not completed prior to age 21;

(b) PA is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/cleft lip must be included in the client's record and a copy sent with the PA request;

(c) Documentation in the client's record must include diagnosis, length and type of treatment;

(d) Payment for appliance therapy includes the appliance and all follow-up visits;

(e) Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). DMAP will reimburse each phase individually (separately);

(f) DMAP will pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the client transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund to DMAP any unused amount of payment, after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;

(g) The length of the treatment plan from the original request for authorization will be used to determine the number of treatment months remaining;

(h) As long as the orthodontist continues treatment no refund will be required even though the client may become ineligible for medical assistance sometime during the treatment period;

(i) Code:

(A) D8660 — PA required (reimbursement for required orthodontia records is included);

(B) Codes D8010-D8999 — PA required.

(20) Anesthesia:

(a) General anesthesia or IV sedation is to be used only for those clients with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);

(b) DMAP reimburses providers for general anesthesia or IV sedation using codes D9220 or D9241, respectively, for the first 30 minutes and using codes D9221 or D9242, respectively, for each additional 15-minute period, up to three hours on the same day of service. When using codes D9221 or D9242, use care when entering quantity. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;

(c) Nitrous Oxide is paid per date of service, not by time;

(d) Oral pre-medication anesthesia for conscious sedation:

(A) Limited to clients through 12 years of age;

(B) Limited to four times per year;

(C) Monitoring and Nitrous Oxide included in the fee; and

(D) Use of multiple agents is required to receive payment;

(e) Upon request, providers must submit to DMAP a copy of their permit to administer anesthesia, analgesia and/or sedation;

(f) Anesthesia — For the purpose of Title XIX and Title XXI, code D9630 is limited to those oral medications used during a procedure and is not intended for "take home" medication.

(21) Office visit for observation — Code D9430 is limited to three visits per year.

[ED. NOTE: Tables are available from the Agency.]

Stat. Auth.: ORS 409.050, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1490

Hospital Dentistry

(1) Division of Medical Assistance Programs (DMAP) hospital dentistry is defined as routine dental services provided in an Ambulatory Surgical Center (ASC), inpatient or outpatient hospital setting under general anesthesia (or intravenous (IV) conscious sedation, if appropriate).

(2) The purpose of hospital dentistry is to provide safe, efficient dental care of covered dental services for DMAP clients who present special challenges requiring general anesthesia (or IV conscious sedation, if appropriate). DMAP reimbursement to hospitals is limited to covered services and may be prorated if non-covered dental services are performed during the same hospital visit.

(3) The use of general anesthesia (or IV conscious sedation, if appropriate) is sometimes necessary to provide quality dental care for the client. Depending on the client, this can be done in an ASC, a day surgery center, outpatient hospital or inpatient hospital setting with the use of pre- and/or postoperative patient admission to the hospital.

(4) Refer to OAR 410-123-1060 for definitions of general anesthesia and conscious sedation.

(5) The need to diagnose and treat, as well as the safety of the client and the practitioner, must justify the use of general anesthesia (or IV conscious sedation, if appropriate). The decision to use general anesthesia or IV conscious sedation must take into consideration:

(a) Alternative behavior management modalities;

(b) Client's dental needs;

(c) Quality of dental care;

(d) Quantity of dental care;

(e) Client's emotional development;

(f) Client's physical considerations;

(g) Clients requiring dental care for whom the use of general anesthesia (or IV conscious sedation, if appropriate) may protect the developing psyche.

(6) Client, parental or guardian written consent must be obtained prior to the use of general anesthesia (or IV conscious sedation, if appropriate).

(7) The following information must be included in the client's dental record:

(a) Informed consent;

(b) Justification for the use of general anesthesia (or IV conscious sedation, if appropriate).

(8) Indications for the use of general anesthesia (or IV conscious sedation, if appropriate) for children 18 or younger are limited to:

(a) Children through age 3 with extensive dental needs;

(b) Children 4 years of age or older after treatment is attempted in the office setting with some type of sedation or nitrous oxide. If treatment in an office setting is not possible, documentation in the client's dental record as to why, in the estimation of the dentist, the client will not be responsive to office treatment;

(c) Acute situational anxiety, fearfulness, extreme uncooperative behavior, uncommunicative such as a client with developmental or mental disability, a client that is pre-verbal or extreme age where dental needs are deemed sufficiently important that dental care cannot be deferred;

(d) Requiring dental care for whom the use of general anesthesia (or IV conscious sedation) is to protect the developing psyche;

(e) Client who has sustained extensive orofacial or dental trauma;

(f) Physical, mental or medically compromising conditions;

(g) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate);

(h) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate).

(9) The intent to cover hospital dentistry in adults is limited to:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate);

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate);

(c) Client who has sustained extensive orofacial or dental trauma; or

(d) Clients who are medically fragile, have complex medical needs, contractures or other significant medical conditions potentially making the dental office setting unsafe for the client (not for the convenience of the client or the dentist) that prevent dental care without general anesthesia (or IV conscious sedation, if appropriate).

(10) Contraindications for hospital dentistry under general anesthesia (or IV conscious sedation, if appropriate):

(a) Client convenience. Refer to OAR 410-120-1200;

(b) A healthy, cooperative client with minimal dental needs;

(c) Medical contraindication to general anesthesia (or IV conscious sedation, if appropriate); or

(d) Non-covered dental services. Refer to OAR 410-123-1220 and the document: Covered and Non-Covered Dental Services, dated January 1, 2009, found at the website http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.htm. This rule incorporates by reference the Covered and Non-Covered Dental Services document.

(11) Hospital dentistry requires prior authorization (PA) regardless of whether or not a client is enrolled in a Fully Capitated Health Plan (FCHP) or Dental Care Organization (DCO). All requests for PA require the DMAP 3301 form to be completed.

(12) Obtaining PA:

(a) If a client is enrolled in an FCHP and a DCO:

(A) The attending dentist is responsible for contacting the FCHP for PA requirements and arrangements when provided in an inpatient hospital, outpatient hospital or ambulatory surgical center;

(B) The attending dentist is responsible for submitting documentation to the FCHP and simultaneously to the DCO on the DMAP 3301 form;

(C) The medical and dental plans should review the DMAP 3301 form and raise any concerns they have to the other, in addition to contacting the attending dentist. This allows for mutual plan involvement and monitoring;

(D) The total response turn around time should not exceed 14 calendar days from the date of submission of all required documentation for routine dental care and should be processed according to the urgent/emergent dental care timelines;

(E) The FCHP is responsible for payment of all facility and anesthesia services. The DCO is responsible for payment of all dental professional services;

(b) If a client is fee-for-service for medical services and enrolled in a DCO:

(A) The attending dentist is responsible for faxing the DMAP 3301 form and a completed American Dental Association (ADA) form to the DMAP Dental Program Coordinator;

(B) DMAP is responsible for payment of facility and anesthesia services. The DCO is responsible for payment of all dental professional services;

(C) DMAP will issue a decision on PA requests within 30 days of receipt of the request;

(c) If a client is enrolled in an FCHP and is fee-for-service dental:

(A) The individual dentist is responsible for contacting the FCHP, obtaining PA and arrangement for hospital dentistry;

(B) It is the responsibility of the individual dentist to submit required documentation on the DMAP 3301 form to the FCHP;

(C) The FCHP is responsible for all facility and anesthesia services. DMAP is responsible for payment of all dental professional services;

(d) If a client is fee-for-service for both medical and dental:

(A) The individual dentist is responsible for faxing the DMAP 3301 form and a completed ADA form to the DMAP Dental Program Coordinator;

(B) DMAP is responsible for payment of all facility, anesthesia services and dental professional charges.

(13) DMAP will not approve any subsequent hospital dentistry requests without clinical documentation as to why the treatment plan provided, and outlined in the PA request, was not completed.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409.050, 414.051, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

410-123-1620
ICD-9-CM

(1) ICD-9-CM diagnosis codes are not required for dental services submitted on an American Dental Association (ADA) form. When Oregon Administrative Rule (OAR) 410-123-1260 requires dental services to be billed on a CMS-1500 claim form, ICD-9-CM diagnosis codes are required.

(2) The appropriate code or codes from 001.0 through V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit. Diagnosis codes are required on all claims, including those submitted by independent laboratories and portable x-ray providers. Always provide the client's diagnosis to ancillary service providers when prescribing services, equipment and supplies.

(3) The principal diagnosis is listed in the first position; the principal diagnosis is the code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Up to three additional diagnoses codes may be listed on the claim for documented conditions that co-exist at the time of the encounter/visit and require or affect patient care, treatment, or management.

(4) The diagnosis codes must be listed using the highest degree of specificity available in the ICD-9-CM. A three-digit code is used only if it is not further subdivided. Whenever fourth or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. A code is invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards that are in effect for the date the service(s) was provided.

(a) For dental services, use Current Dental Terminology (CDT) codes as maintained and distributed by the American Dental Association;

(b) For physician services and other health care services, use Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes.

Stat. Auth.: ORS 409.050, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

10-123-1670
OHP Standard Limited Emergency Dental Benefit

(1) The Oregon Health Plan (OHP) Standard Limited Emergency Dental benefit is intended to provide services requiring immediate treatment and is not intended to restore teeth.

(2) This rule incorporates by reference the Covered and Non-Covered Dental Services document, dated January 1, 2009, found at website http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.htm. Procedures listed as "Yes" for the OHP Standard Benefit Package in the Covered and Non-Covered Dental Services document are covered but are limited to treatment for conditions such as:

(a) Acute infection;

(b) Acute abscesses;

(c) Severe tooth pain;

(d) Tooth re-implantation when clinically appropriate; and

(e) Extraction of teeth, limited only to those teeth that are symptomatic.

(3) Hospital Dentistry is not a covered benefit for the OHP Standard population, with the following exceptions:

(a) Clients who have a developmental disability or other severe cognitive impairment, with acute situational anxiety and extreme uncooperative behavior that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate); or

(b) Clients who have a developmental disability or other severe cognitive impairments and have a physically compromising condition that prevents dental care without general anesthesia (or IV conscious sedation, if appropriate).

(4) Any limitations or prior authorization requirements on services listed in OAR 410-123-1260 or 410-123-1160 will also apply to services in the OHP Standard benefit.

Stat. Auth.: ORS 409.050, 414.065

Stats. Implemented: ORS 414.065

Hist.: OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09

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Rule Caption: January 2009 federal billing code requirements.
Adm. Order No.: DMAP 39-2008
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 1-1-09
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Rules Amended: 410-125-0020, 410-125-0041, 410-125-0045, 410-125-0080, 410-125-0085, 410-125-0155, 410-125-0181, 410-125-0195, 410-125-1020
Subject: The Hospital Services program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to certain clients. DMAP amended rules listed above to clarify text and to comply with federal billing code requirements. Text is revised to improve readability and take care of necessary "housekeeping" corrections (i.e., 410-125-0045: added an ending parentheses in (1) only).
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-125-0020
Retroactive Eligibility

(1) The Division of Medical Assistance Programs (DMAP) may pay for services provided to a person who does not have Medicaid coverage at the time services are provided if the person is made retroactively eligible for medical assistance and eligibility is extended back to the date services were provided. Contact the local branch concerning possible retroactive eligibility. In some cases, the date you contact the branch may be considered the date of application for eligibility.

(2) When clients are not eligible at the time services are provided, it is not possible to get prior authorization (PA) for service. However authorization for payment may be given after the service is provided under limited circumstances. For additional PA information see OAR 410-125-0080 and 410-125-0047.

Stat. Auth.: ORS 409.025, 409.040, 409.050 & 414.065

Stats. Implemented: ORS 409.010

Hist.: AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0160, 461-015-0230 & 461-015-0370; HR 42-1991, f. & cert. ef. 10-1-91, Renumbered from 410-125-0160 & 410-125-0440; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0041
Non-Title XIX/XXI Clients

(1) State-funded clients are clients who have not qualified for medical assistance through a federal program but have access to medical benefits through state funded programs. There are two categories of clients who are in State-funded programs.

(2) Program General Assistance (GA) clients: Program GA clients are children in foster care, in Services to Children and Families (SCF) custody, who are not eligible for Title XIX/Title XXI programs. They have access to the full range of Medicaid covered services, but payment for services provided may be different from that for Title XIX/Title XXI clients. For additional reimbursement information see the Hospital Services Supplemental Information on the Division of Medical Assistance Programs (DMAP) web site.

(3) Program SF clients: Program SF clients are individuals who are receiving treatment in a state facility, such as Oregon State Hospital, or the Eastern Oregon Training Center. These clients may need to receive hospital care outside the state facility. They are entitled to the full range of Medicaid covered hospital services. These individuals will be referred by the state facility for services. They do not have Medical Care Identification cards. They are not enrolled in a Fully Capitated Health Plan. The state facility from which the client is transferred will contact the hospital regarding billing instructions for these clients.

Stat. Auth.: ORS 409.025, 409.040, 409.050, 414.019 & 414.025

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; OMAP 34-1999, f. & cert. ef.

10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0045
Coverage and Limitations

In general, most medically appropriate services are covered. There are, however, some restrictions and limitations. Please refer to the General rules for information on general scope of coverage and limitations. Some of the limitations and restrictions that apply to hospital services are:

(1) Prior authorization (PA): Some services require prior authorization. The Plus and Standard Benefit Packages may have different PA requirements. For the Plus Benefit Package check OAR 410-125-0080. Detailed PA information for the Standard Benefit Package is on the web site (http://www.dhs.state.or.us/healthplan/guides/hospital).

(2) Non-Covered services:

(a) Services that are not medically appropriate, unproven medical efficacy or services that are the responsibility of another Division are not covered by the Division of Medical Assistance Programs (DMAP);

(b) Service coverage is based on the Health Services Commission's Prioritized List of Services and the benefit package;

(c) See the General rules (Chapter 410 Division 120) and other program divisions in Chapter 410 for a list of not covered services. Further information on covered and non-covered services is found in the Revenue Code section in the Hospital Services Supplemental Information.

(3) Limitations on Hospital Benefit Days: Clients have no hospital benefit day limitations for treatment of covered services.

(4) Dental Services: Clients have dental/denturist services identified as covered on the Health Services Commission Prioritized List (OAR 410-141-520).

(5) Services provided outside of the hospital's licensed facilities; for example, in the client's home or in a nursing home, are not covered by DMAP as hospital services. The only exceptions to this are Maternity Case Management services and specific nursing or physician services provided during a ground or air ambulance transport.

(6) Dialysis Services require a written physician prescription. The prescription must indicate the ICD-9 diagnosis code and must be retained by the provider of dialysis services for the period of time specified in the General Rules.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; HR 3-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0080
Inpatient Services

(1) Elective (not urgent or emergent) admission:

(a) Fully Capitated Health Plan (FCHP) and Mental Health Organization (MHO) clients — contact the client's MHO or FCHP. The health plan may have different prior authorization requirements than the Division of Medical Assistance Programs (DMAP);

(b) Medicare Clients — DMAP does not require prior authorization for inpatient services provided to clients with Medicare Part A or B coverage;

(c) For DMAP clients covered by the Oregon Health Plan (OHP) Plus Benefit Package:

(A) Hospital admissions for any of the medical and surgical procedures shown in Table 125-0080-1 require prior authorization, unless they are urgent or emergent;

(B) For prior authorization contact the DMAP contracted Quality Improvement Organization (QIO) unless otherwise indicated in Table125-0080-1;

(d) DMAP clients covered by the OHP Standard Benefit Package have a limited hospital benefit package. Specific coverage and prior authorization requirements are listed in the DMAP Hospital Services Supplemental Information or at DMAP Web site http://www.dhs.state.or.us/healthplan/guides/hospital (referenced in OAR 410-125-0047).

(2) Transplant services:

(a) Complete rules for transplant services are in the DMAP Transplant Services rules (OAR 410 division 124);

(b) Clients are eligible for transplants covered by the Health Services Commission's Prioritized List of Health Services. See the Transplant Services rules for criteria. For clients enrolled in a FCHP, contact the plan for authorization. Clients not enrolled in an FCHP, contact the DMAP Medical Director's office.

(3) Out-of-state non-contiguous hospitals:

(a) All non-emergent/non-urgent services provided by hospitals more than 75 miles from the Oregon border require prior authorization;

(b) Contact the DMAP Medical Director's office for authorization for clients not enrolled in a Prepaid Health Plan (PHP). For clients enrolled in a PHP, contact the plan.

(4) Out-of-state contiguous hospitals: services provided by contiguous-area hospitals, less than 75 miles from the Oregon border, are prior authorized following the same rules and procedures as in-state providers.

(5) Transfers to another hospital:

(a) Transfers for the purpose of providing a service listed in Table 125-0080-1, e.g., inpatient physical rehabilitation care, require prior authorization — contact the DMAP contracted QIO;

(b) Transfers to a long term acute care hospital, skilled nursing facility, intermediate care facility or swing bed — contact Seniors and People with Disabilities (SPD). SPD reimburses nursing facilities and swing beds through contracts with the facilities. For FCHP clients — transfers require authorization and payment (for first 20 days) from the FCHP;

(c) Transfers for the same or lesser level inpatient care to a general acute care hospital — DMAP will cover transfers, including back transfers, which are primarily for the purpose of locating the patient closer to home and family, when the transfer is expected to result in significant social/psychological benefit to the patient:

(A) The assessment of significant benefit shall be based on the amount of continued care the patient is expected to need (at least seven days) and the extent to which the transfer locates the patient closer to familial support;

(B) Transfers not meeting these guidelines may be denied on the basis of post-payment review;

(d) Exceptions:

(A) Emergency transfers do not require prior authorization;

(B) In state or contiguous non-emergency transfers for the purpose of providing care which is unavailable in the transferring hospital do not require prior authorization unless the planned service is listed in Table 125-0080-1 of this rule;

(C) All non-urgent transfers to out-of-state non-contiguous hospitals require prior authorization.

(6) Dental procedures provided in a hospital setting:

(a) DMAP will reimburse for hospital services when covered dental services are provided in a hospital setting for clients not enrolled in a FCHP, when a hospital setting is medically appropriate:

(b) For prior authorization for fee-for-service clients, contact the DMAP Dental Services Program coordinator;

(c) For clients enrolled in a FCHP, contact the client's FCHP;

(d) Emergency dental services do not require prior authorization.

(7) **Table 125-0080-1**.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409.010, 409.050 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 30-1982, f. 4-26-82 & AFS 51-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 11-1983, f. 3-8-83, ef. 4-1-83; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 6-1984(Temp), f. 2-28-84, ef. 3-1-84; AFS 36-1984, f. & ef. 8-20-84; AFS 22-1985, f. 4-23-85, ef. 6-1-85; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 46-1987, f. & ef. 10-1-87; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 45-1989, f. & cert. ef. 8-21-89; HR 9-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0190; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 7-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 28-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 9-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 50-2005, f. 9-30-05, cert. ef. 10-1-05; DMAP 27-2007(Temp), f. & cert. ef. 12-20-07 thru 5-15-08; DMAP 12-2008, f. 4-29-08, cert. ef. 5-1-08; DMAP 19-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0085
Outpatient Services

(1) Outpatient services that may require prior authorization include (see the individual Program rules):

(a) Physical Therapy (chapter 410 division 131);

(b) Occupational Therapy (chapter 410 division 131);

(c) Speech Therapy (chapter 410 division 129);

(d) Audiology (chapter 410 division 129);

(e) Hearing Aids (chapter 410 division 129);

(f) Dental Procedures (chapter 410 division 123);

(g) Drugs (chapter 410 division 121);

(h) Apnea monitors, services, and supplies (chapter 410 division 131);

(i) Home Parenteral/Enteral Therapy (chapter 410 division 148);

(j) Durable Medical Equipment and Medical supplies (chapter 410 division 122);

(k) Certain hospital services.

(2) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

(3) Outpatient Surgical procedures:

(a) FCHP Clients: Contact the client's FCHP. The health plan may have different prior authorization requirements than the Division of Medical Assistance Programs (DMAP). Some services are not covered under FCHP contracts and require prior authorization from the DMAP contracted Quality Improvement Organization (QIO), or the DMAP Dental Program coordinator.

(b) Medicare Clients enrolled in FCHPs: These services must be authorized by the plan even if Medicare is the primary payer. Without this authorization, the provider will not be paid beyond any Medicare payments (see also OAR 410-125-0103).

(c) For the Plus benefit package DMAP clients:

(A) Surgical procedures listed in OAR 410-125-0080 require prior authorization when performed in an outpatient or day surgery setting, unless they are urgent or emergent.

(B) Contact DMAP contracted QIO (unless indicated otherwise in OAR 410-125-0080).

(d) For the Standard benefit package DMAP client's outpatient surgical procedures: see OAR 410-125-0047 and the OHP Standard Population — Limited Hospital Benefit Package Code List (www.dhs.state.or.us/policy/healthplan/guides/hospital), or contact DMAP for a hardcopy, for coverage and prior authorization requirements.

(c) Out-of-State Services — Outpatient services provided by hospitals located less than 75 miles from the border of Oregon do not require prior authorization unless specified in these rules. All non-urgent or non-emergent services provided by hospitals located more than 75 miles from the border of Oregon require prior authorization. For clients enrolled in an FCHP, contact the plan for authorization. For clients not enrolled in a prepaid health plan, contact the DMAP Medical Director's office.

Stat. Auth.: ORS 409.025, 409.040, 409.050, 414.025, 414.727 & 414.743

Stats. Implemented: ORS 414.065

Hist.: HR 42-1991, f. & cert. ef. 10-1-91; HR 39-1992, f. 12-31-92, cert. ef. 1-1-93; HR 36-1993, f. & cert. ef. 12-1-93; HR 5-1994, f. & cert. ef. 2-1-94; HR 4-1995, f. & cert. ef. 3-1-95; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 70-2004, f. 9-15-04, cert. ef. 10-1-04; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0155

Upper Limits on Payment (UPL) of Hospital Claims

(1) Payments will not exceed total of billed charges:

(a) Upper limits on payment of claims does not apply to Proportional Share (Pro-Share) eligible academic hospitals, as defined in OAR 410-125-0145 and 410-125-0215;

(b) The total reimbursement during each hospital's fiscal year for inpatient services, including the sum of Diagnostic Related Grouper (DRG) payments, cost outlier, capital, and graduate medical education payments shall not exceed the individual hospital's total billed charges for the period for these services;

(c) If the total billed charges for all inpatient claims during the hospital's fiscal year is less than the total Division Medical Assistance Programs (DMAP) payment for those services, the overpayment shall be recovered;

(d) For Type A, Type B, and Critical Access Hospitals, reimbursement shall be limited to the lesser of allowable costs or billed charges. This limitation shall be applied separately to inpatient and outpatient services.

(2) Payments will not exceed final approved plan:

(a) Total reimbursements to a state-operated facility made during the DMAP fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in the final approved plan;

(b) Total aggregate inpatient and outpatient reimbursements to all hospitals made during the DMAP fiscal year (July 1 through June 30) may not exceed any limit imposed under federal law in the final approved plan.

Stat. Auth.: ORS 409.025, 409.040, 409.050, 414.025 & 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 53-1991, f. & cert. ef. 11-18-91; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 35-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0181

Non-Contiguous and Contiguous Area Out-of-State Hospitals — Outpatient Services

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with the Division of Medical Assistance Programs (DMAP) regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(1) Laboratory, diagnostic and therapeutic radiology, nuclear medicine, CT scans, MRI services, other imaging services, and maternity case management services will be reimbursed under a DMAP fee schedule.

(2) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(3) Notwithstanding subsections (1)–(2) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained. Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement with DMAP regarding reimbursement for specialized services, these hospitals will be reimbursed as follows:

(a) Clinical laboratory services will be reimbursed under a DMAP fee schedule;

(b) All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

(4) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

Stat. Auth.: ORS 409.025, 409.040, 409.050, 414.025 & 414.743

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04; OMAP 27-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-0195

Outpatient Services In-State DRG Hospitals

In-State Diagnostic Related Grouper (DRG) hospital outpatient and emergency services are reimbursed under a cost-based methodology.(1) The National Drug Code (NDC) must be included on the electronic (837I) and paper (UB 04) claims for physician administered drug codes required by the Deficit Reduction Act of 2005.

(2) Interim reimbursement:

(a) The interim reimbursement percentage is developed using the cost-to-charge ratio methodology, derived from the Medicare cost report, and applied to billed charges;

(b) The interim payment is the estimated percentage needed to achieve 80% of hospital cost in aggregate.

(c) This interim percentage is applied to all outpatient charges except for clinical laboratory services. The Division of Medical Assistance Programs (DMAP) fee schedule is used as interim reimbursement for clinical laboratory.

(3) Settlement reimbursement:

(a) For Title XIX/Title XXI clients; an adjustment to 80 percent of outpatient costs is made during the cost settlement process;

(b) For GA clients, outpatient hospital services are reimbursed at 50 percent of billed charges or 59 percent of costs, whichever is less.

Stat. Auth.: ORS 409.025, 409.040, 409.050, 414.025 & 414.743

Stats. Implemented: ORS 414.065

Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Renumbered from 461-015-0120(5); AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 45-1984, f. & ef. 10-1-84; AFS 6-1985, f. 1-28-85, ef. 2-1-85; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS

46-1986(Temp), f. 6-25-86, ef. 7-1-86; AFS 61-1986, f. 8-12-86, ef. 9-1-86; AFS 33-1987(Temp), f. & ef. 7-22-87; AFS 46-1987, f. & ef. 10-1-87; AFS 62-1987(Temp), f. 12-30-87, ef. 1-1-88; AFS 12-1988, f. 2-10-88, cert. ef. 6-1-88; AFS 26-1988, f. 3-31-88, cert. ef. 4-1-88; AFS 47-1988(Temp), f. 7-13-88, cert. ef. 7-1-88; AFS 63-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 7-1989(Temp), f. 2-17-89, cert. ef. 3-1-89; AFS 15-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 36-1989(Temp), f. & cert. ef. 6-30-89; AFS 37-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 45-1989, f. & cert. ef. 8-21-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0124; HR 18-1990(Temp), f. 6-29-90, cert. ef 7-1-90; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0540 & 461-015-0550; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 2-1991, f. & cert. ef. 1-4-91; HR 15-1991(Temp), f. & cert. ef. 4-8-91; HR 28-1991(Temp), f. & cert. ef. 7-1-91; HR 32-1991(Temp), f. & cert. ef. 7-29-91; HR 53-1991, f. & cert. ef. 11-18-91, Renumbered from 410-125-0780 & 410-125-0800; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 36-1993, f. & cert. ef. 12-1-93; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 13-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 16-2003(Temp), f. & cert. ef. 3-10-03 thru 8-1-03; OMAP 37-2003, f. & cert. ef. 5-1-03; OMAP 90-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 78-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; Administrative correction, 3-18-05; OMAP 21-2005, f. 3-21-05, cert. ef. 4-1-05; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; OMAP 17-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 43-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

410-125-1020
Filing of Cost Statement

(1) The hospital must file an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital with Division of Medical Assistance Programs (DMAP):

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with DMAP, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the DMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

(2) Twelve months after the hospital's fiscal year end, DMAP will send the hospital a computer printout listing all transactions between the hospital and DMAP during that auditing period. The Calculation of Reasonable Cost statement (DMAP 42) is due within 90 days of receipt by the hospital of the computer printout. Failure to file within 90 days may result in a 20 percent reduction in the payment rate:

(a) Hospitals without an agreement with Medicare may be subject to a field audit;

(b) Hospitals without an agreement with Medicare are required to submit a financial statement giving details of all assets, liabilities, income, and expenses, audited by a Certified Public Accountant.

(3) Improperly completed or incomplete Calculation of Reasonable Cost statements will be returned to the hospital for proper completion. The statement is not considered to be filed until it is received in a correct and complete form.

(4) If a hospital knowingly, or has reason to know, files a cost statement containing false information, such action constitutes cause for termination of its agreement with DMAP. Hospitals filing false reports may also be referred to prosecution under applicable statutes.

(5) Each Calculation of Reasonable Cost statement submitted to DMAP must be signed by the individual who normally signs the hospital's Medicare reports, federal income tax return, and other reports. If the hospital has someone, other than an employee prepare the cost statement, that individual will also sign the statement and indicate his or her status with the hospital.

(6) Notwithstanding subsection (1) of this rule, this subsection becomes effective for dates of service on and after January 1, 2006, but will not be operative as the basis for payments until DMAP determines all necessary federal approvals have been obtained. The hospital must file with DMAP, an annual Calculation of Reasonable Cost (DMAP 42), covering the latest fiscal period of operation of the hospital:

(a) A Calculation of Reasonable Cost statement is filed for less than an annual period only when necessitated by the hospital's termination of their agreement with DMAP, a change in ownership, or a change in the hospital's fiscal period;

(b) The hospital must use the same fiscal period for the DMAP 42 as that used for its Medicare report. If it doesn't have an agreement with Medicare, the hospital must use the same fiscal period it uses for filing its federal tax return;

(c) The report must be filed for both inpatient and outpatient services, even if the service is paid under a prospective payment system or fee schedule (e.g., DRG payments, outpatient clinical laboratory, etc.);

(d) In the absence of an agreement with Medicare, the hospital must use the same fiscal period as that used for filing their Federal tax return.

Stat. Auth.: ORS 409.025, 409.040, 409.050, 414.025 & 414.065
Stats. Implemented: ORS 414.065
Hist.: AFS 14-1980, f. 3-27-80, ef. 4-1-80; AFS 57-1980, f. 8-29-80, ef. 9-1-80; AFS 18-1982(Temp), f. & ef. 3-1-82; AFS 60-1982, f. & ef. 7-1-82; Former (2) thru (5) Renumbered to 461-015-0121 thru 461-015-0124; AFS 37-1983(Temp), f. & ef. 7-15-83; AFS 1-1984, f. & ef. 1-9-84; AFS 52-1985, f. 9-3-85, ef. 10-1-85; AFS 46-1987, f. & ef. 10-1-87; AFS 39-1989(Temp), f. 6-30-89, cert. ef. 7-1-89; AFS 49-1989(Temp), f. 8-24-89, cert. ef. 9-1-89; AFS 72-1989, f. & cert. ef. 12-1-89, Renumbered from 461-015-0105, 461-015-0120 & 461-015-0122; HR 21-1990, f. & cert. ef. 7-9-90, Renumbered from 461-015-0650; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 34-1999, f. & cert. ef. 10-1-99; OMAP 73-2005, f. 12-29-05, cert. ef. 1-1-06; DMAP 39-2008, f. 12-11-08, cert. ef. 1-1-09

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Rule Caption: January 2009; to comply with Federal requirements; update Prioritized List.
Adm. Order No.: DMAP 40-2008
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 11-1-2008
Rules Amended: 410-141-0120, 410-141-0266, 410-141-0520
Rules Repealed: 410-141-0520(T)
Subject: The Oregon Health Plan Managed Care program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to clients. DMAP amended rules 410-141-0120 and 410-141-0266 to comply with federal requirements and provide better guidance to MCO's ensuring providers are not sanctioned by the U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), DHHS Office of Inspector General or Oregon Department of Human Services (DHS). Having temporarily amended 410-141-0520 on October 1, 2008, DMAP permanently amended the rule to reference the additional interim modifications and technical changes effective October 1, 2008 to the biennial January 1, 2008-December 31, 2009 Prioritized List of Health Services. The October 1, 2008 interim modifications and technical changes include application of 2008 national code to the HSC lines and HSC guideline refinements.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-141-0120
Oregon Health Plan Prepaid Health Plan Provision of Health Care Services

CAF: Children, Adults and Families
CMS: Centers for Medicare and Medicaid Services
DHS: Department of Human Services
FCHP: Fully Capitated Health Plans
MHO: Mental Health Organization
OHP: Oregon Health Plan
DMAP: Division of Medical Assistance Programs
AMH: Addictions and Mental Health Division
PCO: Physician Care Organization
PCP: Primary Care Provider
PHP: Prepaid Health Plan

(1) PHPs shall have written policies and procedures that ensure the provision of all medically and dentally appropriate covered services, including urgent care services and emergency services, preventive services and Ancillary services, in those categories of services included in contract or agreements with DMAP and Addictions and Mental Health Division (AMH). PHPs shall communicate these policies and procedures to providers, regularly monitor providers' compliance with these policies and procedures, and take any corrective action necessary to ensure provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) PHPs shall ensure that all participating providers providing covered services to DMAP members are credentialed upon initial contract with the PHP and recredentialed no less frequently than every three years thereafter. The credentialing and recredentialing process shall include review of any information in the National Practitioners Databank and a determination, based on the requirements of the discipline or profession, that participating providers have current licensure in the state in which they practice, appropriate certification, applicable hospital privileges and appropriate malpractice insurance. This process shall include a review and determination based on the activity and results of a professional quality improvement

review. PHPs may elect to contract for or to delegate responsibility for this process. PHPs shall accept both the Oregon Practitioner Credentialing Application and the Oregon Practitioner Recredentialing Application, both of which were approved by the Advisory Committee on Physician Credentialing Information (ACPI) on September 28, 2004, thereby implementing ORS 442.807. PHPs shall retain responsibility for delegated activities, including oversight of the following processes:

(A) PHPs shall ensure that covered services are provided within the scope of license or certification of the participating provider or facility, and within the scope of the participating provider's contracted services and that participating providers are appropriately supervised according to their scope of practice;

(B) PHPs shall provide training for PHP staff and participating providers and their staff regarding the delivery of covered services, OHP administrative rules, and the PHP's administrative policies;

(C) PHPs shall maintain records documenting academic credentials, training received, licenses or certifications of staff and facilities used, and reports from the National Practitioner Data Bank and must provide accurate and timely information about license or certification expiration and renewal dates to DMAP. PHPs shall not refer DMAP Members to or use Providers who do not have a valid license or certification required by state or federal law. If a PHP knows or has reason to know that a provider's license or certification is expired or not renewed or is subject to licensing or certification sanction, the PHP must immediately notify the DMAP Provider Services Unit.

(D) PHPs shall not refer DMAP members to or use providers who have been terminated from the Oregon Medical Assistance Program or excluded as Medicare/Medicaid providers by CMS or who are subject to exclusion for any lawful conviction by a court for which the provider could be excluded under 42 CFR 1001.101. PHPs shall not accept billings for services to DMAP Members provided after the date of such provider's exclusion,conviction or termination. DHS has developed disclosure statement forms for individual practitioners and entities. If a PHP wishes to use their own disclosure statement form, they must submit to their PHP Coordinator for DHS approval prior to use. PHPs must obtain information required on the appropriate disclosure form from individual practitioners and entities and must retain the disclosure statements in the PHP credential files. If a PHP knows or has reason to know that a provider has been convicted of a felony or misdemeanor related to a crime, or violation of federal or state laws under Medicare, Medicaid or Title XX (including a plea of "nolo contender"), the PHP must immediately notify the DMAP Provider Services Unit.

(E) PHPs must obtain and use a DMAP Provider Enrollment (encounter) number for providers when submitting provider capacity reports. Only registered National Provider Identifiers (NPIs) and taxonomy codes are to be used for purposes of encounter data submission, prior to submitting encounter data in connection with services by the provider. Effective January 1, 2007, provider number "999999" may no longer be used in encounter data reporting or provider capacity reporting. PHPs must require each qualified provider to have and use a National Provider Identifier as enumerated by the National Plan and Provider Enumeration System (NPPES).

(F) The provider enrollment request (for encounter purposes) and disclosure statement described in paragraphs (D) and (E) require the disclosure of taxpayer identification numbers. The taxpayer identification number will be used for the administration of this program including provider enrollment, internal verification and administrative purposes for the medical assistance program, for administration of tax laws and may be used to confirm whether the individual or entity is subject to exclusion from participation in the medical assistance program. Taxpayer identification number includes Employer Identification Number (EIN), Social Security Number (SSN), Individual Tax Identification Number (ITIN) used to identify the individual or entity on the enrollment request form or disclosure statement. Disclosure of tax identification numbers for these purposes is mandatory. Failure to submit the requested taxpayer identification number(s) may result in denial of enrollment as a provider and denial of a provider number for encounter purposes, or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider for encounters.

(b) FCHPs, PCOs, DCOs and CDOs shall have written procedures that provide newly enrolled DMAP members with information about which participating providers are currently not accepting new patients (except for staff models);

(c) FCHPs, PCOs, DCOs and CDOs shall have written procedures that allow and encourage a choice of a PCP or clinic for physical health, and dental health services by each DMAP member. These procedures shall enable a DMAP member to choose a participating PCP or clinic (when a choice is available for PCPs or clinics) to provide services within the scope of practice to that DMAP member;

(d) If the DMAP member does not choose a PCP within 30 calendar days from the date of enrollment, the FCHP or PCO must ensure the DMAP member has an ongoing source of primary care appropriate to his or her needs by formally designating a practitioner or entity. FCHPs and PCOs that assign DMAP members to PCPs or clinics shall document the unsuccessful efforts to elicit the DMAP member's choice before assigning a DMAP member to a PCP or clinic. FCHPs and PCOs who assign PCPs before 30 calendar days after enrollment, must notify the DMAP member of the assignment and allow the DMAP member 30 calendar days after assignment to change the assigned PCP or clinic.

(2) In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414-153:

(a) Unless cause can be demonstrated to DMAP's satisfaction why such an agreement is not feasible, FCHPs and PCOs shall execute agreements with publicly funded Providers for payment of point-of-contact services in the following categories:

(A) Immunizations;

(B) Sexually transmitted diseases; and

(C) Other communicable diseases.

(b) DMAP members may receive the following services from appropriate non-participating Medicaid providers. If the following services are not referred by the FCHP or PCO in accordance with the FCHP's or PCO's referral process (except as provided for under 410-141-0420 Billing and Payment under the OHP), DMAP is responsible for payment of such services:

(A) Family planning services; and

(B) Human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevention services.

(c) FCHPs and PCOs are encouraged to execute agreements with publicly funded providers for authorization of and payment for services in the following categories:

(A) Maternity case management;

(B) Well-child care;

(C) Prenatal care;

(D) School-based clinic services;

(E) Health services for children provided through schools and Head Start programs; and

(F) Screening services to provide early detection of health care problems among low-income women and children, migrant workers and other special population groups.

(d) Recognizing the social value of partnerships between county health departments, other publicly supported programs, and health providers, FCHPs and PCOs are encouraged to involve publicly supported health care and service programs in the development and implementation of managed health care programs through inclusion on advisory and/or planning committees;

(e) FCHPs and PCOs shall report to DMAP on their status in executing agreements with publicly funded providers and on the involvement of publicly supported health care and service programs in the development and implementation of their program on an annual basis.

(3) FCHPs and PCOs shall ensure a newly enrolled DMAP member receives timely, adequate and appropriate health care services necessary to establish and maintain the health of the DMAP member. An FCHP's liability covers the period between the DMAP member's Enrollment and Disenrollment with the FCHP, unless the DMAP member is hospitalized at the time of disenrollment. In such an event, an FCHP is responsible for the inpatient hospital services until discharge or until the DMAP member's PCP or designated practitioner determines the care is no longer medically appropriate.

(4) A PCO's liability covers the period between the DMAP members' enrollment and disenrollment with the PCO, unless the DMAP member is hospitalized at the time of disenrollment. In such an event, the PCO is not responsible for the inpatient hospital services by definition and the inpatient hospital services will be the responsibility of DMAP.

(5) The DMAP member shall obtain all covered services, either directly or upon referral, from the PHP responsible for the service from the date of enrollment through the date of disenrollment.

(6) FCHPs and PCOs with a Medicare HMO component and MHOs have significant and shared responsibility for capitated services, and shall

coordinate benefits for shared DMAP members to ensure that the DMAP member receives all medically appropriate services covered under respective capitation payments. If the fully dual eligible DMAP member is enrolled in a FCHP or PCO with a Medicare HMO component the following apply:

(a) Mental health services covered by Medicare shall be obtained from the FCHP or PCO or upon referral by the FCHP or PCO;

(b) Mental health services that are not covered by the FCHP or PCO that are covered by the MHO shall be obtained from the MHO or upon referral by the MHO.

(7) PHPs shall coordinate services for each DMAP member who requires services from agencies providing health care services not covered under the capitation payment. The PCP shall arrange, coordinate, and monitor other medical and mental health, and/or dental care for that DMAP member on an ongoing basis except as provided for in Section (7)(c) of this rule:

(a) PHPs shall establish and maintain working relationships with local or allied agencies, community emergency service agencies, and local providers;

(b) PHPs shall refer DMAP members to the divisions of DHS and local and regional allied agencies which may offer services not covered under the capitation payment;

(c) FCHPs and PCOs shall not require DMAP members to obtain the approval of a PCP in order to gain access to mental health and alcohol and drug assessment and evaluation services. DMAP members may refer themselves to MHO services.

Stat. Auth.: ORS 409.010, 409.050, SB 163 (2007), OL 2007 Ch. 798
Stats. Implemented: ORS 414.065, 414.727, 414.050, 414.010, 192.518 -192.526
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 65-2005, f. 11-30-05, cert. ef. 1-1-06; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09

410-141-0266
PHP's Responsibility for Documentation and Quality Improvement Review of the Grievance System

(1) The PHP's documentation shall include, at minimum, a log of all oral and written complaints and appeals received by the PHP. The log shall identify the Division of Medical Assistance Programs (DMAP) Member and the following additional information:

(a) For complaints, the date of the complaint, the nature of the complaint, the disposition and date of disposition of the complaint;

(b) For appeals, the date of the Notice of Action, the date of the appeal, the nature of the appeal, whether continuing benefits were requested and provided, the resolution and date of resolution of the appeal. If an Administrative Hearing was requested, whether continuing benefits were requested and provided, and the effect of the final order of the Administrative Hearing.

(2) The PHP shall also maintain a record for each of the complaints and appeals included in the log. The record shall include records of the review or investigation and resolution, including all written decisions and copies of correspondence with the DMAP member. The PHPs shall retain documentation of complaints and appeals for seven years to permit evaluation.

(3) The PHPs shall have written procedures for the review and analysis of the Grievance System, including all complaints and appeals received by the PHP. The analysis of the grievance system shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards:

(a) PHPs shall monitor the completeness and accuracy of the written log, on a monthly basis;

(b) Monitoring of complaints and appeals shall review, at minimum, completeness, accuracy, timeliness of documentation, and compliance with written procedures for receipt, disposition, and documentation of complaints and appeals, and compliance with Oregon Health Plan rules.

Stat. Auth.: ORS 409.010, 409.050, SB 163 (2007), OL 2007 Ch. 798
Stats. Implemented: ORS 414.065, 414.727, 414.050, 414.010, 192.518 -192.526
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09

410-141-0520
Prioritized List of Health Services

(1) The Prioritized List of Health Services (Prioritized List) is the Oregon Health Services Commission's (HSC) listing of physical health services with "expanded definitions" of Preventive Services and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The HSC maintains the most current list on the HSC website: www.oregon.gov/DHS/healthplan/priorlist/main, or, for a hardcopy contact the Office of Oregon Health Policy and Research. Effective January 1, 2008, this rule incorporates by reference the CMS approved Biennial January 1, 2008-December 31, 2009 Prioritized List, including technical revisions and interim modifications effective April 1, 2008 and October 1, 2008, expanded definitions, and practice guidelines that are available on the HSC website.

(2) Certain Mental Health services are only covered for payment when provided by a Mental Health Organization (MHO), Community Mental Health Program (CMHP) or authorized Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO). These codes are identified on their own Mental Health (MH) section of the appropriate lines on the Prioritized List of Health Services.

(3) Chemical dependency (CD) services are covered for eligible OHP clients when provided by an FCHP, PCO, or by a provider who has a letter of approval from the Office of Mental Health and Addiction Services and approval to bill Medicaid for CD services.

(4) Effective October 1, 2008, the January 1, 2008 — December 31, 2009 Prioritized List, with technical revisions and interim modifications effective April 1, 2008 and October 1, 2008, is in effect and condition treatment pairs through line 503 are funded.

Stat. Auth.: SB 163 (2007), 2007 OL Ch. 798, ORS 409.010 & 409.050
Stats. Implemented: ORS 414.065, 414.727, 414.050, 414.010,192.518 - 192.526
Hist.: HR 7-1994, f. & cert. ef. 2-1-94; OMAP 33-1998, f. & cert. ef. 9-1-98; OMAP 40-1998(Temp), f. & cert. ef. 10-1-98 thru 3-1-99; OMAP 48-1998(Temp), f. & cert. ef. 12-1-98 thru 5-1-99; OMAP 21-1999, f. & cert. ef. 4-1-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 9-2000(Temp), f. 4-27-00, cert. ef. 4-27-00 thru 9-26-00; OMAP 13-2000, f. & cert. ef. 9-12-00; OMAP 14-2000(Temp), f. 9-15-00, cert. ef. 10-1-00 thru 3-30-01; OMAP 40-2000, f. 11-17-00, cert. ef. 11-20-00; OMAP 22-2001(Temp), f. 3-30-01, cert. ef. 4-1-01 thru 9-1-01; OMAP 28-2001, f. & cert. ef. 8-10-01; OMAP 53-2001, f. & cert. ef. 10-1-01; OMAP 18-2002, f. 4-15-02, cert. ef. 5-1-02; OMAP 64-2002, f. & cert. ef. f. & cert. ef. 10-2-02; OMAP 65-2002(Temp), f. & cert. ef. 10-2-02 thru 3-15-0; OMAP 88-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 30-2003, f. 3-31-03 cert. ef. 4-1-03; OMAP 79-2003(Temp), f. & cert. ef. 10-2-03 thru 3-15-04; OMAP 81-2003(Temp), f. & cert. ef. 10-23-03 thru 3-15-04; OMAP 94-2003, f. 12-31-03 cert. ef. 1-1-04; OMAP 17-2004(Temp), f. 3-15-04 cert. ef. 4-1-04 thru 9-15-04; OMAP 28-2004, f. 4-22-04 cert. ef. 5-1-04; OMAP 48-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 51-2004, f. 9-9-04, cert. ef. 10-1-04; OMAP 68-2004(Temp), f. 9-14-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 83-2004, f. 10-29-04 cert. ef. 11-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 54-2005(Temp), f. & cert. ef. 10-14-05 thru 4-1-06; OMAP 62-2005, f. 11-29-05, cert. ef. 12-1-05; OMAP 71-2005, f. 12-21-05, cert. ef. 1-1-06; OMAP 6-2006, f. 3-22-06, cert. ef. 4-1-06; OMAP 46-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 14-2007(Temp), f. & cert. ef. 10-1-07 thru 3-28-08; DMAP 28-2007(Temp), f. & cert. ef. 12-20-07 thru 3-28-08; DMAP 8-2008, f & cert. ef. 3-27-08; DMAP 10-2008(Temp), f. & cert. ef. 4-1-08 thru 9-15-08; DMAP 23-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 31-2008(Temp), f. & cert. ef. 10-1-08 thru 3-29-09; DMAP 40-2008, f. 12-11-08, cert. ef. 1-1-09

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Rule Caption: Non-substantive revision to update the date of referenced documents.
Adm. Order No.: DMAP 41-2008
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 11-1-2008
Rules Amended: 410-146-0040
Subject: The American Indian/Alaska Native Services program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to certain clients. DMAP updated the year in effect for current procedure code manuals for providers to ensure Oregon Administrative Rules (OARs) are current and accurate. Text is revised to improve readability and take care of necessary "housekeeping" corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-146-0040
ICD-9-CM Diagnosis Codes and CPT/HCPCs Procedure Codes

(1) The Division of Medical Assistance Program (DMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(2) The appropriate code or codes from 001.0 through V82.9 must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-9-CM. Use a three-digit code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. DMAP considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided.

(a) For dental services, use codes that are in effect for the date the services(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the services(s) was provided. These services include, but are not limited to, the following:

(A) Physician services;

(B) Physical and occupational therapy services;

(C) Radiology procedures;

(D) Clinical laboratory tests;

(E) Other medical diagnostic procedures;

(F) Hearing and vision services.

(6) DMAP maintains unique coding and claim submission requirements for Administrative Exams and Death With Dignity services. Refer to OAR 410 Division 150, Administrative Examination and Billing Services, and OAR 410- 130-0670, Death with Dignity Services for specific requirements.

Stat. Auth.: 409.050, 404.110, 414.065

Other Auth.: Title 19 of the Social Security Act, Title 42 Public Health of the Code of Federal Regulations, OAR 410-120, 42USC1396a(bb, 1396d (United States Code 42, Ch. 7, Sub. 19). Public Law 93 -638. Sec. 1603 of Title 25

Stats. Implemented: ORS 414.065

Hist.: OMAP 2-1999, f. & cert. ef. 2-1-99; OMAP 25-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 6-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 45-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 59-2002, f. & cert. ef. 10-1-02; OMAP 68-2003, f. 9-12-03, cert. ef. 10-1-03; OMAP 62-2004, f. 9-10-04, cert. ef. 10-1-04; DMAP 19-2007, f. 12-5-07, cert. ef. 1-1-08; DMAP 41-2008, f. 12-11-08, cert. ef. 1-1-09

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Rule Caption: Non-substantive revision to update the date of referenced documents.
Adm. Order No.: DMAP 42-2008
Filed with Sec. of State: 12-11-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 11-1-2008
Rules Amended: 410-147-0040
Subject: The General Rules program administrative rules govern Division of Medical Assistance Programs' (DMAP) payment for services provided to clients. DMAP amended rule 410-120-1340 to follow the standards for payment methods subsequent to the yearly revisions to the Relative Value Units (RVU) weights made by Centers of Medicare and Medicaid (CMS). This rule is amended to specify which RVUs will be utilized for the calendar year 2009 and include a COLA to the RVU conversion factor of 3.5%. Text is revised to improve readability and take care of necessary "housekeeping" corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-147-0040
ICD-9-CM Diagnosis and CPT/HCPCs Procedure Codes

(1) The appropriate ICD-9-CM diagnosis code or codes from 001.0 through V99.9 must be used to identify:

(a) Diagnoses;

(b) Symptoms;

(c) Conditions;

(d) Problems;

(e) Complaints; or

(f) Other reasons for the encounter/visit.

(2) The Division of Medical Assistance Program (DMAP) requires diagnosis codes on all claims, including those submitted by independent laboratories and portable radiology, including nuclear medicine and diagnostic ultrasound providers. A clinic must always provide the client's diagnosis to ancillary service providers when prescribing services, equipment, and supplies.

(3) Clinics must list the principal diagnosis in the first position on the claim. Use the principal diagnosis code for the diagnosis, condition, problem, or other reason for an encounter/visit shown in the medical record to be chiefly responsible for the services provided. Clinics may list up to three additional diagnosis codes on the claim for documented conditions that coexist at the time of the encounter/visit and require or affect client care, treatment, or management.

(4) Clinics must list the diagnosis codes using the highest degree of specificity available in the ICD-9-CM. Use a three-digit diagnosis code only if the diagnosis code is not further subdivided. Whenever fourth-digit or fifth-digit subcategories are provided, the provider must report the diagnosis at that specificity. DMAP considers a diagnosis code invalid if it has not been coded to its highest specificity.

(5) DMAP requires providers to use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise directed in rule, providers must accurately code claims according to the national standards in effect for the date the service(s) was provided:

(a) For dental services, use codes that are in effect for the date the service(s) was provided that are found in Dental Procedures and Nomenclature as maintained and distributed by the American Dental Association for dental services;

(b) For health care services, use the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the service(s) was provided. These services include, but are not limited to, the following:

(A) Physician services;

(B) Physical and occupational therapy services;

(C) Radiology procedures;

(D) Clinical laboratory tests;

(E) Other medical diagnostic procedures;

(F) Hearing and vision services.

(6) DMAP maintains unique coding and claim submission requirements for Administrative Exams and Death with Dignity services. Refer to OAR 410 Division 150, Administrative Examination and Billing Services, and OAR 410-130-0670, Death with Dignity Services, for specific requirements.

Stat. Auth.: ORS 409.050, 409.110, 414.065

Stats. Implemented: ORS 414.065

Hist.: HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 7-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00; OMAP 8-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 19-2001, f. 3-30-01, cert, ef, 4-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0020; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0060; OMAP 71-2003, f. 9-15-03, cert. ef. 10-1-03; OMAP 27-2006, f. 6-14-06, cert. ef. 7-1-06; DMAP 10-2007, f. 6-14-07, cert. ef. 7-1-07; DMAP 25-2008, f. 6-13-08, cert. ef. 7-1-08; DMAP 42-2008, f. 12-11-08, cert. ef. 1-1-09

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Department of Public Safety Standards and Training
Chapter 259

Rule Caption: Amend Rules relating to Denial or revocation of certification, moral fitness definition and arbitration.
Adm. Order No.: DPSST 21-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 3-1-2008
Rules Amended: 259-008-0010, 259-008-0011, 259-008-0070
Subject: Amends definition of Moral Fitness for law enforcement officers.

Amends rules generally relating to grounds for mandatory denial or revocation of certification as well as discretionary disqualifying

misconduct as grounds for denying or revoking certification and establishes periods of ineligibility.

Establishes misconduct categories and initial periods of ineligibility; and includes process for misconduct cases in which there has been an arbitrator's opinion.

Rules Coordinator: Bonnie Salle—(503) 378-2431

259-008-0010

Minimum Standards for Employment as a Law Enforcement Officer

(1) Citizenship.

(a) A person may not be employed as a corrections officer for more than one year unless the person is a citizen of the United States.

(b) A person may not be employed as a police or parole and probation officer for more than 18 months unless the person is a citizen of the United States.

(2) Age. No law enforcement unit in this state shall employ as a police officer, corrections officer or parole and probation officer, any person who has not yet attained the age of 21 years.

(3) Fingerprints. On or within 90 days prior to the date of employment, each police, corrections, or parole and probation officer shall be fingerprinted on standard applicant fingerprint cards. The hiring agency is responsible for fingerprinting and shall forward two (2) cards to the Oregon State Police Identification Services Section for processing and assignment of identification number.

(a) Applicant's fingerprints will be retained and kept on file with the Oregon State Police Identification Services Section.

(b) The Oregon State Police Identification Services Section will notify the Department and the employing agency of any criminal record disclosed through processing the applicant's fingerprint card.

(c) If any procedural change is made by either the Federal Bureau of Investigation or the Oregon State Police Identification Services Section the Department shall comply with the most current requirements.

(d) If the fingerprint clearance has not been obtained prior to submission of the application for certification, a criminal history affidavit provided by the Department shall be completed and returned to the Department by the applicant pending fingerprint clearance.

(4) Criminal Records. No police, corrections, or parole and probation officer shall have been convicted:

(a) In this state or any other jurisdiction, of a crime designated under the law where the conviction occurred as being punishable as a felony or as a crime for which a maximum term of imprisonment of more than one (1) year may be imposed;

(b) Of violating any law involving the unlawful use, possession, delivery, or manufacture of a controlled substance, narcotic, or dangerous drug;

(c) In this state of violating any law subject to denial or revocation as identified in OAR 259-008-0070 or has been convicted of violating the statutory counterpart of any of those offenses in any other jurisdiction.

(5) Notification of Conviction:

(a) A law enforcement officer, instructor, telecommunicator, or EMD who is convicted of a crime, as identified in OAR 259-008-0070, while employed by a public or private safety agency must notify the agency head within 72 hours of the conviction.

(b) When an agency receives notification of a conviction from its employee, or another source, they must notify the Department within five (5) business days. The notification to the Department must be in writing and include the specific charges of the conviction, the county and state where the conviction occurred, the investigating agency and the date of the conviction.

(6) Moral Fitness (Professional Fitness). All law enforcement officers must be of good moral fitness.

(a) For purposes of this standard, lack of good moral fitness includes, but is not limited to:

(A) Mandatory disqualifying misconduct as described in OAR 259-008-0070(3); or

(B) Discretionary disqualifying misconduct described in OAR 259-008-0070(4).

(7) Education:

(a) Applicants for the position of a law enforcement officer will be required to furnish documentary evidence of one of the following:

(A) High School diploma; or

(B) Successful completion of the General Educational Development (GED) Test.

(i) For the purpose of determining high school graduation level as required by these rules, the applicant must have achieved a score no less than that required by the Oregon Board of Education before issuing an Oregon GED certificate.

(ii) Applicants holding a GED from another state may be required to obtain an Oregon certificate at the discretion of the Department.

(b) Evidence of the above shall consist of official transcripts, diplomas, or GED test report forms. Other documentation may be accepted, at the discretion of the Department.

(c) Reading and Writing Standard. Before beginning basic police training, challenging basic police training, or beginning the police career officer development course, each applicant shall provide evidence to DPSST that the applicant has attained a minimum of a 12th grade reading and writing level in the English language.

(A) The hiring agency is responsible for administering a reading and writing instrument, approved by DPSST, and shall forward the results to DPSST on an application for training (Form F-5) prior to the applicant being admitted to basic police training.

(B) Individuals submitting transcripts verifying that they possess at least a four-year academic degree from an institution recognized by DPSST under the provisions of OAR 259-008-0045 are exempt from completing the 12th grade reading/writing test prior to attending a course identified in this section.

(8) Physical Examination. All law enforcement officers and applicants must be examined by a licensed physician or surgeon.

(a) The medical examination shall be completed not more than 180 days prior to initial offer of employment, nor more than 90 days after initial offer of employment, and shall conform to applicable standards of the Americans with Disabilities Act (ADA). Title 42 USC 12101.

(b) Individuals who have had a successfully completed physical examination (while at the same employer) and are selected for a certifiable position in a discipline in which the individual is not yet certified must complete and pass a new physical examination.

(c) The Department will not require a new physical examination when a law enforcement officer obtains employment, or re-employment, in the same discipline if the officer:

(A) Has had a successfully completed a physical examination, and

(B) Is currently certified; or

(C) Is an officer currently employed full-time in another jurisdiction who has successfully completed a comparable physical examination in that jurisdiction.

(d) Notwithstanding subsection (c), a medical examination may be required by a hiring agency at its discretion.

(e) Police, Corrections, and Parole and Probation applicants must meet the following criteria:

(A) Visual Acuity. Corrected vision must be at least 20/30 (Snellen) in each eye. Due to the demonstrated likelihood of dislodgment or breakage, candidates who are able to wear only glasses with frames must meet an uncorrected standard not worse than 20/100 (Snellen) in each eye. Those candidates who use soft contact lenses (SCLs) must have vision correctable to at least 20/30 in each eye, with no uncorrected standard, provided the employing agency will monitor compliance. Replacement glasses or lenses (as appropriate) must be on the person or readily available at all times during each work shift.

(B) Color Vision. Red or green deficiencies may be acceptable, providing the applicant can read at least nine (9) of the first thirteen (13) plates of the Ishihara Test (24 Plate Edition). Applicants who fail the Ishihara test can meet the color vision standard by demonstrating that they can correctly discriminate colors via a field test conducted by the employer and approved by DPSST.

(C) Depth Perception. Depth Perception must be sufficient to demonstrate stereopsis adequate to perform the essential tasks of the job. The recommended test is the Random Stereo Test with 60 seconds of arc.

(D) Peripheral Vision. Visual Field Performance must be 140 degrees in the horizontal meridian combined.

(E) Night Blindness. A history of night blindness should be evaluated to determine applicant's capacity to perform essential tasks at night or in dark or low light settings.

(f) Applicants for the position of police or corrections officer must have sufficient hearing in both ears to perform essential tasks without posing a direct threat to themselves or others. The applicant must have no average loss greater than 25 decibels (db) at the 500, 1,000, 2,000 and 3,000-Hertz levels in either ear with no single loss in excess of 40 db.

(g) Applicants for the position of parole and probation officer must have sufficient hearing in both ears to perform essential tasks without posing a direct threat to themselves or others. The applicant must have no aver-

age loss greater than 35 decibels (db) at the 500, 1000, 2000, and 3000 Hertz levels in either ear with no single loss in excess of 45 db.

(h) If amplification device(s) is (are) necessary to meet the criteria in (f) or (g) above, or if applicant cannot meet the above criteria and wishes to pursue application, applicant must:

(A) Obtain a hearing evaluation by a licensed audiologist or otorhinolaryngologist (ear, nose, throat) to determine current hearing aid requirement; and

(B) Achieve a Speech Reception Threshold (SRT) of no greater than 25 db for each ear;

(C) Police, corrections and parole and probation officers must achieve a Speech Discrimination test score of no less than 90% utilizing a standard 50-word presentation at 60 db Hearing Threshold Level (HTL). The Department may require an applicant to have another examination by a licensed audiologist or otorhinolaryngologist (ear, nose, and throat) designated by the Department to verify that the applicant's hearing meets the Board's minimum hearing standard. The verification examination will be at the expense of the applicant or the applicant's employing agency. The equipment utilized for all of these evaluations must be calibrated annually using current ANSI standards.

(D) Hearing amplification devices used to meet the hearing standard must be the type that protects the applicant from further hearing degradation due to amplification of loud sounds.

(i) Applicants for the position of police, corrections, or parole and probation officer must be able to use vocal chords and have significant speaking ability to perform speaking-related essential tasks. For police and corrections officers abnormalities of the nose, throat or mouth must not interfere with the applicant's breathing or proper fitting of gas mask or similar device.

(j) Applicants for the position of police, corrections, or parole and probation officer who have a history of organic cardio-vascular disease or a finding during the medical examination of organic cardio-vascular disease will necessitate further medical evaluation.

(A) Resting blood pressure must be less than or equal to 140 mmHg systolic and 90 mmHg diastolic on three successive readings.

(B) Applicants must not have a functional and therapeutic cardiac classification greater than the Heart Association's Class A.

(C) Failure to meet guidelines (j), (A) and (B) will require further medical evaluation.

(D) If the applicant has controlled hypertension not exceeding the above standards and is on medication with side effect profiles, which do not interfere with performance of duty, then the condition may not be excludable.

(E) Functional Capacity I patients with cardiac disease may not be excludable, if they have no limitations of physical activity and ordinary physical activity does not cause discomfort and they do not have symptoms of cardiac insufficiency, nor experience angina pain.

(F) Therapeutic Classification A patients with cardiac disease, whose physical activity is restricted, should be evaluated thoroughly.

(G) If further medical examination is required under (j), it will be at the expense of the applicant or hiring authority.

(k) All law enforcement applicants must submit a current-version DPSST Medical Examination Report (DPSST Form F2), or a medical report completed by a licensed physician containing at a minimum the information on Form F2 and a signed statement by the examining physician that the applicant does not have any condition, physical, mental, or emotional, which, in his/her opinion, suggests further examination. This Report will be furnished to the examining physician by the hiring agency. The physician must indicate that the applicant is or is not physically able to perform the duties of a law enforcement officer as prescribed by DPSST.

(l) A copy of the Medical Examination Report must be sent to the Department prior to acceptance into a basic course, or any course where such report is required by the Department.

(m) The Department may require an applicant offered conditional employment to take a subsequent examination by a licensed physician of the Department's choice at the expense of the applicant or the hiring authority.

(n) The Board may waive any physical requirement where, in its judgment, the waiver would not be detrimental to the performance of an officer's duties, including the protection of the public and the safety of coworkers. The applicant may be required to demonstrate the ability to perform the essential functions of the job.

(o) A person or department head requesting a waiver of any physical requirement set forth in section (8) of this rule shall submit the request to the Department in writing, accompanied by supporting documents or pertinent testimony which would justify the action requested. The supporting documents must include information pertinent to the waiver request. The Board or Department may require additional documentation or testimony by the person or department head requesting the waiver if clarification is needed. Any expense associated with providing documentation or testimony will be borne by the person requesting the waiver or the requesting agency. If the person requesting the waiver does not obtain employment within one (1) year from the date a waiver is granted, the waiver will be considered void.

(A) If the Board grants a waiver, it will be recorded on the certification and any subsequent certification unless removed by the Board upon proof that the condition prompting the waiver no longer exists.

(B) If the Board denies a request for a waiver of any physical requirement set forth in section (8) of this rule, the Department will issue Notice and proceed as provided in section (9) of this rule.

(9) Contested Case Hearing Process for denial of waiver.

(a) Initiation of Proceedings: Upon determination that the reason for denial of a waiver is supported by factual data meeting the statutory and administrative rule requirements, a contested case notice will be prepared.

(b) Contested Case Notice: The "Contested Case Notice" will be prepared in accordance with the Attorney General's Model Rules of Procedure adopted under OAR 259-005-0015. The Department will have a copy of the notice served on the public safety professional or individual.

(c) Response Time: A party who has been served with a "Contested Case Notice" has 60 days from the date of mailing or personal service of the notice in which to file with the Department a written request for a hearing.

(d) Default Order: If a timely request for a hearing is not received, the Contested Case Notice will become a final order denying the requested waiver.

(e) Hearing Request: When a request for a hearing is received in a timely manner, the Department will refer the matter to the Office of Administrative Hearings.

(f) Proposed Order: The assigned Administrative Law Judge will prepare Findings of Fact, Conclusions of Law and Proposed Final Order and serve a copy on the Department and on each party.

(g) Exceptions and Arguments: A party must file specific written exceptions and arguments with the Department no later than 14 days from date of service of the Findings of Fact, Conclusions of Law, and Proposed Final Order.

(A) The Department may extend the time within which the exceptions and arguments must be filed upon a showing of good cause.

(B) When the exceptions and arguments are filed, the party making the exceptions and arguments must serve a copy on all parties of record in the case and provide the Department with proof of service. A failure to serve copies and provide proof of service will invalidate the filing of exceptions and arguments as being untimely, and the Department may disregard the filing in making a final determination of the case.

(h) Final Order: The Department will issue a final order if a public safety professional or individual fails to file exceptions and arguments in a timely manner.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 181.640, 181.644, 183.341

Stats. Implemented: ORS 181.640, 181.644, 183.341

Hist.: PS 12, f. & ef. 12-19-77; PS 1-1981, f. 9-26-81, ef. 11-2-81; PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; PS 1-1987, f. & ef. 10-26-87; Renumbered from 259-010-0015, PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 2-1996, f. 5-15-96, cert. ef. 5-20-96; PS 4-1997, f. 3-20-97, cert. ef. 3-25-97; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 1-1999, f. & cert. ef. 3-9-99; BPSST 9-2000, f. 11-13-00, cert. ef. 11-15-00; BPSST 3-2001, f. & cert. ef. 8-22-01; BPSST 12-2001(Temp), f. & cert. ef. 10-26-01 thru 4-5-02; BPSST 5-2002(Temp), f. 4-3-02, cert. ef. 4-6-02 thru 8-1-02; BPSST 16-2002, f. & cert. ef. 7-5-2002; BPSST 20-2002, f. & cert. ef. 11-21-02; DPSST 3-2003, f. & cert. ef. 1-22-03; DPSST 6-2003, f. & cert. ef. 4-11-03; DPSST 8-2003, f. & cert. ef. 4-18-03; DPSST 14-2003, f. & cert. ef. 12-22-03; DPSST 3-2006, f. & cert. ef. 2-28-06; DPSST 12-2006, f. & cert. ef. 10-13-06; DPSST 10-2007, f. & cert. ef. 10-15-07; DPSST 13-2007(Temp), f. & cert. ef. 11-1-07 thru 4-18-08; DPSST 1-2008(Temp), f. & cert. ef. 1-15-08 thru 4-18-08; DPSST 4-2008, f. & cert. ef. 4-15-08; DPSST 21-2008, f. 12-15-08, cert. ef. 1-1-09

259-008-0011

Minimum Standards for Employment as a Telecommunicator and Emergency Medical Dispatcher

(1) On or before the date of employment, each telecommunicator and emergency medical dispatcher shall be fingerprinted on standard applicant fingerprint cards.

(a) The hiring agency, if a public agency, is responsible for fingerprinting and shall forward two (2) cards to the Oregon State Police Identification Services Section for processing and assignment of identification number.

(b) If the hiring agency is a private agency it is responsible for fingerprinting and shall forward two (2) cards to the Department along with the appropiate fee.

(A) Applicant's fingerprints will be retained and kept on file with the Oregon State Police Identification Services Section.

(B) The Oregon State Police Identification Services Section shall notify the Department and the employing agency of any criminal record disclosed through processing the applicant's fingerprint card.

(C) If any procedural change is made by either the Federal Bureau of Investigation or the Oregon State Police Identification Services Section, the Department shall comply with the most current requirements.

(D) If the fingerprint clearance has not been obtained prior to submission of the application for certification, a criminal history affidavit provided by the Department shall be completed and returned to the Department by the applicant pending fingerprint clearance.

(2) Criminal Records. No telecommunicator or emergency medical dispatcher shall have been convicted:

(a) In this state or any other jurisdiction, of a crime designated under the law where the conviction occurred as being punishable as a felony or as a crime for which a maximum term of imprisonment of more than one (1) year may be imposed;

(b) Of violating any law involving the unlawful use, possession, delivery, or manufacture of a controlled substance, narcotic, or dangerous drug;

(c) In this state of violating any law subject to denial or revocation as identified in OAR 259-008-0070 or has been convicted of violating the statutory counterpart of any of those offenses in any other jurisdiction.

(3) Moral Fitness (Professional Fitness). All telecommunicators and emergency medical dispatchers must be of good moral fitness.

(a) For purposes of this standard, lack of good moral fitness includes, but is not limited to:

(A) Mandatory disqualifying misconduct as described in OAR 259-008-0070(3); or

(B) Discretionary disqualifying misconduct as described in OAR 259-008-0070(4).

(4) Education:

(a) Applicants for the position of a telecommunicator or emergency medical dispatcher will be required to furnish documentary evidence of one of the following:

(A) High School diploma; or

(B) Successful completion of the General Educational Development (GED) Test.

(i) For the purpose of determining high school graduation level as required by these rules, the applicant must have achieved a score no less than that required by the Oregon Board of Education before issuing an Oregon GED certificate.

(ii) Applicants holding a GED from another state may be required to obtain an Oregon certificate at the discretion of the Department.

(b) Evidence of the above shall consist of official transcripts, diplomas, or GED test report forms. Other documentation may be accepted, at the discretion of the Department.

(5) Reading and Writing Standard. Before beginning basic telecommunicator or Emergency Medical Dispatcher (EMD) training or challenging basic telecommunicator training, each applicant shall provide evidence to DPSST that the applicant has attained a minimum of a 12th grade reading and writing level in the English language.

(A) The hiring agency is responsible for administering a reading and writing instrument, approved by DPSST, and shall forward the results to DPSST on an application for training (Form F-5) prior to the applicant being admitted to basic telecommunicator or EMD training.

(B) Individuals submitting transcripts verifying that they possess at least a four-year academic degree from an institution recognized by DPSST under the provisions of OAR 259-008-0045 are exempt from completing the 12th grade reading/writing test prior to attending a course identified in this section.

(6) Physical Examination. All Telecommunicators and Emergency Medical Dispatcher applicants must be examined by a licensed physician.

(a) The medical examination must be completed not more than 180 days prior to initial offer of employment, nor more than 90 days after initial offer of employment, and must conform to applicable standards of the Americans with Disabilities Act (ADA). Title 42 USC 12101.

(b) Individuals who have had a successfully completed physical examination (while at the same employer) and are selected for a certifiable position in a discipline in which the individual is not yet certified must complete and pass a new physical examination.

(c) The Department will not require a new physical examination when a Telecommunicator or Emergency Medical Dispatcher obtains employment, or re-employment, in the same discipline if the Telecommunicator or Emergency Medical Dispatcher:

(A) Has had a successfully completed a physical examination, and

(B) Is currently certified; or

(C) Is currently employed full-time in another jurisdiction and has successfully completed a comparable physical examination in that jurisdiction.

(d) Notwithstanding subsection (c), a medical examination may be required by a hiring agency at its discretion.

(e) Telecommunicator and Emergency Medical Dispatcher applicants must meet the following criteria:

(A) Visual Acuity. Corrected vision must be at least 20/30 (Snellen) when tested using both eyes together.

(B) Color Vision. Red or green deficiencies may be acceptable, providing the applicant can read at least nine (9) of the first thirteen (13) plates of the Ishihara Test (24 Plate Edition). Applicants who fail the Ishihara test can meet the color vision standard by demonstrating that they can correctly discriminate colors via a field test conducted by the employer and approved by DPSST. The results of the field test and the methods for testing must be maintained by the employing agency.

(i) Any employing agency that conducts a field test to meet the color vision standard must also complete a Department approved affidavit attesting that the applicant can either correctly discriminate colors or is able to successfully perform the required tasks of a Telecommunicator or Emergency Medical Dispatcher, notwithstanding the applicant's inability to correctly discriminate colors.

(ii) Any affidavit required by (i), that the Department receives and accepts, is non-transferable to any subsequent employer and may not be used by any other entity for certification purposes.

(iii) Notwithstanding subsection (c) of this rule, each employer must complete an agency-specific field test and a Department approved affidavit as described in subsection (i) of this section for any Telecommunicator or Emergency Medical Dispatcher who previously met the color vision standard by completing a field test.

(C) Peripheral Vision. Visual Field Performance must be 120 degrees in the horizontal meridian combined.

(f) Applicants for the position of Telecommunicator or Emergency Medical Dispatcher must have sufficient hearing in both ears to perform essential tasks without posing a direct threat to themselves or others. The applicant must meet National Emergency Number Association (NENA) hearing standard 54-002 (June 10, 2006).

(g) Applicants for the position of Telecommunicator or Emergency Medical Dispatcher must be able to use vocal cords and have significant speaking ability to perform speaking-related essential tasks.

(7) If further medical examination is required, it will be at the expense of the applicant or the hiring authority.

(8) All Telecommunicator and Emergency Medical Dispatcher applicants must submit a current-version DPSST Medical Examination Report for Telecommunicators and Emergency Medical Dispatchers (DPSST Form F-2T), or a medical report completed by a licensed physician containing at a minimum the information on Form F-2T. This Report will be furnished to the examining physician by the hiring agency.

(9) A copy of the Medical Examination Report must be sent to the Department prior to acceptance into a basic course, or any course where such report is required by the Department.

(10) The Department may require an applicant offered conditional employment to take a subsequent examination by a licensed physician of the Department's choice at the expense of the applicant or the hiring authority.

(11) The Board may waive any physical requirement where, in its judgment, the waiver would not be detrimental to the performance of a Telecommunicator or Emergency Medical Dispatcher's duties. The applicant may be required to demonstrate the ability to perform the essential functions of the job.

(12) A person or department head requesting a waiver of any physical requirement set forth in section (11) of this rule must submit the request to the Department in writing, accompanied by supporting documents or pertinent testimony which would justify the action requested. The supporting documents must include information pertinent to the waiver request. The Board or Department may require additional documentation or testimony by the person or department head requesting the waiver if clarification is needed. Any expense associated with providing documentation or testimony will be borne by the person requesting the waiver or the requesting

agency. If the person requesting the waiver does not obtain employment within one (1) year from the date a waiver is granted, the waiver will be considered void.

(A) If the Board grants a waiver, it will be recorded on the certification and any subsequent certification unless removed by the Board upon proof that the condition prompting the waiver no longer exists.

(B) If the Board denies a request for a waiver of any physical requirement set forth in section (8) of this rule, the Department will issue Notice and proceed as provided in section (13) of this rule.

(13) Contested Case Hearing Process for denial of waiver.

(a) Initiation of Proceedings: Upon determination that the reason for denial of a waiver is supported by factual data meeting the statutory and administrative rule requirements, a contested case notice will be prepared.

(b) Contested Case Notice: The "Contested Case Notice" will be prepared in accordance with the Attorney General's Model Rules of Procedure adopted under OAR 259-005-0015. The Department will have a copy of the notice served on the public safety professional or individual.

(c) Response Time: A party who has been served with a "Contested Case Notice" has 60 days from the date of mailing or personal service of the notice in which to file with the Department a written request for a hearing.

(d) Default Order: If a timely request for a hearing is not received, the Contested Case Notice will become a final order denying the requested waiver.

(e) Hearing Request: When a request for a hearing is received in a timely manner, the Department will refer the matter to the Office of Administrative Hearings.

(f) Proposed Order: The assigned Administrative Law Judge will prepare Findings of Fact, Conclusions of Law and Proposed Final Order and serve a copy on the Department and on each party.

(g) Exceptions and Arguments: A party must file specific written exceptions and arguments with the Department no later than 14 days from date of service of the Findings of Fact, Conclusions of Law, and Proposed Final Order.

(A) The Department may extend the time within which the exceptions and arguments must be filed upon a showing of good cause.

(B) When the exceptions and arguments are filed, the party making the exceptions and arguments must serve a copy on all parties of record in the case and provide the Department with proof of service. A failure to serve copies and provide proof of service will invalidate the filing of exceptions and arguments as being untimely, and the Department may disregard the filing in making a final determination of the case.

(h) Final Order: The Department will issue a final order if a public safety professional or individual fails to file exceptions and arguments in a timely manner.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 181.640, 181.644, 183.341

Stats. Implemented: ORS 181.640, 181.644, 183.341

Hist.: BPSST 1-2002, f. & cert. ef. 2-6-02; DPSST 1-2004, f. 1-16-04, cert. ef. 1-20-04; DPSST 5-2004, f. & cert. ef. 4-23-04; DPSST 3-2007, f. & cert. ef. 1-12-07; DPSST 10-2007, f. & cert. ef. 10-15-07; DPSST 5-2008, f. & cert. ef. 4-15-08; DPSST 21-2008, f. 12-15-08, cert. ef. 1-1-09

259-008-0070
Denial/Revocation

(1) It is the responsibility of the Board to set the standards, and of the Department to uphold them, to insure the highest levels of professionalism and discipline. These standards shall be upheld at all times unless the Board determines that neither the safety of the public or respect of the profession is compromised. Definitions

(2) For purposes of this rule, the following definitions apply:

(a) "Denial" or "Deny" means the refusal to grant a certification for mandatory grounds or discretionary disqualifying misconduct as identified in this rule, pursuant to the procedures identified in (9) of this rule.

(b) "Discretionary Disqualifying Misconduct" means misconduct identified in OAR 259-008-0070(4).

(c) "Revocation" or "Revoke" means to withdraw the certification of a public safety professional or instructor for mandatory grounds or discretionary disqualifying misconduct as identified in this rule, pursuant to the procedures identified in section (9) of this rule. Grounds for Mandatory Denial or Revocation of Certification

(3) Mandatory Grounds for Denying or Revoking Certification of a Public Safety Professional or Instructor:

(a) The Department must deny or revoke the certification of any public safety professional or instructor after written notice and hearing, based upon a finding that:

(A) The public safety professional or instructor has been discharged for cause from employment as a public safety professional or instructor. For purposes of this rule, "discharged for cause," means an employer-initiated termination of employment for any of the following reasons after a final determination has been made. If, after service by the Department of a Notice of Intent to Deny or Revoke Certifications (NOI), the public safety professional or instructor provides notice to the Department within the time stated in the NOI that the discharge has not become final, then the Department may stay further action pending a final determination.

(i) Dishonesty: Includes untruthfulness, dishonesty by admission or omission, deception, misrepresentation, falsification; (Comment: Conduct underlying the mandatory disqualifying misdemeanors involving these elements in Subsection (D) and the Category I offenses in section (4), is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.)

(ii) Disregard for the Rights of Others: Includes violating the constitutional or civil rights of others, conduct demonstrating a disregard for the principles of fairness, respect for the rights of others, protecting vulnerable persons, and the fundamental duty to protect and serve the public. (Comment: Conduct underlying the Category II offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.)

(iii) Gross Misconduct: means an act or failure to act that creates a danger or risk to persons, property, or to the efficient operation of the agency, recognizable as a gross deviation from the standard of care that a reasonable public safety professional or instructor would observe in a similar circumstance; (Comment: Conduct underlying the Category IV offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction).

(iv) Incompetence: means a demonstrated lack of ability to perform the essential tasks of a public safety professional or instructor that remedial measures have been unable to correct.

(v) Misuse of Authority: Includes abuse of public trust, abuse of authority to obtain a benefit, avoid a detriment, or harm another, and abuse under the color of office. (Comment: Conduct underlying the Category III offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.)

(B) The public safety professional or instructor has been convicted in this state or any other jurisdiction of a crime designated under the law where the conviction occurred as being punishable as a felony or as a crime for which a maximum term of imprisonment of more than one year may be imposed;

(C) The public safety professional or instructor has been convicted of violating any law of this state or any other jurisdiction involving the unlawful use, possession, delivery or manufacture of a controlled substance, narcotic or dangerous drug except the Department may deny certification for a conviction of possession of less than one ounce of marijuana, which occurred prior to certification; or

(D) The public safety professional or instructor has been convicted in this state of any of the following offenses, or of their statutory counterpart(s) in any other jurisdiction, designated under the law where the conviction occurred as being punishable as a crime:

162.075 (False swearing),
162.085 (Unsworn falsification),
162.145 (Escape in the third degree),
162.175 (Unauthorized departure),
162.195 (Failure to appear in the second degree),
162.235 (Obstructing governmental or judicial administration),
162.247 (Interfering with a peace officer),
162.257 (Interfering with a firefighter or emergency medical technician),
162.295 (Tampering with physical evidence),
162.305 (Tampering with public records),
162.315 (Resisting arrest),
162.335 (Compounding),
162.365 (Criminal impersonation),
162.369 (Possession of false law enforcement identification),
162.375 (Initiating a false report),
162.385 (Giving false information to a peace officer for a citation or arrest warrant),
162.415 (Official misconduct in the first degree),
163.200 (Criminal mistreatment in the second degree),
163.454 (Custodial sexual misconduct in the second degree),
163.687 (Encouraging child sexual abuse in the third degree),
163.732 (Stalking),
164.045 (Theft in the second degree),
164.085 (Theft by deception),
164.095 (Theft by receiving),
164.125 (Theft of services),
164.235 (Possession of a burglary tool or theft device),
164.877 (Unlawful tree spiking; unlawful possession of substance that can damage certain wood processing equipment)

165.007 (Forgery in the second degree),
165.017 (Criminal possession of a forged instrument in the second degree),
165.037 (Criminal simulation),
165.042 (Fraudulently obtaining a signature),
165.047 (Unlawfully using slugs),
165.055 (Fraudulent use of a credit card),
165.065 (Negotiating a bad check),
165.080 (Falsifying business records),
165.095 (Misapplication of entrusted property),
165.100 (Issuing a false financial statement),
165.102 (Obtain execution of documents by deception),
165.825 (Sale of drugged horse),
166.065(1)(b) (Harassment),
166.155 (Intimidation in the second degree),
166.270 (Possession of weapons by certain felons),
166.350 (Unlawful possession of armor-piercing ammunition),
166.416 (Providing false information in connection with a transfer of a firearm),
166.418 (Improperly transferring a firearm),
166.470 (Limitations and conditions for sales of firearms),
167.007 (Prostitution),
Oregon Laws 2007, Chapter 869, Sec. 2 (Furnishing sexually explicit material to a child),
167.075 (Exhibiting an obscene performance to a minor),
167.080 (Displaying obscene materials to minors),
167.132 (Possession of gambling records in the second degree),
167.147 (Possession of a gambling device),
167.222 (Frequenting a place where controlled substances are used),
167.262 (Adult using minor in commission of controlled substance offense),
167.320 (Animal abuse in the first degree),
167.330 (Animal neglect in the first degree),
167.332 (Prohibition against possession of domestic animal),
167.333 (Sexual assault of animal),
167.337 (Interfering with law enforcement animal),
167.355 (Involvement in animal fighting),
167.370 (Participation in dogfighting),
167.431 (Participation in cockfighting),
167.820 (Concealing the birth of an infant),
475.525 (Sale of drug paraphernalia),
475.840 (Manufacture or deliver a controlled substance),
475.860 (Unlawful delivery of marijuana),
475.864 (Unlawful possession of marijuana),
475.906 (Distribution of controlled substance to minors),
475.910 (Application of controlled substance to the body of another person),
475.912 (Unlawful delivery of imitation controlled substance),
475.914 (Unlawful acts, registrant delivering or dispensing controlled substance),
475.916 (Prohibited acts involving records and fraud),
475.918 (Falsifying drug test results),
475.920 (Providing drug test falsification equipment),
475.950 (Failure to report precursor substances transaction),
475.955 (Failure to report missing precursor substances),
475.960 (Illegally selling drug equipment),
475.965 (Providing false information on precursor substances report or record),
475.969 (Unlawful possession of phosphorus),
475.971 (Unlawful possession of anhydrous ammonia),
475.973 (Unlawful possession of ephedrine, pseudoephedrine or phenylpropanolamine; unlawful distribution),
475.975 (Unlawful possession of iodine in its elemental form),
475.976 (Unlawful possession of iodine matrix),
807.520 (False swearing to receive license),
807.620 (Giving false information to police officer),
Any offense involving any acts of domestic violence as defined in ORS 135.230.

(b) The Department must take action on a mandatory disqualifying conviction, regardless of when it occurred, unless the Department, or the Board, has previously reviewed the conviction and approved the public safety professional or instructor for certification under a prior set of standards. Discretionary Disqualifying Misconduct as Grounds for Denying or Revoking Certification

(4) Discretionary disqualifying misconduct as Grounds for Denying or Revoking Certification(s) of a Public Safety Professional or Instructor:

(a) The Department may deny or revoke the certification of any public safety professional or instructor, after written notice, and a hearing, if requested, based upon a finding that:

(A) The public safety professional or instructor falsified any information submitted on the application for certification or on any documents submitted to the Board or Department;

(B) The public safety professional or instructor fails to meet the applicable minimum standards, minimum training or the terms and conditions established under ORS 181.640;

(C) The public safety professional or instructor has been convicted of an offense, listed in subsection (4), punishable as a crime, other than a mandatory disqualifying crime listed in section (3) of this rule, in this state or any other jurisdiction; or

(D) A public safety professional failed to attend at least one session with a mental health professional within six months after the public safety professional was involved in using deadly physical force, as required by ORS 181.789.

(b)For purposes of this rule, discretionary disqualifying misconduct includes misconduct falling within the following categories:

(A) Category I: Dishonesty: Includes untruthfulness, dishonesty by admission or omission, deception, misrepresentation, falsification; (Comment: Conduct underlying the mandatory disqualifying misdemeanors involving these elements in Subsection (D) and the Category I offenses in section (4), is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.)

(B) Category II: Disregard for the Rights of Others: Includes violating the constitutional or civil rights of others, and conduct demonstrating a disregard for the principles of fairness, respect for the rights of others, protecting vulnerable persons, and the fundamental duty to protect and serve the public. (Comment: Conduct underlying the Category II offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in criminal conviction.)

(C) Category III: Misuse of Authority: Includes abuse of public trust, obtaining a benefit, avoidance of detriment, or harming another, and abuses under the color of office. (Comment: Conduct underlying the Category III offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.)

(D) Category IV: Gross Misconduct: Means an act or failure to act that creates a danger or risk to persons, property, or to the efficient operation of the agency, recognizable as a gross deviation from the standard of care that a reasonable public safety professional or instructor would observe in a similar circumstance; (Comment: Conduct underlying the Category IV offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.)

(E) Category V: Misconduct: Misconduct includes conduct that violates the law, practices or standards generally followed in the Oregon public safety profession. NOTE: It is the intent of this rule that "Contempt of Court" meets the definition of Misconduct within this category; (Comment: Conduct underlying the Category V offenses identified in section (4) is illustrative of the types of conduct falling within this definition. However, misconduct need not have resulted in a criminal conviction.) or

(F) Category VI: Insubordination: Includes a refusal by a public safety professional or instructor to comply with a rule or order, where the order was reasonably related to the orderly, efficient, or safe operation of the agency, and where the public safety professional's or instructor's refusal to comply with the rule or order constitutes a substantial breach of that person's duties. (Note: There are no category VI crimes.)

(c) For discretionary disqualifying misconduct under (a) (A) or (B), the applicable category will be determined based on the facts of each case. For discretionary disqualifying misconduct under (a)(C), the following list identifies the applicable category for each discretionary offense:

162.405 (Official Misconduct in the Second Degree) – Category III,
162.425 (Misuse of Confidential Information) – Category III,
162.455 (Interfering with Legislative Operations) – Category V,
162.465 (Unlawful Legislative Lobbying) – Category I,
163.160 (Assault in the Fourth Degree) – Category II,
163.187 (Strangulation) – Category II,
163.190 (Menacing) – Category II,
163.195 (Recklessly Endangering Another Person) – Category IV,
163.212 (Unlawful Use of Stun Gun, Tear Gas or Mace in the Second Degree) – Category IV,
163.415 (Sexual Abuse in the Third Degree) – Category II,
163.435 (Contributing to the Sexual Delinquency of a Minor) – Category II,
163.445 (Sexual Misconduct) – Category II,
163.465 (Public Indecency) – Category II,
163.467 (Private Indecency) – Category II,
163.545 (Child Neglect in the Second Degree) – Category IV,
163.693 (Failure to Report Child Pornography) – Category IV,
163.575 (Endangering the Welfare of a Minor) – Category III,
163.700 (Invasion of Personal Privacy) – Category II,
163.709 (Unlawful Directing of Light from a Laser Pointer) – Category IV,
164.043 (Theft in the Third Degree) – Category V,
164.132 (Unlawful Distribution of Cable Equipment) – Category V,
164.140 (Criminal Possession of Rented or Leased Personal Property) – Category V,
164.162 (Mail Theft or Receipt of Stolen Mail) – Category I,
164.243 (Criminal Trespass in the Second Degree by a Guest) – Category V,
164.245 (Criminal Trespass in the Second Degree) – Category V,
164.255 (Criminal Trespass in the First Degree) – Category V,
164.265 (Criminal Trespass While in Possession of a Firearm) – Category IV,
164.272 (Unlawful Entry into a Motor Vehicle) – Category V,
164.278 (Criminal Trespass at Sports Event) – Category V,
164.335 (Reckless Burning) – Category IV,
164.345 (Criminal Mischief in the Third Degree) – Category V,
164.354 (Criminal Mischief in the Second Degree) – Category V,
164.373 (Tampering with Cable Television Equipment) – Category V,
164.377 (Computer Crime) – Category V,
164.775 (Deposit of Trash Within 100 Yards of Water) – Category V,
164.785 (Placing Offensive Substances in waters/on highways or property) – Category IV,

164.805 (Offensive Littering) – Category V,
164.813 (Unlawful Cutting and Transporting of Special Forest Products) – Category V,
164.815 (Unlawful Transport of Hay) – Category V,
164.825 (Cutting and Transport of Coniferous Trees without Permit/Bill of Sale) – Category V,
164.845 (FTA on Summons for ORS 164.813 or 164.825) – Category V,
164.863 (Unlawful Transport of Meat Animal Carcasses) – Category V,
164.865 (Unlawful Sound Recording) – Category V,
164.875 (Unlawful Video Tape Recording) – Category V,
164.887 (Interference with Agricultural Operations) – Category II,
165.107 (Failing to Maintain a Metal Purchase Record) – Category V,
165.109 (Failing to Maintain a Cedar Purchase Record) – Category V,
165.540 (Obtaining Contents of Communications) – Category V,
165.555 (Unlawful Telephone Solicitation) – Category V,
165.570 (Improper Use of Emergency Reporting System) – Category IV,
165.572 (Interference with Making a Report) – Category II,
165.577 (Cellular Counterfeiting in the Third Degree) – Category I,
165.805 (Misrepresentation of Age by a Minor) – Category I,
166.025 (Disorderly Conduct in the Second Degree) – Category IV,
166.027 (Disorderly Conduct in the First Degree) – Category IV,
166.075 (Abuse of Venerated Objects) – Category II,
166.076 (Abuse of a Memorial to the Dead) – Category II,
166.090 (Telephonic Harassment) – Category II,
166.095 (Misconduct with Emergency Telephone Calls) – Category IV,
166.155 (Intimidation in the Second Degree) – Category II,
166.180 (Negligently Wounding Another) – Category IV,
166.190 (Pointing a Firearm at Another) – Category IV,
166.240 (Carrying a Concealed Weapon) – Category V,
166.250 (Unlawful Possession of a Firearm) – Category V,
166.320 (Setting of a Springgun or Setgun) – Category IV,
166.385 (Possession of Hoax Destructive Device) – Category IV,
166.425 (Unlawful Purchase of Firearm) – Category I,
166.427 (Register of Transfers of Used Firearms) – Category V,
166.480 (Sale or Gift of Explosives to Children) – Category IV,
166.635 (Discharging Weapon or Throwing Object at Trains) – Category IV,
166.638 (Discharging Weapon Across Airport Operational Surfaces) – Category IV,
166.645 (Hunting in Cemeteries) – Category V,
166.649 (Throwing Object off Overpass in the Second Degree) – Category IV,
167.122 (Unlawful Gambling in the Second Degree) – Category V,
167.312 (Research and Animal Interference) – Category II,
167.315 (Animal Abuse in the Second Degree) – Category IV,
167.325 (Animal Neglect in the Second Degree) – Category IV,
167.340 (Animal Abandonment) – Category IV,
167.351 (Trading in Nonambulatory Livestock) – Category V,
167.352 (Interfering with Assistance, Search and Rescue or Therapy Animal) – Category IV,
167.385 (Unauthorized Use of Livestock Animal) – Category II,
167.388 (Interference with Livestock Production) – Category II,
167.390 (Commerce in Fur of Domestic Cats and Dogs) – Category V,
167.502 (Sale of Certain Items at Unused Property Market) – Category V,
167.506 (Record Keeping Requirements) – Category V,
167.808 (Unlawful Possession of Inhalants) – Category IV,
167.810 (Creating a Hazard) – Category IV,
167.822 (Improper Repair Vehicle Inflatable Restraint System) – Category IV,
411.320 (Disclosure and Use of Public Assistance Records) – Category II,
468.922 (Unlawful disposal, storage or treatment of hazardous waste in the second degree) – Category V,
468.929 (Unlawful transport of hazardous waste in the second degree) – Category V,
468.936 (Unlawful Air Pollution in the Second Degree) – Category V,
468.943 (Unlawful Water Pollution in the Second Degree) – Category V,
468.956 (Refusal to Produce Material Subpoenaed by the Commission) – Category V,
471.410 (Providing Liquor to Person under 21 or to Intoxicated Person) – Category IV,
496.994 (Obstruction to the Taking of Wildlife) – Category V,
496.996 (Attempt to Take Wildlife Decoy) – Category V,
498.164 (Use of Dogs or Bait to hunt Black Bears or Cougars) – Category V,
717.200 to 717.320 (Any violation) – Category V,
803.225 (Failure to Designate Replica..Vehicle in Title or Registration Application) – Category I,
807.430 (Misuse of Identification Card) – Category I,
807.510 (Transfer of documents for the purpose of misrepresentation) – Category I,
807.530 (False Application for License) – Category I,
807.570 (Failure to Carry or Present License) – Category V,
807.580 (Using Invalid License) – Category I,
807.590 (Permitting Misuse of License) – Category I,
807.600 (Using Another's License) – Category I,
811.060 (Vehicular Assault of Bicyclist or Pedestrian) – Category V,
811.140 (Reckless Driving) – Category IV,
811.172 (Improperly Disposing of Human Waste) – Category V,
811.182 (Criminal Driving While Suspended or Revoked) – Category V,
811.231 (Reckless Endangerment of Highway Workers) – Category IV,
811.540 (Fleeing or Attempt to Elude a Police Officer) – Category IV,
811.700 (Failure to Perform Duties of Driver when Property is Damaged) – Category V, 811.740 (False Accident Report) – Category I, and
813.010 (Driving Under the Influence of Intoxicants) – Category IV.
Initial Periods of Ineligibility

(d) Upon determination to proceed with the denial or revocation of a public safety professional's or instructor's certification based on discretionary disqualifying misconduct identified in subsection (a), an initial minimum period of ineligibility to apply for certification will be determined based upon the category of misconduct (i.e., Dishonesty, Disregard for Rights of Others, Misuse of Authority, Gross Misconduct, Misconduct or Insubordination).

(e) Following review and recommendation by a Policy Committee, the Board will determine the initial minimum period of ineligibility for discretionary disqualifying misconduct identified in subsection (a) from the time frame identified below for each category of discretionary disqualifying misconduct:

(A) Category I: Dishonesty (5 years to Lifetime).

(B) Category II: Disregard for Rights of Others (5 years to 15 years).

(C) Category III: Misuse of Authority (5 years to 10 years).

(D) Category IV: Gross Misconduct (5 years to 10 years).

(E) Category V: Misconduct (3 years to 7 years).

(F) Category VI: Insubordination (3 years to 7 years). Eligibility to Reapply; Ineligibility Periods

(5) A person is not eligible to reapply for training or certification if the person had training or certification denied or revoked for:

(a) Mandatory grounds identified in section (3) of this rule; or

(b) Discretionary Disqualifying Misconduct identified in section (4) of this rule that is determined to be a Category I lifetime disqualifier.

(6) Eligibility to reapply for certification:

(a) In determining the initial minimum period of ineligibility within any category for discretionary disqualifying misconduct listed in section (4) of this rule, the Board will take into consideration any mitigating or aggravating factors, subject to the provisions of section (9) of this rule.

(b) The initial minimum period of ineligibility will be included in any Final Order of the Department.

(c) Any subsequent eligibility to apply for certification will be determined by the Board, after Policy Committee review, subject to the provisions of section (11) of this rule. Guidelines for Denial or Revocation Based on Discretionary Disqualifying Misconduct

(7) In determining whether to take action on a conviction, the Department must use the following guidelines:

(a) In making a decision on a discretionary denial or revocation, the Department will consider the implementation dates relating to new mandatory conviction notification requirements adopted in 2003 and statutory changes dealing with lifetime disqualifier convictions for public safety officers adopted in 2001.

(b) The Department will not take action on a conviction constituting discretionary disqualifying misconduct that occurred prior to January 1, 2001. However, the Department may consider such conviction as evidence that a public safety professional or instructor does not meet the established moral fitness guidelines.

(c) The Department may take action on any conviction constituting discretionary disqualifying misconduct that occurred after January 1, 2001.

(d) The Board may reconsider any mandatory conviction which subsequently becomes a conviction constituting discretionary disqualifying misconduct, upon the request of the public safety professional or instructor.

(e) The length of ineligibility for training or certification based on a conviction begins on the date of conviction.

(f) The Department will not take action against a public safety professional, instructor, or agency for failing to report, prior to January 1, 2003, a conviction that constitutes discretionary disqualifying misconduct.

(g) The Department may take action against a public safety professional, instructor, or agency for failing to report, after January 1, 2003, any conviction that constitutes discretionary disqualifying misconduct. Procedure for Denial or Revocation of a Certificate

(8) Scope of Revocation. Whenever the Department revokes the certification of any public safety professional or instructor under the provisions of OAR 259-008-0070, the revocation will encompass all public safety certificates, except fire certification(s), the Department has issued to that person.

(9) Denial and Revocation Procedure.

(a) Agency Initiated Review: When the entity utilizing a public safety professional or instructor requests that a public safety professional's or instructor's certification be denied or revoked, it must submit in writing to the Department the reason for the requested denial or revocation and all factual information supporting the request.

(b) Department Initiated Review: Upon receipt of factual information from any source, and pursuant to ORS 181.662, the Department may request that the public safety professional's or instructor's certification be denied or revoked.

(c) Department Staff Review: When the Department receives information, from any source, that a public safety professional or instructor may not meet the established standards for Oregon public safety professionals or instructors, the Department will review the request and the supporting factual information to determine if the request for denial or revocation meets statutory and administrative rule requirements.

(A) If the reason for the request does not meet the statutory and administrative rule requirements for denial or revocation the Department will notify the requestor.

(B) If the reason for the request does meet statutory and administrative rule requirements but is not supported by adequate factual information, the Department will request further information from the employer or conduct its own investigation of the matter.

(C) If the Department determines that a public safety professional or instructor may have engaged in discretionary disqualifying misconduct listed in subsection (4), the case may be presented to the Board, through a Policy Committee.

(D) The Department will seek input from the affected public safety professional or instructor, allowing him or her to provide, in writing, information for the Policy Committee and Board's review.

(E) In misconduct cases in which there has been an arbitrator's opinion related to the public safety professional's or instructor's employment, the Department will proceed as follows:

(i) If the arbitrator's opinion finds that underlying facts supported the allegations of misconduct, the department will proceed as identified in paragraphs (A) through (D) of this subsection.

(ii) If the arbitrator has ordered employment reinstatement after a discharge for cause without a finding related to whether the misconduct occurred, the Department will proceed as identified in paragraphs (A) through (D) of this subsection.

(iii) If the arbitrator's opinion finds that underlying facts did not support the allegation(s) of misconduct, the Department will proceed as identified in paragraph (A) of this subsection and administratively close the matter.

(d) Policy Committee and Board Review: In making a decision to authorize initiation of proceedings under subsection (e) of this rule, based on discretionary disqualifying misconduct, the Policy Committees and Board will consider mitigating and aggravating circumstances, including, but not limited to, the following:

(A) When the misconduct occurred in relation to the public safety professional's or instructor's employment in public safety (i.e., before, during after);

(B) If the misconduct resulted in a conviction:

(i) Whether it was a misdemeanor or violation;

(ii) The date of the conviction(s);

(iii) Whether the public safety professional or instructor was a minor at the time and tried as an adult;

(iv) Whether the public safety professional or instructor served time in prison/jail and, if so, the length of incarceration;

(v) Whether restitution was ordered, and whether the public safety professional or instructor met all obligations;

(vi) Whether the public safety professional or instructor has ever been on parole or probation. If so, the date on which the parole/probation period expired or is set to expire;

(vii) Whether the public safety professional or instructor has more than one conviction and if so, over what period of time;

(C) Whether the public safety professional or instructor has engaged in the same misconduct more than once, and if so, over what period of time;

(D) Whether the actions of the public safety professional or instructor reflect adversely on the profession, or would cause a reasonable person to have substantial doubts about the public safety professional's or instructor's honesty, fairness, respect for the rights of others, or for the laws of the state or the nation;

(E) Whether the misconduct involved domestic violence;

(F) Whether the public safety professional or instructor self reported the misconduct;

(G) Whether the conduct adversely reflects on the fitness of the public safety professional or instructor to perform as a public safety professional or instructor;

(H) Whether the conduct renders the public safety professional or instructor otherwise unfit to perform their duties because the agency or public has lost confidence in the public safety professional or instructor;

(I) What the public safety professional's or instructor's physical or emotional condition was at the time of the conduct.

(e) Initiation of Proceedings: Upon determination that the reason for denial or revocation is supported by factual data meeting the statutory and administrative rule requirements, a contested case notice will be prepared.

(f) Contested Case Notice: The "Contested Case Notice" will be prepared in accordance with OAR 137-003-0001 of the Attorney General's Model Rules of Procedure adopted under OAR 259-005-0015. The Department will have a copy of the notice served on the public safety professional or instructor.

(g) Response Time:

(A) A party who has been served with a "Contested Case Notice of Intent to Deny Certification" has 60 days from the date of mailing or personal service of the notice in which to file with the Department a written request for a hearing.

(B) A party who has been served with the "Contested Case Notice of Intent to Revoke Certification" has 20 days from the date of mailing or personal service of the notice in which to file with the Department a written request for hearing.

(h) Default Order: If a timely request for a hearing is not received, the Contested Case Notice will become a final order denying or revoking certification pursuant to OAR 137-003-0645.

(i) Hearing Request: When a request for a hearing is received in a timely manner, the Department will refer the matter to the Office of Administrative Hearings in accordance with OAR 137-003-0515.

(j) Proposed Order: The assigned Administrative Law Judge will prepare Findings of Fact, Conclusions of Law and Proposed Final Order and serve a copy on the Department and on each party.

(k) Exceptions and Arguments: A party must file specific written exceptions and arguments with the Department no later than 14 days from date of service of the Findings of Fact, Conclusions of Law, and Proposed Final Order.

(A) The Department may extend the time within which the exceptions and arguments must be filed upon a showing of good cause.

(B) When the exceptions and arguments are filed, the party making the exceptions and arguments must serve a copy on all parties of record in the case and provide the Department with proof of service. A failure to serve copies and provide proof of service will invalidate the filing of exceptions and arguments as being untimely, and the Department may disregard the filing in making a final determination of the case.

(l) Final Order: A final order will be issued pursuant to OAR 137-003-0070 if a public safety professional or instructor fails to file exceptions and arguments in a timely manner.

(m) Stipulated Order Revoking Certification: The Department may enter a stipulated order revoking the certification of a public safety professional or instructor upon the person's voluntary agreement to terminate an administrative proceeding to revoke a certification, or to relinquish a certification, under the terms and conditions outlined in the stipulated order. Appeals, Reapplication, and Eligibility Determinations

(10) Appeal Procedure. A public safety professional or instructor, aggrieved by the findings and Order of the Department may, as provided in ORS 183.480, file an appeal with the Court of Appeals from the final Order of the Department.

(11) Reapplication Process.

(a) Any public safety professional or instructor whose certification has been denied or revoked pursuant to section (4) of this rule, may reapply for certification within the applicable timeframes described in sections (4) through (6) of this rule. The initial minimum ineligibility period will begin on the date an Order of the Department denying or revoking certification becomes final. The initial minimum ineligibility period will cease when the applicable timeframe stated in the Order has been satisfied.

(b) Any public safety professional or instructor whose certification has been denied or revoked based on discretionary disqualifying misconduct may not reapply for certification until:

(A) The initial minimum period of ineligibility stated in an Order of the Department denying or revoking certification has been satisfied;

(i) If the initial period of ineligibility for the individual was for a period of less than the maximum period identified in section (4) of this rule, and the Board determines that an individual must remain ineligible to apply for certification, then the individual may not reapply for certification under the provisions of this rule until after the maximum initial period of ineligibility identified in (4) of this rule has been satisfied.

(ii) If the individual has satisfied the maximum initial period of ineligibility and the Board determines that an individual must remain ineligible to apply for certification, then the individual may not submit any further requests for an eligibility determination, and the original denial or revocation remains permanent.

(B) A written request for an eligibility determination has been submitted to the Department and a Policy Committee has recommended that a public safety professional's or instructor's eligibility to apply for public safety or instructor certification be restored and the Board has upheld the recommendation;

(i) A request for an eligibility determination should include documentation or information that supports the public safety professional's or instructor's request for eligibility to apply for certification.

(ii) In considering a request for an eligibility determination, the Policy Committee and the Board may consider mitigating and aggravating circumstances identified in Section 9(d) of this rule.

(iii) After reviewing a written request for an eligibility determination, the Board, through a Policy Committee, may determine that the individual's eligibility to apply for certification be restored if the criteria for certification have been met; or determine that the factors that originally resulted in denial or revocation have not been satisfactorily mitigated and the individual must remain ineligible to apply for certification.

(C) The public safety professional or instructor is employed or utilized by a public safety agency; and

(D) All requirements for certification have been met.

Stat. Auth.: ORS 181.640, 181.661, 181.662, 181.664 & 183.341
Stats. Implemented: ORS 181.640, 181.661, 181.662 & 181.664
Hist.: PS 12, f. & ef. 12-19-77; PS 1-1979, f. 10-1-79, ef. 10-3-79; PS 1-1980(Temp), f. & ef. 6-26-80; PS 2-1980, f. & ef. 12-8-80; PS 1-1981, f. 9-26-81, ef. 11-2-81; PS 1-1983, f. & ef. 12-15-83; PS 1-1985, f. & ef. 4-24-85; Renumbered from 259-010-0055, PS 1-1990, f. & cert. ef. 2-7-90; PS 2-1995, f. & cert. ef. 9-27-95; PS 2-1996, f. 5-15-96, cert. ef. 5-20-96; PS 10-1997(Temp), f. & cert. ef. 11-5-97; BPSST 1-1998, f. & cert. ef. 5-6-98; BPSST 2-1998(Temp), f. & cert. ef. 5-6-98 thru 6-30-98; BPSST 3-1998, f. & cert. ef. 6-30-98; BPSST 6-2000, f. & cert. ef. 9-29-00; BPSST 14-2001(Temp), f. & cert. ef. 10-26-01 thru 4-5-02; BPSST 5-2002(Temp) f. 4-3-02, cert. ef. 4-6-02 thru 8-1-02; BPSST 16-2002, f. & cert. ef. 7-5-02; BPSST 22-2002, f. & cert. ef. 11-18-02; DPSST 7-2003, f. & cert. ef. 4-11-03; DPSST 7-2004, f. & cert. ef. 4-23-04; DPSST 10-2006, f. & cert. ef. 7-6-06; DPSST 16-2008, f. & cert. ef. 10-15-08; DPSST 21-2008, f. 12-15-08, cert. ef. 1-1-09

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Department of State Lands
Chapter 141

Rule Caption: To adopt current Model Rules, update language concerning notification and correct ORS and ORS references.
Adm. Order No.: DSL 6-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 12-10-08
Notice Publication Date: 9-1-2008
Rules Amended: 141-001-0000, 141-001-0005, 141-001-0010, 141-001-0020
Subject: The Department of State Lands is revising these general administrative rules to be consistent with the current Model Rules adopted by the Attorney General as provided in ORS 83.341(1). In addition, the Department is updating the rules concerning notification as directed by ORS 183.341(4), which requires an agency to "provide a reasonable opportunity for interested persons to be notified of the agency's intention to adopt, amend, or repeal a rule." The Department is also correcting ORS and OAR references.
Rules Coordinator: Elizabeth Martino—(503) 986-5239

141-001-0000
Notice of Proposed Rule

The purpose of this rule is to provide a reasonable opportunity for interested persons to be notified of the proposed actions of the State Land Board and/or the Department of State Lands. Prior to the adoption, amendment, or repeal of any rule, the State Land Board and/or the Department of State Lands will give notice of the proposed adoption, amendment, or repeal:

(1) In the Secretary of State's Bulletin referred to in ORS 183.360 at least 21 days prior to the effective date;

(2) By e-mailing or mailing a copy of the notice to persons on the State Land Board's and/or Department of State Lands' mailing list established pursuant to ORS 183.335(8) at least 28 days prior to effective date;

(3) By mailing a copy of the notice to persons referred to in ORS 183.335(15) at least 49 days before the effective date;

(4) By mailing or e-mailing a copy of the notice to The Associated Press and to any interested parties identified as being specifically effected by the rulemaking, including cities, counties, other government agencies, organizations or business associations.

Stat. Auth.: ORS 183
Stats. Implemented: ORS 183.341 & 273.045
Hist.: LB 32, f. & ef. 11-18-75; DSL 3-2005(Temp), f. 5-18-05, cert. ef. 5-19-05 thru 11-15-05; DSL 4-2005, f. 11-3-05, cert. ef. 11-15-05; DSL 6-2008, f. & cert. ef. 12-10-08

141-001-0005
Model Rules of Procedure

Pursuant to ORS 183.341, the Department of State Lands and the State Land Board adopt the Attorney General's Model Rules of Procedure under the Administrative Procedures Act as amended January 1, 2008.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the office of the Attorney General or Department of State Lands.]
Stat. Auth.: ORS 183.413 - 183.470
Stats. Implemented: ORS 273
Hist.: LB 10, f. 11-15-71, ef. 12-1-71; LB 13, f. 1-21-74, ef. 2-11-74; LB 35, f. & ef. 1-6-76; LB 2-1978, f. & ef. 4-20-78; LB 1-1980, f. & ef. 2-20-80; LB 1-1982, f. & ef. 2-25-82; LB 4-1983, f. & ef. 12-23-83; LB 4-1989, f. & cert. ef. 7-25-89; LB 2-1992, f. & cert. ef. 6-15-92; LB 1-1994, f. & cert. ef. 4-13-94; DSL 7-1998, f. & cert. ef. 7-15-98; DSL 3-2002, f. & cert. ef. 4-24-02; DSL 3-2005(Temp), f. 5-18-05, cert. ef. 5-19-05 thru 11-15-05; DSL 4-2005, f. 11-3-05, cert. ef. 11-15-05; DSL 6-2008, &. cert. ef. 12-10-08

141-001-0010
Contested Case Hearings

Procedures for contested case hearings for the Department of State Lands are provided in the Model Rules of Procedure, OAR 137-003-0501 to 137-003-0700 by the Office of Administrative Hearings. The rules in this Division (001) are subject to the approval of the Attorney General and are intended to supplement the Model Rules of Procedure providing additional guidance for conduct of contested case hearings. An officer or employee of the Department is authorized to appear on behalf of the agency with the following restrictions in hearings conducted before another agency:

(1) The agency representative may not make legal argument on behalf of the agency.

(2) Legal argument as used in ORS 183.452(3) and this rule has the same meaning as in OAR 137-003-0008(1)(c) and (d).

(3) When an agency officer or employee represents the agency, the presiding officer will advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer will provide reasonable opportunity for the agency officer or employee to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after conclusion of the hearing.

Stat. Auth.: ORS 183.413 - 183.470
Stats. Implemented: ORS 183.341 & 273.045
Hist.: LB 1-1995, f. & cert. ef. 2-15-95; DSL 6-2008, f. & cert. ef. 12-10-08

141-001-0020
Confidentiality and Inadmissibility of Mediation Communications

(1) The words and phrases used in this rule have the same meaning as given to them in ORS 36.110 and 36.234.

(2) Nothing in this rule affects any confidentiality created by other law. Nothing in this rule relieves a public body from complying with the Public Meetings Law, ORS 192.610 to 192.690. Whether or not they are confidential under this or other rules of the agency, mediation communications are exempt from disclosure under the Public Records Law to the extent provided in ORS 192.410 to 192.505.

(3) This rule applies only to mediations in which the agency is a party or is mediating a dispute as to which the agency has authority. This rule does not apply when the agency is acting as the "mediator" in a matter in which the agency also is a party as defined in ORS 36.234.

(4) To the extent mediation communications would otherwise compromise negotiations under ORS 40.190 (OEC Rule 408), those mediation communications are not admissible as provided in ORS 40.190 (OEC Rule 408), notwithstanding any provisions to the contrary in section (9) of this rule.

(5) Mediations Excluded. Sections (6)-(10) of this rule do not apply to:

(a) Mediation of workplace interpersonal disputes involving the interpersonal relationships between this agency's employees, officials or employees and officials, unless a formal grievance under a labor contract, a tort claim notice or a lawsuit has been filed; or

(b) Mediation in which the person acting as the mediator will also act as the hearings officer in a contested case involving some or all of the same matters;

(c) Mediation in which the only parties are public bodies;

(d) Mediation involving two or more public bodies and a private party if the laws, rule or policies governing mediation confidentiality for at least one of the public bodies provide that mediation communications in the mediation are not confidential; or

(e) Mediation involving 15 or more parties if the agency has designated that another mediation confidentiality rule adopted by the agency may apply to that mediation.

(6) Disclosures by Mediator. A mediator may not disclose or be compelled to disclose mediation communications in a mediation and, if disclosed, such communications may not be introduced into evidence in any subsequent administrative, judicial or arbitration proceeding unless:

(a) all the parties to the mediation and the mediator agree in writing to the disclosure; or

(b) the mediation communication may be disclosed or introduced into evidence in a subsequent proceeding as provided in subsections (c)-(d), (j)-(l) or (o)-(p) of section (9) of this rule.

(7) Confidentiality and Inadmissibility of Mediation Communications. Except as provided in sections (8)-(9) of this rule, mediation communications are confidential and may not be disclosed to any other person, are not admissible in any subsequent administrative, judicial or arbitration proceeding and may not be disclosed during testimony in, or during any discovery conducted as part of a subsequent proceeding, or introduced as evidence by the parties or the mediator in any subsequent proceeding.

(8) Written Agreement. Section (7) of this rule does not apply to a mediation unless the parties to the mediation agree in writing, as provided in this section, that the mediation communications in the mediation will be confidential and/or nondiscoverable and inadmissible. If the mediator is the employee of and acting on behalf of a state agency, the mediator or an authorized agency representative must also sign the agreement. The parties' agreement to participate in a confidential mediation must substantially be in the following form. This form may be used separately or incorporated into an "agreement to mediate."

Agreement to Participate in a Confidential Mediation

The agency and the parties to the mediation agree to participate in a mediation in which the mediation communications are confidential and/or nondiscoverable and inadmissible to the extent authorized by OAR 141-001-0020(7) and this agreement. This agreement relates to the following mediation:

(a) _____

(Identify the mediation to which this agreement applies)

b) To the extent authorized by OAR 141-001-0020(7), mediation communications in this mediation are: (check one or more)

___ confidential and may not be disclosed to any other person

___ not admissible in any subsequent administrative proceeding and may not be disclosed during testimony in, or during any discovery conducted as part of a subsequent administrative proceeding, or introduced as evidence by the parties or the mediator in any subsequent administrative proceeding

___ not admissible in any subsequent administrative, judicial or arbitration proceeding and may not be disclosed during testimony in, or during any discovery conducted as part of a subsequent administrative, judicial or arbitration proceeding, or introduced as evidence by the parties or the mediator in any subsequent administrative, judicial or arbitration proceeding

(c) _____

Name of Agency

_____ Date _____

Signature of Agency's authorized representative (when agency is a party) or Agency employee acting as the mediator (when Agency is mediating the dispute)

(d) _____

Name of party to the mediation

_____ Date _____

Signature of party's authorized representative

(e) _____

Name of party to the mediation

_____ Date _____

Signature of party's authorized representative

(9) Exceptions to confidentiality and inadmissibility.

(a) Any statements, memoranda, work products, documents and other materials, otherwise subject to discovery that were not prepared specifically for use in the mediation are not confidential and may be disclosed or introduced into evidence in a subsequent proceeding.

(b) Any mediation communications that are public records, as defined in ORS 192.410(4), and were not specifically prepared for use in the mediation are not confidential and may be disclosed or introduced into evidence in a subsequent proceeding unless the substance of the communication is confidential or privileged under state or federal law.

(c) A mediation communication is not confidential and may be disclosed by any person receiving the communication to the extent that person reasonably believes that disclosing the communication is necessary to prevent the commission of a crime that is likely to result in death or bodily injury to any person. A mediation communication is not confidential and may be disclosed in a subsequent proceeding to the extent its disclosure may further the investigation or prosecution of a felony crime involving physical violence to a person.

(d) Any mediation communication related to the conduct of a licensed professional that is made to or in the presence of a person who, as a condition of his or her professional license, is obligated to report such communication by law or court rule is not confidential and may be disclosed to the extent necessary to make such a report.

(e) The parties to the mediation may agree in writing that all or part of the mediation communications are not confidential or that all or part of the mediation communications may be disclosed and may be introduced into evidence in a subsequent proceeding unless the substance of the communication is confidential, privileged or otherwise prohibited from disclosure under state or federal law.

(f) A party to the mediation may disclose confidential mediation communications to a person if the party's communication with that person is privileged under ORS Chapter 40 or other provision of law. A party to the mediation may disclose confidential mediation communications to a person for the purpose of obtaining advice concerning the subject matter of the mediation, if all the parties agree.

(g) An employee of the agency may disclose confidential mediation communications to another agency employee so long as the disclosure is necessary to conduct authorized activities of the agency. An employee receiving a confidential mediation communication under this subsection is bound by the same confidentiality requirements as apply to the parties to the mediation.

(h) A written mediation communication may be disclosed or introduced as evidence in a subsequent proceeding at the discretion of the party who prepared the communication so long as the communication is not otherwise confidential under state or federal law and does not contain confidential information from the mediator or another party who does not agree to the disclosure.

(i) In any proceeding to enforce, modify or set aside a mediation agreement, a party to the mediation may disclose mediation communications and such communications may be introduced as evidence to the extent necessary to prosecute or defend the matter. At the request of a party, the court may seal any part of the record of the proceeding to prevent further disclosure of mediation communications or agreements to persons other than the parties to the agreement.

(j) In an action for damages or other relief between a party to the mediation and a mediator or mediation program, mediation communications are not confidential and may be disclosed and may be introduced as evidence to the extent necessary to prosecute or defend the matter. At the request of a party, the court may seal any part of the record of the proceeding to prevent further disclosure of the mediation communications or agreements.

(k) When a mediation is conducted as part of the negotiation of a collective bargaining agreement, the following mediation communications are not confidential and such communications may be introduced into evidence in a subsequent administrative, judicial or arbitration proceeding:

(A) a request for mediation; or

(B) a communication from the Employment Relations Board Conciliation Service establishing the time and place of mediation; or

(C) a final offer submitted by the parties to the mediator pursuant to ORS 243.712; or

(D) a strike notice submitted to the Employment Relations Board.

(l) To the extent a mediation communication contains information the substance of which is required to be disclosed by Oregon statute, other than ORS 192.410 to 192.505, that portion of the communication may be disclosed as required by statute.

(m) Written mediation communications prepared by or for the agency or its attorney are not confidential and may be disclosed and may be introduced as evidence in any subsequent administrative, judicial or arbitration proceeding to the extent the communication does not contain confidential information from the mediator or another party, except for those written mediation communications that are:

(A) Attorney-client privileged communications so long as they have been disclosed to no one other than the mediator in the course of the mediation or to persons as to whom disclosure of the communication would not waive the privilege; or

(B) Attorney work product prepared in anticipation of litigation or for trial; or

(C) Prepared exclusively for the mediator or in a caucus session and not given to another party in the mediation other than a state agency; or

(D) Prepared in response to the written request of the mediator for specific documents or information and given to another party in the mediation; or

(E) Settlement concepts or proposals, shared with the mediator or other parties.

(n) A mediation communication made to the agency may be disclosed and may be admitted into evidence to the extent the Agency director determines that disclosure of the communication is necessary to prevent or mit-

igate a serious danger to the public's health or safety, and the communication is not otherwise confidential or privileged under state or federal law.

(o) The terms of any mediation agreement are not confidential and may be introduced as evidence in a subsequent proceeding, except to the extent the terms of the agreement are exempt from disclosure under ORS 192.410 to 192.505, a court has ordered the terms to be confidential under ORS 17.095 or state or federal law requires the terms to be confidential.

(p) The mediator may report the disposition of a mediation to the agency at the conclusion of the mediation so long as the report does not disclose specific confidential mediation communications. The agency or the mediator may use or disclose confidential mediation communications for research, training or educational purposes, subject to the provisions of ORS 36.232(4).

(10) When a mediation is subject to section (7) of this rule, the agency will provide to all parties to the mediation and the mediator a copy of this rule or a citation to the rule and an explanation of where a copy of the rule may be obtained. Violation of this provision does not waive confidentiality or inadmissibility.

Stat. Auth.: ORS 36.224
Stats. Implemented: ORS 36.224, 36.228, 36.230 & 36.232
Hist.: DSL 3-2005(Temp), f. 5-18-05, cert. ef. 5-19-05 thru 11-15-05; DSL 4-2005, f. 11-3-05, cert. ef. 11-15-05; DSL 6-2008, f. & cert. ef. 12-10-08

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Rule Caption: Updating to reflect technological changes in recordkeeping, information security and business claims criteria.
Adm. Order No.: DSL 7-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 9-1-2008
Rules Adopted: 141-040-0213
Rules Amended: 141-040-0020, 141-040-0030, 141-040-0211, 141-040-0212, 141-040-0214
Rules Repealed: 141-040-0035, 141-040-0040
Subject: OARs 141-050-0005 through 0220 establish a uniform procedures for responding to requests for information about unclaimed and escheat property reported or remitted to the Department of State Lands and to establish fees that the Department may charge in doing so. The Department is updating these rules to reflect current technological changes regarding recordkeeping of records available for review and to safeguard the personal and confidential information of owners of unclaimed property in the Department's custody according to current federal and state mandates. In addition, the Department is updating the criteria for business claims.
Rules Coordinator: Elizabeth Martino—(503) 986-5239

141-040-0020
Definitions

As used in OAR 141-040-0010 to 141-040-0220:

(1) "Agent" means a person who is filing a claim to recover unclaimed property on behalf of a claimant.

(2) "Claimant" means a person or entity claiming to be the rightful owner, or a person claiming to be legally authorized to act on behalf of a person or entity claiming to be the rightful owner, and claiming to be legally entitled to unclaimed property held by the Department.

(3) "Department" means the Department of State Lands.

(4) "Entity" includes a domestic or foreign limited liability company, corporation, professional corporation, foreign corporation, domestic or foreign nonprofit corporation, domestic or foreign cooperative corporation, profit or nonprofit unincorporated association, business trust, domestic or foreign general or limited partnership, or trust.

(5) "Escheat property" means:

(a) Property paid or delivered to the Department because the distributee, devisee, or heir could not be found, or refused to accept the property;

(b) Funds paid or delivered to the State of Oregon prior to October 4, 1997 according to ORS 179.540 from state a state institution where an inmate or patient has been released, paroled, escaped, or died, and one year after such occurrence, the inmate or patient has not claimed funds left behind.

(6) "Finder" means any person who independently searches for and finds the owners of unclaimed or escheat property for a fee paid by the owner.

(7) "Finder's Report of Unclaimed or Escheat Property" means a report that lists the names of owners of unclaimed or escheat property in the custody of the Department, and may include additional information that would assist in finding the owners.

(8) "Governmental Entity" means the federal government, the state, any agency or political subdivision of the state or federal government, or any unit of local government.

(9) "Holder" means a person, wherever organized or domiciled, who is in possession of property belonging to another, a trustee or indebted to another on an obligation.

(10) "Owner" means a depositor in case of a deposit, a beneficiary in case of a trust other than a deposit in trust, a creditor, claimant, or payee in case of other intangible property, or a person, or the person's legal representative, having a legal or equitable interest in property.

(11) "Unclaimed Property" means any asset that is paid or delivered to the Department pursuant to ORS 98.352 because the owner cannot be found by the company or person holding the asset.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 2-1989, f. 5-19-89, cert. ef. 6-1-89; LB 2-1995, f. & cert. ef. 6-15-95; DSL 12-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 7-2008, f. 12-10-08, cert. ef. 1-1-09

141-040-0030
Finder's Report

(1) The Department may compile information and produce a Finder's Report of Unclaimed and Escheat Property in a format chosen by the Department.

(2) To obtain a Finder's Report, a person shall submit a written request to the Department along with the appropriate fee. The Department may require a waiting period of up to 20 days if payment is made by other than cashier's check or money order.

(3) The fee for the Finder's Report shall be a minimum of $150 per release.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 2-1989, f. 5-19-89, cert. ef. 6-1-89; LB 2-1995, f. & cert. ef. 6-15-95; DSL 12-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 7-2008, f. 12-10-08, cert. ef. 1-1-09

141-040-0211
Claim Format

(1) Pursuant to ORS 98.392, a person claiming interest in unclaimed property reported or remitted to the Department may file a claim for the property or proceeds from the sale of the property at any time.

(2) A person shall file a claim with the Department on forms provided by the Department, or in a format acceptable by the Department.

(3) A complete claim shall be considered filed upon its receipt by the Department.

(4) In order to be complete, each claim shall include:

(a) The name and current photo identification or other satisfactory proof of identity of the claimant, such as a driver's license or passport;

(b) Current mailing address of the claimant and satisfactory documentation to prove current residence;

(c) A description of the claimant's interest in the property;

(d) Evidence of the claimant's Business Tax ID, or Federal Tax ID number for business entity claims;

(e) Evidence of ownership satisfactory to establish the validity of the claim; and

(f) An acknowledged indemnification agreement signed by the claimant that is provided by, or acceptable to the Department.

(5) In addition to the information required under subsection (4) of this section, if the claimant is the original owner, a description of the nature of the property.

(6) In addition to the information required under subsection (4) of this section, if the claimant is other than the original owner, a description of the relationship of the claimant to the original owner, and documentation of the basis on which both the original owner and the claimant have legal authority to claim the property. If the original owner of the unclaimed property is deceased and the claimant is an heir or devisee, then the claimant must describe the claimant's relationship to the deceased owner and include documentation that establishes that claimant is the heir or devisee of the original owner. If the owner is a minor or is incapacitated, then the claimant must provide proof of guardianship or conservatorship. Proof of guardianship or conservatorship must be no more than 60 days old at the time the claim is submitted.

(7) In addition to the information required under subsection (4) of this section, if the claim is being filed by a finder:

(a) The claim shall include an original Power of Attorney or written notarized statement provided by each claimant to the finder authorizing the finder to act on behalf of the claimant.

(b) The finder shall be licensed and comply with the requirements of ORS 703.401 to 703.470. The finder shall include a copy of this license issued by the Oregon Department of Public Safety, Standards and Training with the claim.

(c) An affidavit signed by the claimant for specified types of property as determined by the Department.

(8) In addition to the information required under subsections (4) to (7) of this section, in order to expedite the determination of the rightful owner, a claimant may include the claimant's Social Security number on the claim form.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 27, f. 8-28-75, ef. 9-25-75; LB 5-1987, f. & ef. 8-18-87; LB 2-1995, f. & cert. ef. 6-15-95; DSL 12-1999, f. & cert. ef. 4-5-99, Renumbered from 141-040-0215; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 7-2008, f. 12-10-08, cert. ef. 1-1-09

141-040-0212
Proof of Ownership

(1) The burden is on the claimant to provide sufficient proof to establish the elements of the claim, and it is the claimant's responsibility to contact persons and to search out documents relating to the claim.

(2) Name similarity alone is not sufficient to prove entitlement to unclaimed property.

(3) Documents submitted to establish ownership may include, but are not limited to:

(a) Copies of any documents showing addresses, including but not limited to utility bills, tax records, or original correspondence addressed to the owner at the address shown on the Department's records;

(b) Passbooks, statements of accounts, canceled checks, deposit slips;

(c) Copy of, or original stock certificate in the owner's name, copy of prior dividend payment or statement, stock transmittal receipt, brokerage firm statement;

(d) Original insurance policies, premium or dividend statements;

(e) Original deposit slips or receipts;

(f) Safe deposit box rental receipt or statement regarding the box;

(g) Original certified or photo copies of court documents;

(h) Newspaper articles including marriage announcements, birth or obituary notices;

(i) Family or church records, baptismal certificates, or personal correspondence;

(j) Public or business records;

(k) Signature verification cards from financial institutions;

(l) Testimonial evidence, including properly notarized affidavits; or

(m) Any other forms of evidence the Department may consider sufficient to satisfy a reasonable and prudent person under the circumstances of the particular claim.

(4) When a claimant submits a claim on behalf of the original owner of unclaimed property, the claimant shall provide:

(a) Evidence to establish the claimant's legal authority to make a claim for the original owner; and

(b) Evidence to establish the original owner's right to the unclaimed property.

(5) When a claimant submits a claim on behalf of a successor to the original owner of the property, the claimant shall provide:

(a) Evidence to establish the claimant's legal authority to make a claim for the successor to the original owner; and

(b) Evidence to establish the original owner's right to the unclaimed property; and

(c) Evidence to establish the successor's right to the unclaimed property as a successor to the original owner. The evidence that may be used to establish the successor's right to the unclaimed property as a successor to the original owner consists of but is not limited to, certified copies of probate documents, small estate affidavit, Final Decree of Distribution, a will, death certificates, Letters Testamentary, or Guardianship or Conservatorship, or other appropriate documentation.

(6) When a claimant submits a claim on behalf of a business or governmental entity, the claimant's authority to make a claim on behalf of the business or governmental entity must be established to the satisfaction of the Department in accordance with the requirements of OAR 141-040-0213.

(7) If the claim is for a negotiable instrument, (cashier's check, money order, certified check, traveler's check) the payee shall be considered to be the owner unless the purchaser possesses the instrument or provides evidence of payment satisfying the obligation to the payee.

(8) If the claim is for securities, claimants are entitled to receive either the securities that the holder delivered to the Department if they still remain with the Department, or the proceeds received from the sale, less any amounts deducted pursuant to ORS 98.386.

(9) If the claim is for securities or negotiable instruments, the claimant shall surrender to the Department with the claim the certificate or the original instrument, if the claimant possesses it. If the claimant does not surrender the original certificate, the Department may require the claimant to provide a lost instrument bond.

(10) If a claim is made on behalf of a creditor of an owner of unclaimed property, the creditor shall provide:

(a) A certified copy of the writ of garnishment; and

(b) Evidence to establish that the debtor is the owner of the unclaimed property in the same way as if the owner was making a claim for such property under these rules. The Department shall review the claim in the order received with other claims.

(11) In the case of competing claims, the conflict must be resolved by the claimants prior to a claim being deemed complete.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 2-1995, f. & cert. ef. 6-15-95; DSL 12-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 7-2008, f. 12-10-08, cert. ef. 1-1-09

141-040-0213
Claims Submitted on Behalf of Business Entity or Governmental Entity; Proof of Authority

(1) When a claim is submitted by an employee of a business entity on behalf of a business entity, and the total value of the unclaimed property in addition to the documentation required of all other claimants under OAR 141-040-0211, the employee acting on behalf of the business entity shall provide an original statement on the letterhead of the business entity executed by an individual authorized to bind the business entity, such as an officer of the corporation, managing member of the limited liability company, or partner of a partnership, that recites the authority of the individual to bind the business entity, and that authorizes the employee to submit a claim on behalf of the business entity.

(2) When a claim is submitted by an agent on behalf of a business entity, in addition to the documentation required of all other claimants under OAR 141-040-0211, the agent must provide:

(a) An original power of attorney that authorizes the agent to submit a claim on behalf of the business entity that is executed by an individual authorized to bind the business entity, such as an officer of the corporation, managing member of the limited liability company, or partner of a partnership; and

(b) An original statement on the letterhead of the business entity executed by an individual authorized to bind the business entity, such as an officer of the corporation, managing member of the limited liability company, or partner of a partnership, that recites the authority of the individual to bind the business entity, and that acknowledges that the individual has executed a power of attorney authorizing the agent to submit a claim on behalf of the business entity. The statement must include the name and address of the agent and direction to the Department for payment of any property determined to be due to the business entity. If payment is to be made to the agent, the agent must also provide his/her federal tax identification number.

(3) When a claim is submitted by an employee of a governmental entity on behalf of a governmental entity, in addition to the documentation required of all other claimants under OAR 141-040-0211, the employee acting on behalf of the governmental entity shall provide an original statement on the letterhead of the governmental entity executed by an individual authorized to bind the governmental entity, such as the director of a state agency, county executive, or city manager, that recites the authority of the individual to bind the governmental entity, and that authorizes the employee to submit a claim on behalf of the governmental entity.

(4) When a claim is submitted by an agent on behalf of a governmental entity, in addition to the documentation required of all other claimants under OAR 141-040-0211, the agent must provide:

(a) An original power of attorney that authorizes the agent to submit a claim on behalf of the governmental entity that is executed by an individual authorized to bind the governmental entity, such the director of a state agency, county executive, or city manager; and

(b) An original statement on the letterhead of the business entity executed by an individual authorized to bind the business entity, such as the director of a state agency, county executive, or city manager, that recites the

authority of the individual to bind the governmental entity, and that acknowledges that the individual has executed a power of attorney authorizing the agent to submit a claim on behalf of the governmental entity. The statement must include the name and address of the agent and direction to the Department for payment of any property determined to be due to the governmental entity. If payment is to be made to the agent, the agent must also provide his/her federal tax identification number.

(5) Department staff will not discuss any claim or inquiry with an agent until the agent has provided to the Department the documentation required in subsection (2) and (4) of this section.

(6) When a claim is filed on behalf of a dissolved business entity, in addition to the information required by subsection (1) and (2), above, the person submitting the claim must provide:

(a) A copy of the articles of dissolution if the entity is a corporation or limited liability company; or

(b) A copy of the partnership agreement or other agreement between the partners describing how partnership assets are to be distributed if the entity is a partnership.

(7) When a claim is filed on behalf of an individual but the claim concerns unclaimed property held for the benefit of a business under an assumed business name or "doing business as", in addition to the documentation required of all other claimants under OAR 141-040-0211, the claimant must provide documentation establishing claimant's ownership of the business, such as tax statements or business license. All warrants issued by the Department in such claims shall be made payable to the claimant "doing business as" the name of the assumed business name.

(8) When a claim is filed on behalf of a business entity in bankruptcy, in addition to the documentation required of all other claimants under OAR 141-040-0211, the claimant must provide:

(a) A copy of the order appointing the bankruptcy trustee and a copy of the order authorizing the claimant to make a claim on behalf of the bankruptcy estate; and

(b) If the claim is being filed by an agent, an original power of attorney that authorizes the agent to submit a claim on behalf of the trustee in bankruptcy or on behalf of the person or entity authorized by the bankruptcy court to make a claim on behalf of the bankruptcy estate. When a claim is filed on behalf of a business entity formerly in bankruptcy where the entitlement to the unclaimed property arose before commencement of the bankruptcy, in addition to the documentation required of all other claimants under OAR 141-040-0211, the claimant must provide:

(a) A copy of the order of discharge or other order establishing that the bankruptcy trustee abandoned the bankruptcy estate's interest in the unclaimed property; and

(b) If the claim is being filed by an agent, the agent must also comply with the requirements of OAR 141-040-0213(2), above.

(9) If the Department receives claims filed by two or more individuals on behalf of the same business entity, the Department will notify the business entity in writing. The notice shall identify the names and addresses of the individuals who submitted the claims and shall request that the business entity designate the authorized individual. The Department shall not process either claim unless and until the Department receives written authorization from the business entity.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: DSL 7-2008, f. 12-10-08, cert. ef. 1-1-09

141-040-0214
Review Criteria/Time

(1) The administrator shall approve or deny a claim to recover unclaimed property within 120 days after the claimant files a completed claim form under ORS 98.392.

(2) The Department shall review claims in the order of receipt, unless the claimant provides evidence of extenuating circumstances warranting early review. After reviewing any such request, the Department will make a determination whether to advance the claim ahead of others.

(3) In determining if there is sufficient evidence to support a claim, the Department shall consider:

(a) The age and likelihood of the existence of direct evidence to support the claim;

(b) The existence of any competing claims for the property; and

(c) Any other related evidence the Department determines appropriate under the circumstances of the particular claim.

(4) The Department shall determine whether a preponderance of the evidence proves the claimant is legally entitled to the unclaimed property.

(5) If the Department approves a claim, the Department shall request a warrant from the Oregon State Treasury. If the claim is allowed for funds deposited in the General Fund, the Department shall pay the claim and file a request for reimbursement from the State Treasurer, who shall reimburse the Department within five working days from the fund against which the warrant represented in the claim was issued.

(6) A holder may make payment to, or delivery of property to an owner and file a claim with the Department for reimbursement. The Department shall reimburse the holder within 60 days of receiving proof that the owner was paid. The Department may not assess any fee or other service charge to the holder. Upon receiving the funds from the Department, the holder shall assume liability for the claimed asset and hold the Department harmless from all future claims to the property.

(7) If the property is being recovered by a finder who has submitted a Power of Attorney that authorizes disbursement to the finder, the Department shall issue a warrant payable to both the claimant and Finder and mail the warrant to the finder.

(8) When a claim is for the benefit of the heirs of a deceased owner:

(a) If the amount of the claim is less than $500, the Department shall issue a warrant FBO (For the Benefit of the Heirs of (decedent's name)).

(b) If the amount of the claim is $500 or more, but less than $1000, the Department shall issue a warrant FBO (For the Benefit of the Heirs of (decedent's name)) and, if the estate was not probated, require the claimant to complete an Affidavit in Lieu of Probate.

(c) If the amount of the claim is more than $1000, prior to payment the Department shall require evidence of probate or the filing of probate in accordance with the applicable requirements of Chapters 111, 113 – 117, Oregon Revised Statutes.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 2-1995, f. & cert. ef. 6-15-95; DSL 12-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 7-2008, f. 12-10-08, cert. ef. 1-1-09

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Rule Caption: Implementing statutory changes to certain dormancy periods and updating reporting formatting requirements.
Adm. Order No.: DSL 8-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 9-1-2008
Rules Amended: 141-045-0010, 141-045-0021, 141-045-0031, 141-045-0041, 141-045-0061, 141-045-0100, 141-045-0115, 141-045-0126, 141-045-0130
Subject: OARs 141-045-0005 through 0185 provide consistent procedures for the administration of the Uniform Disposition of Unclaimed Property Act, ORS 98.302 to 98.346, 98.991 and 992 are to ensure that all unclaimed money and property held in safekeeping are reported and paid over to the Department in an accurate and timely manner. The Department is updating these rules to implement statutory changes that went into effect on January 1, 2008, regarding certain dormancy periods and to update reporting formatting requirements.
Rules Coordinator: Elizabeth Martino—(503) 986-5239

141-045-0010
Definitions

(1) "Capital Gain" means gain or profit realized on the sale or exchange of a capital asset, or the excess of proceeds over cost, or other basis, from the sale of a capital asset.

(2) "Credit Memorandum" or "Credit Memo" means a transaction posted to a customer account which reduced the account balance and is related to a previously posted invoice or charge, correcting and reducing the amount originally charged.

(3) "Department" means the Department of State Lands.

(4) "Dividend" means cash which accrues by the earnings of a company and which is paid to the owner of securities issued by that company.

(5) "Dividend Reinvestment Plan" means additional securities of the same company which are credited to an owner's account in lieu of cash.

(6) "Dormant" means without owner generated activity or owner contact for a prescribed time.

(7) "Due Diligence" means the degree of effort required by statute that holders of unclaimed property must take to find the rightful owner of property before the property is remitted to the state.

(8) "Financial Institution" means a financial institution, or a trust company, as those terms are defined in ORS 706.008, a safe deposit com-

pany, a private banker, a savings and loan association, a building and loan association or an investment company.

(9) "Holder" means a person, wherever organized or domiciled, who is:

(a) In possession of property belonging to another;

(b) A trustee; or

(c) Indebted to another on an obligation.

(10) "Inactive" means a lack of owner generated activity or owner contact for a prescribed time.

(11) "Insurance Company" means an association, corporation, or fraternal or mutual benefit organization, whether or not for profit, which is engaged in providing insurance coverage, including, but not limited to, accident, burial, casualty, workers' compensation, credit life, contract performance, dental, fidelity, fire, health, hospitalization, illness, life (including endowments and annuities), malpractice, marine, mortgage, surety, and wage protection insurance.

(12) "Intangible Property" includes but is not limited to:

(a) Credit balances, customer overpayments, security deposits, refunds, credit memos, unpaid wages, unused airline tickets, and unidentified remittances;

(b) Stocks and other intangible ownership interests in business associations;

(c) Money deposited to redeem stock, bonds, coupons, and other securities, or to make distributions;

(d) Amounts due and payable under the terms of insurance policies;

(e) Amounts distributed from a trust or custodial fund established under a plan to provide health, welfare, pension, vacation, severance, retirement, death, stock purchase, profit sharing, employee savings, supplemental unemployment insurance or similar benefits; and

(f) Money, checks, drafts, deposits, interest, dividends, and income.

(13) "Last-known Address" means a description of the location of the apparent owner sufficient for the purpose of delivery of mail.

(14) "Negative Report" means a report showing the holder had no inactive accounts or other unclaimed assets to report for a particular reporting period.

(15) "Owner" means a depositor in case of a deposit, a beneficiary in case of a trust other than a deposit in trust, a creditor, claimant, or payee in case of other intangible property, or a person, or the person's legal representative, having a legal or equitable interest in property.

(16) "Person" means an individual, business association, state or other governmental or political subdivision or agency, public corporation, public authority, estate, trust, two or more persons having a joint or common interest, or any other legal or commercial entity.

(17) "Positive Owner Contact" means documented contact by an owner to the holder either generated or initiated by the owner or in response to the holder.

(18) "Property" includes tangible and intangible property.

(19) "Reportable" means the appropriate dormancy period as set forth in OAR 141-045-026 after which time an owner has not claimed his or her asset from a holding company, and the holder has taken appropriate steps to find the owner, as described in OAR 141-045-0061.

(20) "Safekeeping Depository" means any leased or rented depository used as a deposit for safekeeping of tangible or intangible property.

(21) "Tangible Property" means:

(a) Property actually being held in a safekeeping depository and includes, but is not limited to:

(A) Contents of safe deposit boxes in financial organizations;

(B) Contents of safekeeping repositories located in hospitals, healthcare facilities, motels, hotels, jewelry stores, department stores, professional offices, or any other site where the holder is acting as a safekeeping custodian for the rightful owner.

(b) Property held for the owner by a court, state or other government, governmental subdivision or agency, law enforcement agency, public corporation or public authority (for instance unclaimed court exhibits).

(22) "Third Party Administrator" is a person contracted by the holder to manage and process account records.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 2-1984, f. & ef. 3-13-84; LB 4-1991, f. & cert. ef. 6-21-91; LB 5-1994, f. & cert. ef. 10-20-94; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0021
Dormancy Periods

(1) Except as provided in this rule, the dormancy period for all tangible and intangible property is three years. After the expiration of the dormancy period, the property is presumed abandoned and subject to the provisions of these rules pertaining to unclaimed property.

(2) The dormancy period for the following deposits or refunds held by a utility is one year if unclaimed by the apparent owner after the date of termination of services or when the funds otherwise become payable or distributable:

(a) A deposit to secure payment, or a sum paid in advance for utility services, less lawful deductions; and

(b) A sum received for utility services, which the utility has been ordered to refund, including interest on the sum, less lawful deductions.

(3) The dormancy period is one year for all intangible personal property distributable in the course of dissolution of a business association or financial institution.

(4) The dormancy period for the following property is two years:

(a) Tangible and intangible property held in a safe deposit box or other safekeeping repository;

(b) Assets of dissolved cooperatives;

(c) Stale dated government checks or warrants including unpresented payroll checks;

(d) Tangible and intangible property held by a court, state, or other government, governmental subdivision or agency, law enforcement agency, public corporation or public authority;

(e) Life or endowment insurance policies where the insured would have attained the limiting age under the mortality table of an existing policy; and

(f) All intangible personal property and any income or increment on such property held in a fiduciary capacity.

(6) The dormancy period for money orders is seven years.

(7) The dormancy period for traveler's checks is 15 years.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0031
Examples of Unclaimed Property

(1) The following types of property are considered unclaimed and reportable to the Department after three years without positive owner contact:

(a) Any account deposited in a financial institution and any accrued interest and dividends;

(b) Any account including shares, dividends, deposit accounts, and interest held by credit unions as defined in ORS 723.006 that are due or standing in the name of a member, beneficiary or other person who cannot be contacted by first class mail at the last address shown on the records of the credit union;

(c) Any sums payable for which a financial institution is directly liable, including checks, drafts, cashier's checks, certified checks, or similar instruments;

(d) Any stock, mutual fund, or other certificate of ownership, dividend, profit, distribution interest, payment on principal or other sum held or owing by a business association for a shareholder, certificate holder, member, bondholder or the actual instrument or book entry shares which shows ownership or interest in stocks, bonds, or mutual funds;

(e) Any certificate of deposit. If the account is in the form of a dividend reinvestment plan, the dormancy period shall begin at the first maturity date after the holder determines that the owner cannot be located;

(f) Funds held or owing under any life or endowment insurance policy or annuity contract that has matured or terminated and has become due and payable as established from the records of the insurance company.

(g) Credit memos issued in the ordinary course of the holder's business;

(h) Except as provided in OAR 141-045-0031(3)(c), unpaid wages, including commissions and wages represented by uncashed payroll checks owing in the ordinary course of the holder's business;

(i) Any other disbursements generated during the ordinary course of the holder's business; and

(j) All intangible personal property not otherwise covered by ORS 98.302 through 98.436 that is held or owing in the ordinary course of the holder's business after it becomes due and payable.

(3) The following types of property are considered unclaimed and payable to the Department after two years without owner contact:

(a) A life or endowment insurance policy or annuity contract not matured by actual proof of the death of the insured or annuitant according to the records of the insurance company, pursuant to ORS 98.314(3);

(b) All tangible and intangible property held in a safe deposit box or any other safekeeping depository in the ordinary course of the holder's business after the lease or rental period has expired. This category of property does not include personal property that has been willfully abandoned by the owner, such as automobiles, furniture, household goods, or property covered by other statutes;

(c) All intangible property held for the owner by any court, state or other government, governmental subdivision or agency, county fiscal officer, public corporation, public authority, quasi-governmental agency, public officer of this state, political subdivision of this state, or Public Employees' Retirement System, except those with a court order prohibiting the withdrawal of same, including, but not limited to:

(A) Fines;

(B) Bail;

(C) Restitution;

(D) Child support;

(E) Condemnation payments;

(F) Judgment proceeds;

(G) Unclaimed municipal bonds and the interest thereon.

(d) All intangible personal property and any accrued interest held in a fiduciary capacity, including but not limited to property management security deposits, attorney trust accounts, escrow accounts, trust accounts and funds in an individual retirement account or a retirement plan or a similar account or plan established under the Internal Revenue laws of the United States if under the terms of the account or plan, distribution of all or part of the funds would then be mandatory.

(e) Tangible property held for the owner by a court, state or other government, governmental subdivision or agency, public corporation or public authority; law enforcement agency, other than property seized by a removing authority as defined by ORS 98.245(1)(b);

(f) Property held by a dissolved cooperative.

(4) Funds in an individual retirement account or a retirement plan or a similar account or plan established according to the Internal Revenue laws of the United States of America are not payable or distributable within the meaning of OAR 141-045-0021(4)(f) unless, under the terms of the account or plan, distribution of all or part of the funds would then be mandatory.

(5) The following types of property are considered unclaimed and reportable to the Department after one year without positive owner contact:

(a) Deposits made by a subscriber with a utility to secure payment or any sum paid in advance for utility services;

(b) Sums received for utility services which a utility has been ordered to refund;

(c) All unclaimed intangible personal property distributable in the course of a dissolution of a business association, or financial institution.

(6) Any sums payable on a money order or similar written instrument, other than a third party bank check that has been outstanding for more than seven years after its issuance is considered unclaimed and reportable to the Department.

(7) Any sum payable on a traveler's check that has been outstanding for more than 15 years is considered unclaimed and reportable to the Department.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 4-1991, f. & cert. ef. 6-21-91; LB 5-1994, f. & cert. ef. 10-20-94; LB 2-1995, f. & cert. ef. 6-15-95; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0041
Report Forms

(1) A holder reporting more than 15 properties shall submit reports electronically in a format prescribed by the Department.

(2) A holder reporting 15 or less properties may submit a report electronically or by hard copy report either on the form available on the Department's website or on an internally generated form that contains all of the information required by OAR 141-0045-0100(5) through (10).

(3) The Department shall post on its website the printed report forms, electronic formatting requirements,and instructions. Any changes to electronic formatting requirements shall be posted at least one reporting cycle prior to the effective date.

(4) The Department may provide a separate reporting form to holders of any safekeeping repository, for a detailed listing of all contents and owners.

(5) The Department may, at its discretion, require holders to file negative reports.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 4-1991, f. & cert. ef. 6-21-91; LB 5-1994, f. & cert. ef. 10-20-94; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0061
Actions Required of Holders Before Reporting

(1) As soon as it appears that an account with a value of $100 or more is inactive, but not less than 60 (sixty) days prior to filing the annual report, each holder shall exercise due diligence in making a reasonable, good faith effort to:

(a) Confirm that an account is in fact inactive;

(b) Notify the owner that the holder will report the account to the Department as unclaimed property: and

(c) Locate the owner.

(2) In exercising due diligence under subsection (1) of this section, a holder may:

(a) Verify that the owner has not communicated in writing with the holder concerning the asset;

(b) Verify that the owner has not otherwise indicated an interest in the asset as evidenced by a memorandum or other record on file prepared by an employee of the holder;

(c) Verify that the owner does not own other accounts in the holder's organization about which the owner has communicated with the holder (for example, the Trust Department of a financial institution could contact other departments of that institution): or

(d) Where the account is that of a credit union member, verify that the member has participated in voting during a regularly scheduled credit union meeting.

(3) If a holder is unable to locate an owner, the holder may exercise due diligence under subsection (1) of this section by:

(a) Verifying that the owner is not a current employee of the holder;

(b) Reviewing telephone books to verify address and telephone number;

(c) Verifying that the owner is not a well-known individual or organization (for example, Department of Treasury, IRS); or

(d) Any other effort the holder may take to find an owner.

(4) A holder shall retain records or documentation of its compliance with the requirements of this section for three years and make the records or documentation available for inspection by the Department upon request.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 4-1991, f. & cert. ef. 6-21-91; LB 5-1994, f. & cert. ef. 10-20-94; LB 6-1996, f. & cert. ef. 10-15-96; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0100
Report and Delivery of Unclaimed Property to Division

(1) Every person holding funds or other tangible or intangible property, presumed abandoned according to ORS 98.302 to 98.352 shall report and pay or deliver all such property to the Department, except that funds transferred to the General Fund by governmental agencies pursuant to ORS 293.455(1)(a) shall only be reported to the Department.

(2) Each holder shall be responsible for the content, accuracy, and timeliness of the holder's report, regardless of whether the report is prepared by the holder or its agent. The holder shall designate a staff contact person responsible for the report.

(3) For accounts dormant as of June 30, the holder shall file the report after October 1, but not later than November 1.

(4) The Department may, at its discretion, postpone the reporting date, or allow early reporting and payment or delivery upon written request by any person required to file a report.

(5) A holder shall report property having a value of $50 or more per account or owner of record, individually, and shall include the following information, if known:

(a) The complete name, address of record, Social Security number, previous names, and any previous addresses of each listed owner; and

(b) The type of account, identification number, reference number, and any specific description of the unclaimed property according to the records of the holder.

(6) A holder may report all property having a value of $49.99 or less per account or owner of record, as a lump sum representing various accounts without breaking the amount down by account or by owner. However, the holder shall report separately the total amount held for any one owner who has several small accounts that individually total $49.99 or less, but collectively equal or exceed $50 dollars. In order to assist the Department in locating owners of record, the holder may report the infor-

mation required under subsection (5) of this rule for property having a value of $49.99 or less per account or owner of record.

(7) In addition to the information required above, a life insurance company shall also report the following information, if known:

(a) The full name of each insured or annuitant, or if a class of beneficiaries is named, the full name of each current beneficiary in the class, and last known address according to the holder's records;

(b) The address of each beneficiary; and

(c) The relationship of each beneficiary to the insured.

(8) A holder of safekeeping depositories shall comply with the following additional requirements:

(a) The holder shall complete the specific report form for safekeeping contents or include the required information in the holder's computer-generated format and file the report, separate from the contents, no later than November 1.

(b) In addition to the information required in subsection (5) of this section, list each item left in a safekeeping depository, and the identity of the owner. The holder shall include information about the original box if the holder moved items to a safekeeping area.

(c) In accordance with directions from the Department, the holder shall deliver the package of safekeeping depository contents marked "to be delivered unopened," to the Department by certified mail, return receipt requested or hand carried by a courier. The Department shall sign a receipt for the unopened package upon delivery to the Department, and forward the receipt to the holder within five working days.

(d) The holder shall clearly identify on the package the holder's complete name and return address.

(e) The holder shall forward the complete contents of safekeeping depositories to the Department intact. The holder may not convert, substitute or exchange any coins and currency found in the box.

(f) The holder may include information about safekeeping depository costs in its report to the Department. When the owner files a claim for the property, the Department shall require the owner to furnish a paid receipt or waiver for these costs from the holder before the claim will be approved.

(9) Any holder, business association, transfer agent, registrar or other person acting on behalf of the holder of an intangible equity ownership interest deemed unclaimed according to ORS 98.322 shall, in addition to supplying the information required in OAR 141-045-0100(5) above:

(a) Report and transfer the shares directly to the Department's designated stock broker or transfer agent via available electronic medium and include a confirmation of the transfer with the report.

(b) When an electronic method of transfer is not available the holder shall:

(A) Where the original certificate is being held by the holder for the owner (i.e., stock or other certificate of ownership of a business association which has been returned to the holder, who cannot find the owner), cancel that certificate and issue a replacement certificate of ownership to the Department; or

(B) When the holder does not hold the original certificate, issue a replacement certificate i.e., a duplicate certificate of ownership or other distribution or stock or other certificates of ownership of a business association issued in the name of the Department of State Lands as custodian of unclaimed property. The original certificate of ownership is presumed to be in the possession of the missing owner to the Department.

(c) In any case, the holder shall report and forward to the Department all outstanding accrued dividends, along with the certificate.

(10) In addition to supplying the information required in OAR 141-045-0100(5), a holder reporting mutual funds in book entry form shall:

(a) Transfer the account directly into the Department's account at the Department's designated broker dealer and forward a confirmation of account transfer to the Department along with the report; and

(b) Forward future income in the form of cash (for example, dividends, capital gains, etc.) payable to the Department from mutual fund accounts with dividend reinvestment plans.

(11) If the holder is a dissolved agricultural cooperative, the holder shall forward the original reports detailing unclaimed dissolved agricultural cooperative accounts to the Department along with the funds, and file a copy of the report with the State Board of Higher Education. The Department shall reconcile the report to the delivered funds, deduct the costs as provided for in ORS 62.720 and forward the funds to the State Board of Higher Education within 14 working days after receiving the funds.

(12) The receiver or other liquidating agent for a dissolved corporation shall prepare a report containing the names and last-known addresses of the persons entitled to such funds.

(13) Before October 1 each year, each state agency shall prepare a report of all checks, warrants, and orders drawn by it which have been outstanding for a period of more than two years prior to July 1, and that have not been paid by the State Treasurer. The report shall not include checks or orders that have already been paid pursuant to indemnity bonds. The agency shall forward the report to the Department before November 1.

(14) After October 1, the State Treasurer may refuse payment of the unpresented checks or orders included in the report, and upon instructions by the issuing agency shall:

(a) Transfer and credit the amounts of the unpresented checks or orders dedicated for general funding to the General Fund;

(b) Except for federal funds governed by federal laws and rules as provided in ORS 291.003 and 409.040(2), transfer all other funds to the Department; and

(c) Report information about any payment made to an owner subsequent to filing the report, but before transferring the funds to the Department.

(15) If the holder of the unclaimed account is a successor to other persons who previously held the property, or if the holder has had a name change, the holder shall include in the initial report prior known names and addresses of the original or previous holder.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 4-1991, f. & cert. ef. 6-21-91; LB 5-1994, f. & cert. ef. 10-20-94; LB 6-1996, f. & cert. ef. 10-15-96; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0115
Requirements of the Division of State Lands to Locate Owners

(1) Within one year after receipt of reports, payment, and delivery of accounts as required by OAR 141-045-0100, the Department shall provide public notice that the names of owners of unclaimed property have been added to the Department's unclaimed property Website by publishing notice at least twice in a newspaper or other generally circulated periodical published in this state.

(2) The Department also shall make reasonable efforts to locate the owners of unclaimed property reported and received by the Department. The Department's efforts shall include, but need not be limited to the following:

(a) Contracted services with established firms, credit bureaus, telephone networking companies; or

(b) Interagency agreements with other governmental agencies, such as Social Security Administration, Insurance Commission, Motor Vehicles Division, Corporation Commission; or

(c) Use of the internet, reverse directories, telephone books, or other such publications.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 5-1994, f. & cert. ef. 10-20-94; LB 6-1996, f. & cert. ef. 10-15-96; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0126
Appeal of Examination Findings

(1) Request for a contested case hearing. Any holder adversely affected by the findings or decision of the Department may request a contested case hearing pursuant to the provisions of ORS 183.413 to 183.470. The request for a contested case hearing must be received by the Department within 21 days of the date of mailing or delivery of the final written report described in OAR 141-045-0121(4). If a holder fails to request a contested case herein within the time allowed, the findings and decision shall become final.

(2) Collaborative Dispute Resolution for Findings Based on Estimates. Any holder who is adversely affected by the findings or decision of the Department where the findings or decision are based on estimates as described in OAR 98.412(4) may request the Department engage in collaborative dispute resolution. A holder may retain the right to a contested case while requesting collaborative dispute resolution, but a request to engage in collaborative dispute resolution does not enlarge the time allowed for a holder to request a contested case hearing, as set forth is (1) above. The Department may decline to engage in collaborative dispute resolution and set the case for a contested case hearing. If the Department decides to participate in collaborative dispute resolution the Department shall postpone the contested case hearing to give the parties a reasonable opportunity to complete the collaborative dispute resolution, but in no event shall the hearing be postponed more the 45 days from the date of the request for a contest case hearing. The collaborative dispute resolution shall consist of mediation or such other process as the parties may agree. Department and the

holder shall select a trained facilitator/mediator from a list of pre-qualified individuals and share the costs of the facilitator/mediator.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

141-045-0130
Service Charges and Payments of Interest on Deposit Accounts

(1) With respect to any demand, savings or matured time deposit with a financial institution, including a deposit that is automatically renewable, and any funds paid toward the purchase of a share, mutual investment certificate or any other interest in a financial institution, a holder may not impose any charge or cease payment of interest due to dormancy or inactivity unless:

(a) There is a written contractual agreement between the holder and the owner of the account clearly and prominently setting forth the conditions under which a service charge may be imposed or the payment of interest terminated;

(b) The establishment of a service charge, the change of an existing service charge or the change of a policy pertaining to the payment of interest is uniformly applied to all dormant or inactive accounts;

(c) The holder shall give written notice to the owner at the owner's last-known address whenever an account becomes dormant or inactive; and;

(d) Three months written notice is given by first-class mail to the last-known address of the owner of a dormant or inactive account before the holder may apply a service charge to the account or stop paying interest on that account.

(2) A signature card is not a written contractual agreement for the purposes of subsection (1)(a) of this section, however, the signature card and the written contractual agreement may be contained in one instrument.

(3) A holder may not deduct from the amount of any instrument subject to ORS 98.308(5) or (6) any charge imposed by reason of the failure to present the instrument for payment unless there is a valid and enforceable written contract between the holder and the owner of the instrument pursuant to which the holder may impose a charge, and the holder regularly imposes such charges and does not regularly reverse or otherwise cancel them.

(4) Notwithstanding the provisions in subsections (1) to (3) of this section, a holder may not deduct a service charge or fee or otherwise reduce an owner's unclaimed account unless:

(a) There is a valid written contract between the holder and the owner that allows the holder to impose a charge;

(b) The service charge or fee is imposed uniformly on all accounts; and

(c) Three months' written notice is given by first-class mail to the last-known address of all owners before the charge or fee is levied.

Stat. Auth.: ORS 98.302 - 98.436 & 273.045
Stats. Implemented: ORS 98
Hist.: LB 4-1991, f. & cert. ef. 6-21-91; LB 5-1994, f. & cert. ef. 10-20-94; DSL 13-1999, f. & cert. ef. 4-5-99; DSL 8-2002, f. 12-24-02 cert. ef. 1-1-03; DSL 3-2003, f. 12-15-03, cert. ef. 1-1-04; DSL 8-2008, f. 12-10-08, cert. ef. 1-1-09

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Rule Caption: Deletes obsolete rules and changes rules to improve readability and clarity.
Adm. Order No.: DSL 9-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 12-10-08
Notice Publication Date: 9-1-2008
Rules Amended: 141-050-0500, 141-050-0900, 141-050-0905, 141-050-0920, 141-050-0940, 141-050-0965, 141-050-0972, 141-050-0976, 141-050-0982
Rules Repealed: 141-050-0530, 141-050-0535, 141-050-0910, 141-050-0945
Rules Renumbered: 141-050-0890 to 141-050-0450
Subject: The purpose of these rules is to provide a central and continuing register of areas in Oregon which contain significant natural heritage resources and special species, and which meet the criteria of the Plan for registration under the Oregon Register of Natural Heritage Resources. Ref. ORS 273.581, Chapter 208, Oregon Laws 1981.

The Department of State Lands, on behalf of the Natural Heritage Advisory Council, is updating these rules to improve readability and clarity.
Rules Coordinator: Elizabeth Martino—(503) 986-5239

141-050-0450
Purpose

The purpose of these rules is to provide a central and continuing register of areas in Oregon which contain significant natural heritage resources and special species, and describe the process used to register properties on the Oregon Register of Natural Heritage Resources. Ref. ORS 273.581, Chapter 208, Oregon Laws 1981.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273 .563 - 273 .591
Hist.: LB 26, f. 8-5-75, ef. 8-25-75; LB 9-1982, f. & ef. 10-1-82; Renumbered from 141-050-0890, DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0500
Definitions

As used in these rules, unless the context provides otherwise:

(1) "Agency" means any federal, state or local government agency, department, board, or commission.

(2) "Board" means the State Land Board.

(3) "Candidate Natural Area" means a natural resource area which may be considered for registration or dedication.

(4) "Council" means the Natural Heritage Advisory Council as established in ORS 273.571.

(5) "Dedicated" means the formal recognition and protection of a natural area for natural heritage conservation purposes.

(6) "Document" means a documented record, report or map pertaining to the Natural Heritage Program data.

(7) "Elements" means both the natural heritage resources and the special species.

(8) "Instrument" means any written document intended to convey an interest in real property pursuant to ORS 93.710, or an agreement between parties pursuant to the Natural Heritage Program, the Natural Heritage Plan, or matters related thereto.

(9) "Introduced Species" means exotic or non-native species.

(10) "Managed Area" means a registered or dedicated Natural Heritage Conservation Area that, by management agreement between the Board and private landowner, or agency, the area and its elements are maintained in a manner to protect the natural character.

(11) "Management Scheme" means a plan that sets forth in detail the responsibilities for the administration of an individual Natural Heritage Conservation Area.

(12) "Natural Area" means a unit of land or water, or both, which may be considered for dedication under ORS 273.563 to 273.591. It means a natural heritage resource area which has substantially retained its natural character, or, if altered in character, shall in addition to its natural heritage resource values be valuable as habitat for plant and animal species or for the study and appreciation of natural features. Ref. ORS 273.566(1).

(13) "Natural Heritage Conservation Area" means an area dedicated under the provisions of ORS 273.586.

(14) "Natural Heritage Resources" means the plant community types, aquatic types (or terrestrial ecosystems and aquatic ecosystems) and unique geologic types as defined in the Oregon Natural Heritage Plan; means a unit of land or water which contains a natural resource(s).

(15) "Plan" means the Natural Heritage Plan as established in ORS 273.576, which governs the Natural Heritage Program in the selection of areas for natural heritage conservation. Ref. ORS 273.566, Oregon Laws 1981, C. 208.

(16) "Program" means the Natural Heritage Program as established in ORS 273.566, which provides for the establishment of a limited system of natural heritage conservation areas representing a full range of Oregon's natural heritage resources and includes special species of plants and animals.

(17) "Register" means the Oregon Register of Natural Heritage Resources as established in ORS 273.581. The Register contains an official list of areas which have significant natural heritage resources and special species.

(18) "Special Species" means those species of plants and animals determined by the Council to be of significant value in a Natural Heritage Conservation Area and defined in the Plan.

(19) "Wildlife" means any wild or free living vertebrate or invertebrate animal.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 18, f. 7-29-74, ef. 8-25-74; LB 9-1982, f. & ef. 10-1-82, Renumbered from 141-050-0895 and 141-050-0950; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0900
Criteria for Inclusion in Register

Criteria to be included within the Register must be determined by the Council to fulfill not only the definition of a natural area but the element and site considerations within the Priorities and Criteria for Conservation in the Plan, ORS 273.563 to 273.591 and Chapter 208, Oregon Laws 1981. The following criteria will be used in evaluating a natural area proposed for inclusion in the Register:

(1) The priority for protection of the primary element objective and other elements in the site as presented in the Plan;

(2) The element occurrence(s) is an adequate representative of the type;

(3) The extent to which each natural heritage resource has retained its natural character, i.e., a measurement of the degree of human caused disturbance;

(4) The health and viability of the element occurrence(s), i.e., the ability of each element occurrence to perpetuate itself or its natural sequence of development in the area;

(5) The number of natural heritage resources or elements which will be adequately represented in the area;

(6) The degree of uniqueness, and educational and natural interpretation values of a geologic resource(s);

(7) The priority of protection given to each special species of plant or animal presented in the Plan;

(8) The contribution the particular area will make to the protection of the special species; and

(9) Manageability, i.e., the capability of being managed so as to protect and to maintain the natural values, as well as to make it available and useful for its designated purposes.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 26, f. 8-5-75, ef. 8-25-75; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0905
Procedures for Registering

Each proposal for the Register, together with field evaluation, maps and sufficient data to complete the register file, shall be reviewed by the Council:

(1) A proposal for the Register of private land shall contain the written consent of the landowner.

(2) After review and recommendation by the Council, the Board may place a site onto the Register, or remove a site from the Register. The Board shall notify the Council of its decision.

(3) A voluntary management agreement may be developed between the Board and a private landowner, or agency, of a site on the Register, with the assistance of the Council.

(4) Any area(s) designated by a federal or state agency, having been established by public hearing, may be entered onto the Register by the Council.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 26, f. 8-5-75, ef. 8-25-75; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0920
Location and Maintenance of Register

The data files of the Oregon Register of Natural Heritage Resources will be located at the Oregon Natural Heritage Information Center office in Portland, OR, and will be maintained by the Council.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 26, f. 8-5-75, ef. 8-25-75; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0940
Instruments of Dedication

(1) Private Dedication — A private individual or organization which is the owner of any registered natural area may voluntarily agree to dedicate that area as a Natural Heritage Conservation Area by executing with the Board, following review by the Council, an instrument of dedication. Instrument provisions and policies include, but are not limited to, the following:

(a) An agreement that provides each element in the Natural Heritage Conservation Area with the most secure protection obtainable;

(b) An unlimited period of time, or a term sufficiently long to warrant dedication protection;

(c) Permission for conducting scientific research and other activities shall be commensurate with Program objectives;

(d) Management policies for the site, which may include all or part of the Management of Natural Heritage Conservation Areas in OAR 141-050-0935 through141-050-0999;

(e) Termination of dedication may occur upon written notification to the Board, including specific reasons for termination, and provision by the Council of opportunity for adequate public notice and hearing.

(2) The Instrument of Dedication of an area under private ownership shall be filed by the Board in the office of the clerk of the county in which any or all of the Natural Heritage Conservation Area is located, and shall be effective upon its recording.

(3) A copy of the dedication and management agreement(s) shall be provided to the private owner of a Natural Heritage Conservation Area.

(4) Public Agency Dedication — Any public agency may dedicate lands under the provisions of ORS 273.563 to 273.591, and the Plan, after providing the opportunity for adequate public notice and hearing by the agency.

(5) The Oregon Transportation Commission, the State Fish and Wildlife Commission, the State Board of Forestry, the State Board of Higher Education and the State Land Board shall, with the advice and assistance of the Council, establish procedures for the dedication of Natural Heritage Conservation Areas on land or water, the title of which is held by the State of Oregon, and which is under that agency's management and control. The instrument(s) of dedication and management shall contain any information or provisions as the agency and Council consider necessary to complete the dedication.

(6) Termination of the dedication of a Natural Heritage Conservation Area by a public agency requires:

(a) Provision of opportunity for adequate public notice and hearing;

(b) A finding by the agency of an imperative and unavoidable necessity due to natural disaster in the site, need of the natural resource during time of declared war, or the need of the natural resource because of extreme economic crisis of the state;

(c) A finding by that agency, with the approval of the Council that the Natural Heritage Conservation Area is no longer needed according to the guidelines of the Plan, or has permanently lost its character.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0965
Disturbance of Natural Features

The management of Natural Heritage Conservation Areas shall not include the cutting or removal of vegetation or the disturbance of other natural features, except that which is essential to carry out the management scheme enumerated in these rules.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 18, f. 7-29-74, ef. 8-25-74; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0972
Control of Introduced Plant Species

Control of introduced plant species may be undertaken as provided in the management scheme.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 18, f. 7-29-74, ef. 8-25-74; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0976
Introduction and Management of Special Species

The introduction into or the management of a Natural Heritage Conservation Area for special wildlife species shall be by agreement between the Board and the Oregon Department of Fish and Wildlife, Oregon Department of Agriculture or other agency as provided in the management scheme.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 18, f. 7-29-74, ef. 8-25-74; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

141-050-0982
Collecting Permits

A person wishing to collect material from a site for the purposes of research, education or restoration within a Natural Heritage Conservation Area shall secure written permission from:

(1) The Board; and

(2) The owner of the land; and

(3) The appropriate agency if any, including but not limited to the Oregon Department of Fish and Wildlife.

Stat. Auth.: ORS 273
Stats. Implemented: ORS 273.563 - 273.591
Hist.: LB 18, f. 7-29-74, ef. 8-25-74; LB 9-1982, f. & ef. 10-1-82; DSL 9-2008, f. & cert. ef. 12-10-08

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Rule Caption: Deletes obsolete language and updates agency name.
Adm. Order No.: DSL 10-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 12-10-08
Notice Publication Date: 11-1-2008
Rules Amended: 141-091-0005, 141-091-0015
Subject: These rules establish fees for copies and other staff services. The agency is updating these rules by deleting reference to services no longer provided by the agency and reference to the agency's Deputy Director, no longer a position filled at DSL and replaces this reference to give authority to any of the agency's Assistant Directors to waive the requirement to pay for services in cash at the time of the request.

The agency is also updating the name from Division of State Lands to Department of State Lands.
Rules Coordinator: Elizabeth Martino—(503) 986-5239

141-091-0005
Fees

Unless otherwise stated by rule, the Department of State Lands shall make charges for copies and services as follows:

(1) Per image for Xerox copies:

(a) State agencies — $0.05;

(b) General public for material from Department files, copies made by Department staff — $0.25;

(c) General public for material from Department files, making their own copies — $0.10;

(d) Parties in contested cases, first 20 pages — $0.25 each;

(e) Additional pages — $0.20;

(2) Transcripts, reports, specialized maps, photos, etc. available through the Department: a charge approximating the cost of reproduction and handling.

(3) Certified copies of Department records, per certificate — $5. The charge includes the first four pages of document copied. Additional amount for each page in accordance with section (1).

Stat. Auth.: ORS 192 & 273
Stats. Implemented:
Hist.: LB 11-1982, f. & ef. 12-20-82; DSL 10-2008, f. & cert. ef. 12-10-08

141-091-0015
Billing

Charges shall be paid in cash at the time of request for copies except that at the discretion of the Director or any Assistant Director, billing may accompany mailed copies. State agencies or other governmental bodies may be billed for copies.

Stat. Auth.: ORS 192 & 273
Stats. Implemented: ORS 192 & 273
Hist.: LB 11-1982, f. & ef. 12-20-82; LB 5-1985, f. & ef. 7-24-85; DSL 10-2008, f. & cert. ef. 12-10-08

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Rule Caption: Revisions to the Local Wetlands Inventory Standards and Guidelines.
Adm. Order No.: DSL 11-2008
Filed with Sec. of State: 12-12-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 9-1-2008
Rules Adopted: 141-086-0222
Rules Amended: 141-086-0185, 141-086-0200, 141-086-0210, 141-086-0220, 141-086-0225, 141-086-0228, 141-086-0230, 141-086-0240
Rules Repealed: 141-086-0190
Subject: The Local Wetlands Inventory (LWI) Standards and Guidelines rules establish a method for identifying and mapping wetlands for local planning purposes and for incorporation into the Statewide Wetlands Inventory. Some of the revisions include a clarification of wetland verification; the minimum size of the wetland to be mapped; require a report in addition to the map products; require maps to be GIS products; and clarify when local government are required to expand or amend their LWI.
Rules Coordinator: Elizabeth Martino—(503) 986-5239

141-086-0185
Applicability

(1) Once approved by the Department of State Lands (Department), the LWI must be used in place of the National Wetlands Inventory (NWI) and is incorporated into the SWI.

(2) The approved LWI must be used by cities and counties in lieu of the NWI for notifying the Department of land use applications affecting mapped wetlands and other waters (ORS 215.418 and ORS 227.350).

(3) An LWI fulfills the wetlands inventory requirements for Goal 5 and Goal 17 (OAR 660-015 and 660-023). An LWI that meets the additional WCP requirements specified in these rules must be used as the wetlands inventory basis for a WCP.

(4) A wetland function and condition assessment of mapped wetlands must be conducted as part of the LWI using the *Oregon Freshwater Wetland Assessment Methodology* (*OFWAM*) published by the Department in 1996. An equivalent functional assessment methodology may be used or adjustments may be made to OFWAM upon written approval by the Director. The assessment results are used to determine the relative quality (functions, values, and condition) of the mapped wetlands and to designate significant wetlands (OAR 141-086-0300 through 141-086-0350) as required for Goal 5, or to assess wetland functions and values for a WCP.

(5) An LWI is used by the Department, other agencies and the public to help determine if wetlands or other waters are present on particular land parcels.

(6) An LWI provides information for planning purposes on the location of potentially regulated wetlands and other waters such as lakes and streams, but is not of sufficient detail for permitting purposes under the state Removal-Fill Law (ORS 196.800 through 196.990). Smaller wetlands may not be mapped, and wetlands may be missed due to lack of onsite access, tree canopy cover and other constraints. A wetland delineation or determination report may be needed for parcels without LWI-mapped wetlands. A Department-approved wetland delineation report for wetlands identified in an LWI is usually needed prior to site development.

(7) All wetlands inventory procedures and products are subject to review and approval by the Department before the products:

(a) Are incorporated into the SWI;

(b) Can be used in lieu of the NWI for Wetland Land Use Notification purposes; or

(c) Can be used by a city or county for Goal 5, Goal 17 or WCP purposes.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 196.674 - 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: LB 11-1991, f. & cert. ef. 11-15-91; LB 9-1994, f. & cert. ef. 12-15-94, Renumbered from 141-086-0190(1) & (4); DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0200
Definitions

(1) "Cowardin class or subclass" means the wetland classification according to the U.S. Fish and Wildlife Service's *Classification of Wetlands and Deepwater Habitats of the United States*, Cowardin et al., 1979.

(2) "Director" means the Director of the Oregon Department of State Lands or designee.

(3) "Department" means the Oregon Department of State Lands.

(4) "Georeferenced" means linking geographic data to known coordinates on the surface of the earth.

(5) "GIS" or "Geographic Information System" means a system of hardware, software and data storage that allows for the analysis and display of information that has been geographically referenced.

(6) "HGM class and subclass" means the hydrogeomorphic classification of the wetland based upon its landscape position and hydrology characteristics, according to the HGM classification developed by the Department.

(7) "Indicator" means the soil, vegetation, and hydrology characteristics or other field evidence that indicate that wetlands are present.

(8) "Inventory" means a systematic survey of an area to identify, classify and map the approximate boundaries of wetlands, and includes the supporting documentation required by these rules.

(9) "Mapping" means representing the identified wetlands and their approximate boundaries on a map.

(10) "Offsite Determination" means a wetland determination conducted without field verification using NWI maps, soils maps, and aerial photographs.

(11) "Other Waters" means waters of the state other than wetlands, such as streams and non-vegetated ponds.

(12) "Probable Wetland" or "PW" means an area noted during the course of LWI development that appears to meet wetland criteria but is less than one half of an acre in size or is small and of undetermined size, and is mapped as a point rather than a polygon on the LWI maps.

(13) "Sample Plot" means a specific area on the ground where soils, vegetation and hydrology data are recorded on a field data form per OAR 141-90-0035(14) in order to make a wetland determination.

(14) "Statewide Wetlands Inventory" or "SWI" means an inventory that contains at minimum the location, type (e.g. classification) and approximate extent of wetlands in the State of Oregon. This inventory is continually revised as additional information is received or obtained by the Department.

(15) "Stream" means a watercourse created by natural processes, or one that would be in a natural state if it were not for human-caused alterations. Stream includes a channelized or relocated stream.

(16) "Visually confirm" or "visual confirmation" means to walk over and/or visually check an area to make a wetland determination and map wetlands and other waters.

(17) "Wetlands" means those areas that are inundated or saturated by surface or ground water at a frequency or duration sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted for life in saturated soil conditions (ORS 196.800(16)).

(18) "Wetland Delineation Report" means a written document that contains the methods, data, conclusions and maps used to determine if wetlands and/or other waters of the state are present on a land parcel and, if so, describes and maps their location and geographic extent. A wetland determination report documenting wetland presence or absence is included within this definition (OAR 141-090 et seq.).

(19) "Wetland Determination" means a decision that a site may, does, is unlikely to, or does not contain wetlands. A determination does not include the precise location or boundaries of any wetlands determined to be present (OAR 141-090 et seq).

(20) "Wetland Mosaic" means a complex of several wetlands that are interspersed between areas of non-wetland each less than one half of an acre in size, or less than one tenth of an acre in size for a WCP, making them difficult to map.

Stat. Auth.: ORS 196.674 - 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: LB 11-1991, f. & cert. ef. 11-15-91; LB 9-1994, f. & cert. ef. 12-15-94; DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0210
Inventory Development Process and Standards

(1) Wetland determinations conducted for the purpose of developing the LWI must be conducted according to the criteria, methodologies and guidance currently accepted by the Department (OAR 141-090 et seq.).

(2) Sources of inventory information must include:

(a) U.S.D.A. Natural Resources Conservation Service county soil survey and county list of hydric soils and soils with hydric inclusions, or other available soil surveys;

(b) NWI maps;

(c) USGS topographic maps;

(d) Federal Emergency Management Act floodplain maps, where available;

(e) Other available local wetlands inventories or wildlife habitat inventories that include wetlands;

(f) Department wetland determination/delineation files; and

(g) High resolution (1 meter or finer) color and color infrared (where available) aerial photos taken within five years of inventory initiation. The minimum photo scale must be 1 inch = 200 feet unless another scale is approved by the Department.

(3) Sources of inventory information may include but are not limited to:

(a) LIDAR (Light Detection and Ranging) topographic data;

(b) Irrigation drainage district maps;

(c) Local knowledge of area (e.g., residents);

(d) Oregon State University Institute for Natural Resources Oregon Explorer data;

(e) Department permit files; and

(f) Resource agencies, including the Oregon Department of Fish and Wildlife and U.S. Fish and Wildlife Service.

(4) Before beginning fieldwork, prepare a field map using an aerial photograph and include the approximate location of:

(a) Any wetlands, deepwater habitats, and streams from the NWI;

(b) Any wetlands from the Department's wetland determination/delineation files or from other inventories;

(c) Hydric soils and soils with hydric inclusions (each coded separately);

(d) Wetlands or potential wetlands identified on aerial photos;

(e) Sites to visually confirm based on other leads; and

(f) Properties where access was granted.

(5) Aerial photo interpretation must be tested early in the inventory process by interpreting several wetland types, ground truthing the interpretations, and then completing the aerial photo interpretations.

(6) The local government must be responsible for requesting property access permission from landowners in the study area for parcels identified by inventory staff and/or the Department as possibly containing wetlands.

(7) All potential wetlands that are not assessed with a sample plot and other waters identified through the process described in OAR 141-086-0210(1) through (4) must be visually confirmed to the extent practicable.

(8) Where property access is granted, sample plot data must be provided according to the following minimum standards:

(a) Verify each wetland with at least one sample plot that best characterizes the wetland;

(b) Verify with at least one sample plot each potential wetland where land use activities such as ditching, water diversion, or agricultural practices are likely to have significantly altered site conditions, making observations from a distance or a site walk-over unreliable; and

(c) Verify with at least one-sample plot potential wetlands with unreliable indicators (e.g., one dominant plant that grows in both wetlands and non-wetlands, such as *Phalaris arundinacea*).

(9) If the LWI will be used for a WCP, in addition to the requirements in OAR 141-086-0210(7) and (8), a minimum of one sample plot must be provided that best characterizes each dominant wetland plant community.

(10) If the landowner denies access permission and if visual confirmation from an adjacent property or road is not possible, employ off-site wetland determination methods.

(11) All wetlands greater than or equal to one half of an acre and all wetlands identified in a Department-approved wetland delineation report must be identified and mapped as polygons. Wetlands that are less then one half of an acre may be mapped as polygons or as probable wetlands. Probable wetlands must be represented as points on the appropriate parcel(s) and should be labeled as "PW" on the maps. No further characterization or assessment is required for probable wetlands in the LWI. Probable wetlands will trigger cities and counties to notify the Department of proposed land use activities affecting mapped wetlands and other waters (ORS 215.418 and 227.350). For a WCP, all wetlands one-tenth acre and larger shall be identified and mapped as polygons.

(12) The aim of the LWI is to map the location of wetlands at an accuracy of approximately 5 meters (16.4 feet). However, the actual accuracy may be less for some wetlands such as seasonal or forested wetlands that could not be visually confirmed.

(13) Each wetland must be assigned a unique identification code.

(14) All previously delineated wetlands from the Department's files must be field-verified, if possible, to determine if wetlands are still present and are approximately the same size and configuration as when delineated.

(15) All identified wetlands must be classified:

(a) To the class level of Cowardin (and to subclass for scrub-shrub and forested classes) and must include water regime and special modifiers (e.g., "farmed" or "diked/impounded); and

(b) By dominant HGM class and subclass.

(16) When a wetland contains more than one adjoining Cowardin classification, different classes or subclasses greater than 0.25 acres in size must be mapped and labeled as separate polygons.

(17) Artificially created wetlands or other waters (such as irrigation canals and drains, industrial ponds, log ponds, golf course features, and storm water detention ponds that are greater than one half of an acre in size) must be included in the inventory regardless of their jurisdictional status, and their original purpose must be labeled on the inventory maps.

(18) Where a wetland mosaic occurs, the site must be labeled as a wetland/upland mosaic on all inventory maps and so described on the wetland summary sheet.

(19) Streams and other waters must be mapped, but no further documentation such as wetland summary sheets or OFWAM assessment is

required. If an existing stream geospatial dataset is used, it may be necessary to adjust the layer to align with riparian or other linear wetlands.

(20) Using OFWAM, each wetland in its entirety must be assessed for all four ecological functions: water quality, hydrologic control, wildlife habitat and fish habitat. Any wetlands that may qualify as a Locally Significant Wetland due to education or recreation use must also be evaluated for those social functions (values) in OFWAM. The remaining functions and conditions in OFWAM do not need to be applied to any of the wetland assessment units. Contiguous wetlands or those in close proximity and assigned different codes may be grouped into a single OFWAM assessment unit based upon the guidance in OFWAM and/or in consultation with the Department.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 196.674 - 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: LB 11-1991, f. & cert. ef. 11-15-91; LB 9-1994, f. & cert. ef. 12-15-94; DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0220
LWI Reports

(1) A report that meets the requirements in OAR 141-086-0220 (2) and (3) must be developed and submitted to the Department for approval. A minimum of two sets of the final Department-approved LWI report in both paper and electronic format (.pdf file format) must be prepared; one set must be provided to the Department for inclusion in the SWI and the other must be provided to the local government.

(2) The report must document the inventory and mapping processes and results, and include the following information:

(a) A general description of the study area including a description of the landscape setting;

(b) A description of the wetland inventory process including the public involvement process; the inventory methods including the date(s) and scale(s) of source maps and aerial photos used; the offsite and onsite wetland determination procedures including procedures used for visual confirmation and probable wetland identification; and all mapping and map transfer procedures used;

(c) A summary of the inventory results including the total acreage of the study area and the total number and acreage of wetlands identified within the study area, excluding the acreage of deepwater habitat and artificially created wetlands such as detention ponds or aggregate extraction ponds;

(d) A discussion of the OFWAM assessment process (e.g. how assessment units were defined) and the results;

(e) A summary of Locally Significant Wetlands, if identified (may be in table format); and

(f) All figures, with the study area clearly outlined.

(3) Appendices must include:

(a) Sample plot data on standard field data forms per OAR 141-090 et seq.

(b) A summary sheet for each wetland that must at a minimum include:

(A) The unique wetland code;

(B) Street address or equivalent location description;

(C) Township, Range, Section, Quarter Quarter Section and tax lot(s) that contain the mapped wetland;

(D) Approximate wetland size (in acres);

(E) Cowardin classification(s);

(F) HGM classification(s);

(G) Mapped soil unit(s);

(H) Watershed boundaries at the 6th field Hydrologic Unit Code scale as defined by the US Geological Survey or finer;

(I) Sample plot numbers, if any;

(J) Department wetland determination or delineation file numbers, where applicable;

(K) Scientific and common names of dominant plant species;

(L) Primary hydrology sources;

(M) Sampling or visual confirmation date(s) and method;

(N) Locally Significant Wetland determination, if made; and

(O) Comments that describe the wetland, including topographic position, land uses and significant alterations (including agricultural).

(c) OFWAM assessment results for each wetland assessment unit that must include:

(A) Wetlands of Special Interest for Protection (OFWAM, Chapter Five);

(B) Wetland Characterization results (OFWAM, Appendix B);

(C) Assessment results represented in table format;

(D) Answer sheets for all wetland assessment questions (OFWAM, Appendix C);

(E) Function and condition summary sheets for fish habitat, wildlife habitat, water quality, hydrologic control and, if applicable, education and recreation (OFWAM, Appendix C); and

(F) Watershed summary sheet (OFWAM, Appendix C).

(d) Technical staff members and qualifications.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 196.674 - 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: LB 11-1991, f. & cert. ef. 11-15-91; LB 9-1994, f. & cert. ef. 12-15-94; DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0222
Paper Map Standards

(1) Maps that meet the requirements in OAR 141-086-0222 (2) through (5) must be developed and submitted to the Department for approval. A minimum of two sets of the final Department-approved LWI maps in both paper and electronic format (.pdf file) must be prepared; one set must be provided to the Department for inclusion in the SWI and the other must be provided to the local government.

(2) If the study area is covered by more than one wetland map, a single, smaller scale reference map of the complete study area is required. The reference map shall be indexed to the individual, large-scale maps and show, at a minimum, the Public Land Survey System grid, the location and code of all identified wetlands, streams, the study area boundary, and major, named streets.

(3) Wetland maps must include:

(a) Map name;

(b) Scale bar;

(c) Geographic reference to the Public Land Survey System;

(d) Roads, with major roads named, and railroads;

(e) Streams and stream names;

(f) Artificially created wetlands and other waters labeled with their purpose (e.g. storm water pond);

(g) Tax lot lines;

(h) Watershed boundaries at the 6th field Hydrologic Unit Code scale as defined by the US Geological Survey or finer;

(i) Legend that explains all map symbols, line work, and patterns;

(j) Map date (month and year final map prepared);

(k) All wetlands, clearly and accurately drawn and clearly identified by a unique wetland code that relates each wetland to field data forms, tables, databases, wetland summary sheets, and OFWAM summary forms;

(l) Cowardin classification(s) of each wetland per 141-086-0210(15a & 16);

(m) Disclaimer that reads: "Information shown on this map is for planning purposes, represents the conditions that exist at the map date, and is subject to change. The location and extent of wetlands and other waters is approximate. There may be unmapped wetlands and other waters present that are subject to regulation. A current Oregon Department of State Lands-approved wetland delineation is required for state removal-fill permits. You are advised to contact the Department of State Lands and the U.S. Army Corps of Engineers with any regulatory questions."

(n) Numbered sample plots; and

(o) Study area boundary as defined by the local government.

(4) Minimum map scale must be 1 inch = 200 feet (1:2,400).

Stat. Auth.: ORS 196.674 – 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0225
Digital Data Standards

(1) A minimum of two sets of the final Department-approved LWI geospatial datasets must be prepared; one set must be provided to the Department for inclusion in the SWI and the other must be provided to the local government.

(2) A georeferenced ArcGIS compatible dataset with attribute tables and metadata must be developed for each of the following:

(a) Wetland polygons with a unique wetland identification label, Cowardin classification code(s) and modifiers, HGM classification, approximate wetland size, Locally Significant Wetland significance determination (if made), whether it was visually confirmed, and the Department's wetland delineation report file number, if any.

(b) Probable wetland points with PW label;

(c) Streams with unique identification labels and, where available, names;

(d) Other natural bodies of water with names;

(e) Artificially created wetlands and water features (such as irrigation canals and ditches, industrial ponds, log ponds, golf course features, and

storm water detention ponds) uniquely identified and purpose of artificially-created feature, if known;

(f) Watershed boundaries (6th order Hydrologic Unit Code scale or finer);

(g) Study area boundary;

(h) Tax lot lines and numbers;

(i) Sample plot dataset with unique identification labels that correspond to the field data form; and

(j) Major streets with name labels.

(3) All georeferenced data sets must be projected using the Oregon Geographic Information Council-endorsed state standard: Oregon Lambert conformal conic (Datum: NAD 83; Units: International feet: 3.28084; Spheroid: GRS1980).

(4) Metadata must be completed for each layer, conform to the current Oregon Geographic Information Council Metadata Standard, and must include a disclaimer as described in OAR 141-086-0222(3m).

Stat. Auth.: ORS 273.045
Stats. Implemented: ORS 196.668 - 196.686 & 196.692
Hist.: DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0228
Review and Approval Process

(1) A draft of all the LWI products required in OAR 141-086-0210 through 0225 of these rules must be provided to the Department (if the inventory was not developed by the Department) and the local government(s) for review.

(2) The local government must provide opportunity for public review of and comment on the draft LWI products.

(3) Public and local government comments on draft LWI products must be provided to the Department. The Department will request in writing from the party responsible for preparing the LWI any revisions or additions required in order for the LWI to be approved.

(4) The Department will review final products to ensure that all changes requested by the Department have been adequately addressed.

(5) If the final LWI products meet the requirements in these rules, the Department will send a letter of approval to the local government.

Stat. Auth.: ORS 273.045
Stats. Implemented: ORS 196.668 - 196.686 & 196.692
Hist.: DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0230
Revisions

(1) A city or county may elect to or may be required by the Department of Land Conservation and Development (DLCD) to revise their LWI. An LWI revision consists of either expanding the study area of an existing LWI or incorporating new wetland location and information into an existing LWI study area. The provisions in subsections (a) through (d) must be followed when an LWI is being revised.

(a) All Urban Growth Boundary expansion areas or other areas not included in the original LWI study area must be inventoried according to the requirements in these rules. If the original LWI area is not updated at the same time, it may still be necessary to update the LWI area adjacent to the new LWI area in order to align wetlands that are continuous between the two areas.

(b) When an LWI is being updated, newly identified wetlands or wetland boundary changes equal to or greater than one half of an acre must be identified, mapped and assessed using OFWAM.

(c) Sources of information for review of the previous study area to update the LWI must at a minimum include:

(A) Wetland delineation reports approved by the Department or map errors verified by the Department after the date of the approved LWI;

(B) Aerial photos approved by the Department, taken within five years of inventory revision initiation; and

(C) A field reconnaissance of the study area.

(d) Wetlands not previously mapped on the LWI must be verified by establishing a sample plot or by visual confirmation as required in OAR 141-086-0210(7) and (8) of this rule; previously mapped wetlands no longer apparent on aerial photos must also be verified with a sample plot or visually confirmed as necessary to confirm their absence.

(2) A draft of the revised LWI products as required in OAR 141-086-0228 (1) through (5) must be provided to the Department and is subject to Department review and approval.

(3) If the LWI was used as the basis for an approved WCP, the local jurisdiction must instead:

(a) Provide to the Department, as part of the annual report (OAR 141-086-0035), a revised map and report indicating wetlands filled and wetlands restored, enhanced or created for mitigation; and

(b) Every five years, in conjunction with the Department's five year WCP review (ORS 196.684(6)), conduct an LWI review and incorporate new information, as required in OAR 141-086-0230(1)(b) through (1)(d).

(4) Newly-identified wetlands as identified by a Department-approved wetland delineation report or a removal-fill permit must not be added to the Department-approved Local Wetlands Inventory map without following the procedures outlined by OAR 141-086-0230(1)(a) through (d).

(5) Refinements to the location, extent, and/or absence of wetlands mapped on the LWI, as identified by a Department-approved wetland delineation or a Department wetland determination report, may be made at any time through an administerial process, by annotating the approved LWI or by creating a separate geospatial dataset containing the boundary adjustments, preserving the approved LWI mapping.

Stat. Auth.: ORS 196.674 - 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: LB 11-1991, f. & cert. ef. 11-15-91; LB 9-1994, f. & cert. ef. 12-15-94; DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

141-086-0240
Landowner Notification

(1) When the LWI is approved by the Department, the local jurisdiction must notify by mail within one hundred twenty (120) calendar days all landowners of record whose parcel contains or abuts a mapped wetland or probable wetland.

(2) The local jurisdiction must provide one copy of the landowner notification letter to the Department.

Stat. Auth.: ORS 196.674 - 196.681 & 196.692
Stats. Implemented: ORS 196.668 - 196.692
Hist.: LB 11-1991, f. & cert. ef. 11-15-91; LB 9-1994, f. & cert. ef. 12-15-94; DSL 2-2001, f. & cert. ef. 2-26-01; DSL 11-2008, f. 12-12-08, cert. ef. 1-1-09

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Department of Transportation, Driver and Motor Vehicle Services Division
Chapter 735

Rule Caption: Acceptable Proofs of Full Legal Name, Legal Presence, Identity and Date of Birth.
Adm. Order No.: DMV 27-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Adopted: 735-062-0014
Rules Amended: 735-010-0130, 735-062-0005, 735-062-0015, 735-062-0020
Rules Repealed: 735-010-0130(T), 735-062-0014(T), 735-062-0015(T), 735-062-0020(T)
Subject: DMV implemented the changes required by Oregon Laws 2008, Chapter 1 (SB 1080) on July 1, 2008. Those changes include that all applicants for a driver license, driver permit or identification card must show proof of legal presence in the United States, proof of Social Security number (that must be verified) or proof of not being eligible for a Social Security number, and proof of full legal name.

In implementing the requirements of SB 1080, the department adopted OAR 735-062-0015 and amended OAR 735-062-0020 to require documentation of a legal name change if the applicant's current legal name does not match the name on the document submitted as proof of legal presence or proof of identity. Documentary proof of a legal name change includes a government issued marriage document or certificate of domestic partnership, a judgment of dissolution or annulment, an adoption decree or a court judgment for change of name. DMV determined that requiring documentary proof of a legal name change unnecessarily limits the proof an applicant may provide as proof of his or her current legal name and is overly burdensome for some applicants.

DMV adopted new OAR 735-062-0014, which authorizes DMV to accept an identity document listed in OAR 735-062-0020 as proof of the applicant's current legal name. There must be sufficient connection between the proof of the applicant's legal name and the name on the document submitted as proof of legal presence for DMV to determine the applicant is the person named in the legal presence document. If the applicant's current legal name is not on an identity document, the applicant must provide proof of a legal name

change as described above. This rule also clarifies that a document used to provide proof of a legal name change through marriage must be a government-issued marriage document. DMV does not accept a ceremonial marriage certificate that is presented to the couple at the wedding. The official document recording the marriage is the document filed with the county or state, and it is this document that DMV accepts as proof of a name change.

Oregon Laws 2008, Chapter 1, Section 7 allows DMV to verify with the issuing agency the validity and completeness of each identity source document presented by an applicant for a driver license, driver permit or identification card. DMV will soon begin verifying with the issuing agency those documents presented by permanent legal residents in the United States and persons legally in the United States on a temporary basis. DMV and the United States Department of Homeland Security – U.S. Citizenship and Immigration Services (DHS – USCIS) have an agreement that DMV may verify documents through the Systematic Alien Verification for Entitlements (SAVE) system. DMV plans to begin verifying documents through SAVE in January 2009. DMV amended OAR 735 062-0015 to specify that DMV will only accept documents verified through SAVE as proof of permanent or temporary legal status in the United States.

Also in January 2009, DMV will place on a person's DMV record an indicator of whether the person's SSN has been verified and whether documentation has been presented providing proof of U.S. citizenship, permanent legal residence or that the person is otherwise legally present in the United States. If the person's DMV record shows that the person's SSN has previously been verified and shows the person is a U.S. citizen or is a permanent legal resident of the United States, the person will not need to provide proof of an SSN and proof of legal presence when renewing, replacing or being issued a driver license, driver permit or identification card. Only a person whose documentation shows they are otherwise legally present in the United States (not a citizen or permanent legal resident) will continue to be required to show documentation at each and every visit to DMV. DMV amended OAR 735-062-0005 and 735-062-0015 to specify an applicant need not provide proof of an SSN and proof of legal presence when the person's DMV record indicates that DMV has already verified the person's SSN and viewed the person's proof of U.S. citizenship or permanent legal presence in the United States.

DMV amended OAR 735-062-0015 and 735-062-0020 to remove the section on name change as that information is now contained in OAR 735-062-0014.

DMV amended OAR 735-062-0020 to include as acceptable proof of identity and date of birth, the person's DMV record, including the digital photo on file with DMV. This amendment allows a person who provides proof of U.S. citizenship or permanent legal residence in the U.S. on or after January 1, 2009 to renew or replace a driver license, driver permit or identification card without providing any further proof to DMV (as long as the person has not changed names or moved). DMV can verify through the person's DMV record that the person is eligible to renew or replace a driver license, driver permit or identification card.

Rules Coordinator: Lauri Kunze—(503) 986-3171

735-010-0130
Establishment and Use of Full Legal Name by an Individual

All of the following apply to establishment and use of a full legal name by an individual:

(1) An applicant for an Oregon driver license, driver permit or identification card, shall establish his or her full legal name as supported by one or more documents proving identity and date of birth required under OAR 735-062-0020 or proof of current legal name under 735-062-0014.

(2) An individual shall use only his/her full legal name when conducting any business with DMV, including but not limited to obtaining driving privileges, an identification card, vehicle title and vehicle registration.

(3) If an individual has not established a full legal name as provided in section (1) of this rule, DMV will use the name on his or her customer record as his or her name for vehicle title and registration purposes. An individual who is shown on any application for title as provided in ORS 803.050, any application for salvage title as provided under 803.140 or any transitional ownership record as defined in 801.562, shall use his/her full legal name.

(4) An individual shall use the same name in conducting all business with DMV. The individual must also provide the DMV-assigned customer number shown on the driver license, driver permit or identification card, if known.

(5) An individual's full legal name shall not include a title or honorific such as, but not limited to, Mr., Mrs., Reverend or Doctor.

Stat. Auth.: ORS 184.616, 184.619 & 802.010
Stats. Implemented: ORS 801.562, 803.015, 803.050, 803.140, 803.220, 803.370, 807.050, 807.420, 807.560, 809.135, 821.080 & 2008 OL Ch 1
Hist.: DMV 6-1999, f. & cert. ef. 12-17-99; DMV 1-2008(Temp), f. 1-18-08, cert. ef. 2-4-08 thru 8-1-08; DMV 16-2008, f. 6-23-08, cert. ef. 7-1-08; DMV 23-2008(Temp), f. 9-11-08, cert. ef. 9-15-08 thru 3-13-09; DMV 27-2008, f. 12-15-08, cert. ef. 1-1-09

735-062-0005
SSN — Requirements for Proof of a Verifiable SSN or Ineligibility for a SSN and SSN Verification

(1) Except as provided in OAR 735-062-0032 and 732-062-0033, when a person who is eligible for a SSN applies for any original, renewal or replacement driver license, driver permit or identification card, the person must provide his or her SSN on the application form and the person must provide proof that the SSN is the one assigned to the person by the SSA, unless the person's DMV record shows DMV previously has verified the SSN as provided in section (3) of this rule and shows the person is a citizen or permanent resident of the United States. Proof that the SSN is the one assigned to the person by the SSA may include, but is not limited to, one or more of the following documents:

(a) Social Security Card or other SSA documentation;

(b) Income tax form filed with the Internal Revenue Service or a state tax agency;

(c) Employment document;

(d) Military document (DD214); or

(e) Any document containing full social security number acceptable as proof of legal presence or identity and date of birth as listed in OAR 735-062-0015 or 735-062-0020.

(2) Except as provided in OAR 735-062-0032 and 735-062-0033, a person who applies for any original, renewal or replacement non-commercial driver license or driver permit or identification card and claims to be ineligible for a SSN must provide proof that he or she is not eligible for a SSN. A person may prove his or her ineligibility for a SSN by presenting documents issued by the SSA, the Department of Homeland Security or other federal agencies or federal courts, which demonstrate that the person is not eligible to be assigned a SSN by the SSA. The person must also certify that he or she is ineligible for a SSN.

(3) When an applicant provides a SSN and the proof required by section (1) of this rule, DMV will submit the SSN to the SSA for verification, unless the applicant is a citizen or permanent legal resident of the United States whose SSN previously has been verified under this rule. An applicant's SSN is verified when SSA notifies DMV that the applicant's SSN, name and date of birth are confirmed by SSA's records.

(4) Except as provided in OAR 735-062-0032 and 735-062-0033, DMV will not issue, renew or replace any driver license, driver permit or identification card, unless:

(a) The applicant has proved his or her legal presence in the United States as provided in OAR 735-062-0015, and DMV has verified the applicant's SSN as provided in section (3) of this rule; or

(b) If the applicant claims to be ineligible for a SSN, the applicant has proved his or her ineligibility for a SSN as provided in section (2) of this rule and his or her legal presence in the United States as provided in OAR 735-062-0015.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.050 & 2008 OL Ch. 1
Stats. Implemented: ORS 802.200, 807.050 & 2008 OL Ch. 1
Hist.: MV 6-1990, f. & cert. ef. 4-2-90; DMV 11-1995, f. & cert. ef. 11-15-95; DMV 19-2003, f. 12-15-03 cert. ef. 1-1-04; DMV 2-2008(Temp), f. 1-18-08, cert. ef. 2-4-08 thru 8-1-08; DMV 16-2008, f. 6-23-08, cert. ef. 7-1-08; DMV 27-2008, f. 12-15-08, cert. ef. 1-1-09

735-062-0014
Proof of Legal Name

(1) If the applicant's current legal name is different from the name in the document submitted to prove legal presence pursuant to OAR 735-062-0015, the applicant must provide proof of the applicant's current legal name sufficient to establish that he or she is the same person named in the document submitted as proof of legal presence.

(2) There must be sufficient connection between information shown on the legal presence document and the proof of the applicant's current legal name for DMV to determine that the applicant is the person named in the legal presence document. Examples of connecting information include

first name, middle name or middle initial, previous surnames used, date of birth, place of birth, social security number or mother's maiden name.

(3) DMV may accept an identity document listed in OAR 735-062-0020 as proof of the applicant's current legal name.

(4) DMV may use the applicant's DMV record to help establish a connection between the identity document and the document used to establish legal presence.

(5) If the applicant's proof of legal name does not establish the applicant is the same person named in the document submitted as proof of legal presence, or the applicant's identity document or DMV record do not show the person's current legal name, the applicant must provide documentary proof of a legal name change. Documentary proof of an applicant's legal name change may include, but is not limited to: an official government-issued marriage document, a divorce decree, a certificate of registered domestic partnership, a judgment of dissolution or annulment of marriage or domestic partnership, an adoption decree, and a court decree, order or judgment legally changing the applicant's name.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & OL 2008, Ch 1
Stats. Implemented: OL 2008, Ch 1
Hist.: DMV 23-2008(Temp), f. 9-11-08, cert. ef. 9-15-08 thru 3-13-09; DMV 27-2008, f. 12-15-08, cert. ef. 1-1-09

735-062-0015
Proof of Legal Presence

(1) Except as provided in OAR 735-062-0032 and 735-062-0033, a person who applies for any original, renewal or replacement driver permit, driver license, or identification card must provide valid documentary proof that the person is a citizen or permanent legal resident of the United States or is otherwise legally present in the United States in accordance with federal immigration laws, unless the person's DMV record shows DMV has previously verified the person's SSN and shows that the person is a citizen or permanent legal resident of the United States. The documents provided must be either original or certified copies.

(2) Documents acceptable as proof of U.S. citizenship include, but are not limited to:

(a) A birth certificate issued by a U.S. Territorial government or the government of a state or political subdivision of a state of the United States. DMV will not accept a hospital-issued birth certificate, hospital card or birth registration or baptismal certificate.

(b) U.S. Consular Report of Birth Abroad (FS-240).

(c) U.S. government-issued Certification of Report of Birth (DS-1350 or FS-545).

(d) Request for Verification of Birth (DD372).

(e) United States passport, not expired more than five years.

(f) United States passport card, not expired more than five years.

(g) U.S. Territory passport, not expired more than five years.

(h) Tribal ID card from a federally recognized tribe located in Oregon or a federally recognized tribe with an Oregon affiliation, if DMV determines:

(A) The procedures used in issuing the card are sufficient to prove that a member is legally present in the United States; and

(B) The card contains security features that are sufficient to prevent alteration or counterfeiting of the card.

(i) Certificate of Citizenship (N560 and N561).

(j) Certificate of Naturalization (N550, N570 and N578).

(k) U.S. Citizen Identification Card (I-197 and I-179).

(3) Documents acceptable as proof of permanent legal residence in the U.S include, but are not limited to: Resident Alien card; Permanent Resident card (I-551); or a Permit to Re-Enter (I-327).

(4) Documents acceptable as proof that a person who is not a citizen or permanent legal resident of the United States is legally present in the United States include, but are not limited to:

(a) Valid foreign passport, not expired, with appropriate Arrival/Departure Record (I-94 or CBP I-94A) or a valid I-797 Notice of Action issued by the Department of Homeland Security or Custom and Border Protection.

(b) Passport (containing I-94) issued by the Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI) or Republic of Palau, not expired more than five years.

(c) U.S. Department of Homeland Security issued documents, not expired, including:

(A) Temporary Resident ID card (I-688);

(B) Employment Authorization card (I-688A, I-688B and I-766); or

(C) Refugee Travel Document Form I-571.

(5) DMV will not accept as the proof required by sections (3) and (4) of this rule a document that is not verified through the Systematic Alien Verification for Entitlements (SAVE) system.

(6) Notwithstanding section (5) of this rule, DMV may accept a document described in sections (3) and (4) of this rule that is not verified through the SAVE system if DMV is able to determine through other means that the document is valid.

(7) An applicant who must obtain a document in order to provide proof of legal presence may apply for an applicant temporary driver permit as described in OAR 735-062-0032 that will provide driving privileges for a limited time or an applicant temporary identification card as described in 735-062-0033.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 2008 OL Ch. 1
Stats. Implemented: 2008 OL Ch. 1
Hist.: DMV 16-2008, f. 6-23-08, cert. ef. 7-1-08; DMV 23-2008(Temp), f. 9-11-08, cert. ef. 9-15-08 thru 3-13-09; DMV 27-2008, f. 12-15-08, cert. ef. 1-1-09

735-062-0020
Proof of Identity and Date of Birth Requirements

(1) A person who applies for an original, renewal or replacement driver permit, driver license, or identification card must provide valid documentary proof of the person's identity and date of birth prior to the issuance of such driver permit, driver license, or identification card. Documents must be original or certified copies.

(2) Documents acceptable as proof of identity and date of birth include, but are not limited to:

(a) Any document that provides proof of legal presence as provided in OAR 735-062-0015.

(b) U.S. Military documents including:

(A) Military or Armed Forces ID card;

(B) Military Common Access Card; or

(C) U.S. Uniform Services ID and Privileges card (DD1173 and DD1173-1).

(c) Tribal ID card from a federally recognized tribe located in Oregon or a federally recognized tribe with an Oregon affiliation if DMV determines:

(A) The procedures used in issuing the card are sufficient to prove a member's identity and date of birth; and

(B) The card contains security features that are sufficient to prevent alteration or counterfeiting of the card.

(d) Canadian Government Issued Birth Certificate;

(e) Out-of-state, District of Columbia, U.S. Territorial government or Canadian driver license, instruction permit or identification card, that contains the applicant's photograph, not expired more than one year unless hole-punched or marked "Not Valid as ID."

(f) Oregon driver license, instruction permit, or identification card, not expired more than one year. For the purposes of this subsection, DMV will not accept a driver license that was issued without a photograph.

(g) U.S. Department of State driver license or Non-driver ID card not expired more than one year.

(h) Oregon Concealed Weapon Permit/Concealed Handgun License, not expired more than one year.

(i) A letter verifying identity provided by an Oregon County Community Corrections agency if:

(A) DMV determines the procedures used in issuing the letter are reasonably equivalent to DMV standards for verification of a person's age and identity; and

(B) The letter contains security features that are sufficient to prevent alteration or counterfeiting of the letter.

(j) A letter verifying identity provided by the U.S. Pretrial Services if:

(A) DMV determines the procedures used in issuing the letter are reasonably equivalent to DMV standards for verification of a person's age and identity; and

(B) The letter contains security features that are sufficient to prevent alteration or counterfeiting of the letter.

(k) A letter verifying identity provided by the Oregon Youth Authority Agency if:

(A) DMV determines the procedures used in issuing the letter are reasonably equivalent to DMV standards for verification of a person's age and identity; and

(B) The letter contains security features that are sufficient to prevent alteration or counterfeiting of the letter.

(l) A letter verifying identity provided by a U.S. District Court Probation Office if:

(A) DMV determines the procedures used in issuing the letter are reasonably equivalent to DMV standards for verification of a person's age and identity; and

(B) The letter contains security features that are sufficient to prevent alteration or counterfeiting of the letter.

(m) Oregon Department of Correction Release Identification card, issued after April 30, 2005.

(n) The applicant's DMV record, including the applicant's digital photo, if the applicant has previously been issued an Oregon driver license, driver permit or identification card.

(3) DMV will not accept a document as proof of identity and date of birth if DMV has reason to believe the document is not valid. DMV may request an applicant for a driver permit, driver license, or identification card to present additional documentary proof of identity and date of birth if the document presented does not establish the applicant's identity or date of birth to the satisfaction of DMV.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.050, 807.150 & 807.400
Stats. Implemented: ORS 807.050, 807.062, 807.150, 807.160, 807.220, 807.230 & 807.280
Hist.: MV 14-1987, f. 9-21-87, ef. 9-27-87; March 1988, Renumbered from 735-031-0016; MV 6-1990, f. & cert. ef. 4-2-90; DMV 12-1997, f. & cert. ef. 11-17-97; DMV 7-2001, f. & cert. ef. 3-7-01; DMV 34-2003(Temp), f. 12-15-03 cert. ef. 1-1-04 thru 6-28-04; DMV 5-2004, f. & cert. ef. 3-25-04; DMV 21-2004(Temp), f. & cert. ef. 10-1-04 thru 3-29-05; DMV 8-2005, f. & cert. ef. 2-16-05; DMV 9-2006, f. & cert. ef. 8-25-06; DMV 2-2008(Temp), f. 1-18-08, cert. ef. 2-4-08 thru 8-1-08; DMV 16-2008, f. 6-23-08, cert. ef. 7-1-08; DMV 23-2008(Temp), f. 9-11-08, cert. ef. 9-15-08 thru 3-13-09; DMV 27-2008, f. 12-15-08, cert. ef. 1-1-09

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Rule Caption: Consequences of Violating Conditions of a Hardship or Probationary Permit.
Adm. Order No.: DMV 28-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 11-1-2008
Rules Amended: 735-064-0110
Subject: DMV will revoke a hardship or probationary permit based on information that a person has violated the restrictions or conditions of the permit. DMV may receive a conviction for violating the permit from a court. Or DMV may receive a report that provides enough information for DMV to determine that the person violated the permit. Such a report may be an accident report, a uniform traffic citation or other specific information that the person drove outside of the permit restrictions or conditions. A person whose revocation of hardship or probationary permit is based on a conviction for violating the conditions or restrictions of the permit is entitled to an administrative review and the revocation remains in effect pending the outcome of the review as stated in Section (5) of this rule. When DMV determines that a person has violated a hardship or probationary permit based upon a report, the person is entitled to a contested case hearing. DMV has amended OAR 735-064-0110 (6) so the proposed revocation of the permit will not go into effect pending the outcome of the hearing to give the person the opportunity to challenge the facts of the report before the revocation goes into effect.
Rules Coordinator: Lauri Kunze—(503) 986-3171

735-064-0110
Consequences of Violations of Restrictions, Conditions, Limitations or Requirements of a Hardship or Probationary Permit

(1) DMV will revoke a person's hardship or probationary permit when a person commits a violation of any of the restrictions, conditions, limitations or requirements of a hardship or probationary permit as listed in OAR 735-064-0100, except as provided in section (2) of this rule.

(2) When a program approved by AMH, withdraws a required recommendation under ORS 813.500:

(a) Upon first withdrawal of the recommendation, DMV will suspend the hardship or hardship/probationary permit until the ending date of the DUII suspension or until the driver obtains a new recommendation, whichever is sooner; and

(b) Upon a second withdrawal of the recommendation, DMV will revoke the hardship or hardship/probationary permit.

(3) The person whose hardship permit is revoked will not be eligible for another hardship permit during the suspension period or for one year from the date of revocation, whichever is shorter.

(4) The person whose probationary permit is revoked will not be eligible for another probationary permit for one year from the date of the revocation of the probationary permit.

(5) A person whose hardship or probationary permit is revoked based on a notice from a court as specified in ORS 809.140, is entitled to an administrative review under 809.440(2). The revocation will remain in effect pending the outcome of the administrative review.

(6) A person whose hardship or probationary permit is revoked based on information other than that described in ORS 809.140, is entitled to a contested case hearing under 183.310 to 183.550. The revocation will not go into effect pending the outcome of the hearing.

Stat. Auth.: ORS 184.616, 184.619, 802.010, 807.270 & 813.510
Stats. Implemented: ORS 807.240, 807.270, 813.500 & 813.510
Hist.: MV 7-1984, f. 6-29-84, ef. 7-1-84; MV 17-1986, f. & ef. 10-1-86; MV 12-1987(Temp), f. 9-16-87, ef. 9-27-87; MV 31-1987, f. & ef. 10-5-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0125; MV 4-1991, f. 6-18-91, cert. ef. 7-1-91; MV 17-1991, f. 9-18-91, cert. ef. 9-29-91; DMV 5-1995, f. & cert. ef. 3-9-95; DMV 12-1996, f. & cert. ef. 12-20-96; DMV 4-2002, f. & cert. ef. 3-14-02; DMV 2-2006, f. & cert. ef. 2-15-06; DMV 28-2008, f. & cert. ef. 12-15-08

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Department of Transportation, Highway Division
Chapter 734

Rule Caption: Describes maximum allowed vehicle combination length on certain Oregon highways.
Adm. Order No.: HWD 10-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 11-1-2008
Rules Amended: 734-071-0010
Subject: These rules describe the maximum vehicle combination length allowed without a variance permit for certain Oregon highways. The revision was requested by the Oregon Refuse & Recycling Association, citing a member's need for flexibility in the rule that authorizes operation of a combination of vehicles that exceed the statutory length limits. The member contends that a vehicle combination it utilizes, a truck-tractor and 47 foot semi-trailer combination, can be equipped with an auxiliary axle that will allow the combination to track and maintain its lane of travel on a highway that currently requires a variance permit for operating a combination that includes a trailer over 40 feet in length. These amendments require a motor carrier to prove to the satisfaction of ODOT that the combination can be operated safely with no adverse impact to the infrastructure before it is approved. The combination of vehicles would continue to be subject to overall combination length limits. Other revisions update map revision dates.
Rules Coordinator: Lauri Kunze—(503) 986-3171

734-071-0010
Designated Highways and Definitions

(1) The types of vehicles, combinations of vehicles, or loads listed in Table 1 or Table 2 may operate without special permit upon:

(a) Group 1, Group 2 and Group 3 highways as shown on Group Map 1 as published by the Department when the dimensions do not exceed those listed in Table 1 for the corresponding highway group. Group Map 1, revised January 2008 is adopted by reference and made a part of division 71 rules; and

(b) Routes listed on Route Map 7 as published by the Department when the dimensions do not exceed those listed in Table 2 for the corresponding route listed in Table 2. Route Map 7, revised May 2008 is adopted by reference and made a part of Division 71 rules.

(c) Table 1 and Table 2 are available from the ODOT Over-Dimensional Permit Unit at 550 Capitol St. NE Salem, OR 97301-2530 or on the Motor Carrier Transportation Division Web site at: www.oregon.gov/ODOT/MCT/docs/Div71tables.pdf.

(2) Definitions for the purpose of Division 71 rules:

(a) "Auxiliary axle" is an axle that qualifies as a booster axle, flip axle or lift axle;

(b) "Booster axle" means a separate vehicle bolted or pinned to another vehicle that redistributes weight from one or more axles to other axles and pivots from side to side at the connection point or has wheels that steer during turning;

(c) "Dromedary truck-tractor" means a motor vehicle designed to carry a load on a dromedary box, plate or deck, not exceeding 12'06" in length inclusive of load and designed to pull a semitrailer;

(d) "Flip axle" means an axle that is bolted or pinned to a vehicle and flips from the closed position on the trailer to a deployed position on the ground extending the length and hauling capacity of the trailer;

(e) "Gross Vehicle Weight Rating" (GVWR) means the gross vehicle weight rating as defined in ORS 801.298;

(f) "Lift axle" means an axle that can be raised from or lowered to the surface of the ground;

(g) "MCTD" means the Motor Carrier Transportation Division of the Oregon Department of Transportation;

(h) "Motor truck" means a motor vehicle that is primarily designed or used for carrying loads other than passengers;

(i) "Overall length" includes the vehicle or combination of vehicles and any load overhangs. Exclusions to overall length determination are provided in OAR 734-071-0050.

(j) "Passenger vehicle" or "light vehicle" means a motor vehicle, regardless of design or intended use;

(k) "Pickup truck" means a motor vehicle designed to carry passengers and to carry a load and which shall not tow more than one vehicle, except as provided in OAR 734-071-0060;

(l) "Stinger-steered" is as defined in ORS 801.507;

(m) "Tow-away operation" means an operation where empty trailers constitute the commodity being transported; and

(n) "Truck-tractor" means a motor vehicle designed and used primarily for drawing (towing) other vehicles and constructed so as not to carry any load other than a part of the weight of the vehicle or load, or both, as drawn.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619, 810.050 & 810.060
Stats. Implemented: ORS 810.060 & 818.220
Hist.: 1 OTC 5-1980, f. & ef. 3-27-80; 2HD 5-1982(Temp), f. & ef. 10-5-82; 2HD 8-1983, f. & ef. 3-30-83; HWY 3-1993(Temp), f. & cert. ef. 7-13-93, HWY 3-1994(Temp), f. 5-19-94, cert. ef. 5-20-94; HWY 2-1995, f. & cert. ef. 10-16-95; HWY 5-1997, f. & cert. ef. 5-9-97; TO 5-1998, f. & cert. ef. 4-16-98; TO 2-2001, f. & cert. ef. 6-14-01; TO 10-2002, f. & cert. ef. 12-13-02; HWD 1-2003, f. & cert. ef. 8-21-03; HWD 5-2004, f. & cert. ef. 5-20-04; HWD 7-2004, f. 12-28-04, cert. ef. 1-1-05; HWD 10-2008, f. & cert. ef. 12-15-08

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Rule Caption: Amendment and repeal of rules related to automobile and boat transporters.
Adm. Order No.: HWD 11-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 6-1-2008
Rules Amended: 734-073-0110
Rules Repealed: 734-073-0120
Subject: ODOT amended its rules related to length limitations for automobile and boat transporters to align with federal regulations which allow a vehicle combination overall length of 65 feet for automobile or boat transporters using a semitrailer. Oregon rules previously limited an automobile or boat transporter semitrailer length to 53 feet, which in some cases resulted in a more restrictive overall length allowance than the 65 foot federal standard. Other amendments clarify what is included in length determination and authorized routes. Since vehicle combination length requirements for automobile and boat transporter are the same, a separate rule regarding boat transporters was repealed and boat transporters are now included in the same rule with automobile transporters.
Rules Coordinator: Lauri Kunze—(503) 986-3171

734-073-0110
Specialized Equipment — Automobile/Boat Transporters

The Federal Highway Administration determines Automobile/Boat Transporters are Specialized Equipment as provided by 23 CFR 658.13(e).

(1) Traditional automobile/boat transporters (truck tractor and semitrailer combinations) may operate without a permit on National Network Highways (Route Map 7 Green) and Route Map 7 Brown, Purple and Black Routes with an overall length of 65 feet. The overall length determination excludes load overhangs, provided the load does not extend beyond the front of the power unit by more than four feet and does not extend beyond the rear of the trailer by more than five feet. Such combinations may operate without individual vehicle length restrictions.

(2) Traditional auto/boat transporters (truck tractor and semitrailer combinations) may operate without a permit on National Network Highways (Route Map 7 Green Routes) or Route Map 7 Brown Routes and exceed a length of 65 feet, provided the semitrailer does not exceed 53 feet in length, inclusive of ramps, and the load does not extend beyond the front of the power unit by more than four feet and does not extend beyond the rear of the semitrailer by more than five feet.

(3) Automobile/boat transporters towing stinger-steered trailers may operate without a permit on National Network Highways (Route Map 7 Green Routes) and Route Map 7 Brown Routes with a length of 75 feet, excluding load overhangs, provided the load does not extend beyond the front of the power unit by more than four feet and does not extend beyond the rear of the trailer by more than five feet. Such combinations may operate without individual vehicle length restrictions.

(4) Automobile/Boat transporter operations other than those described in this rule shall not exceed the length restrictions as shown on the reverse of Group Map 1 or Route Map 7, whichever is greater.

(5) Automobile/boat transporters are authorized to transport automobiles/boats on racks above and behind the power unit cab.

(6) Automobile/boat transporters are authorized to have load protection devices or aerodynamic devices provided the devices do not exceed legal load extensions as defined in section (2) of this rule and the device is not load bearing.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619, 810.050 & 810.060
Stats. Implemented: ORS 818.100, 818.200 & 818.220
Hist.: HWY 1-1995, f. & cert. ef. 9-18-95; HWY 8-1997, f. & cert. ef. 8-26-97; HWD 2-2005, f. & cert. ef. 3-18-05; HWD 11-2008, f. & cert. ef. 12-15-08

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Department of Transportation, Motor Carrier Transportation Division
Chapter 740

Rule Caption: Limit who may apply for a PIN to transact business with ODOT on behalf of a motor carrier.
Adm. Order No.: MCTD 4-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 11-1-2008
Rules Amended: 740-015-0020, 740-015-0040
Subject: These amendments limit who may apply for a PIN to transact business electronically with ODOT on behalf of a motor carrier. Issuance of a PIN will be limited to responsible officials of a motor carrier or trucking company. Limiting direct access to owners, partners, corporate officers and managers (if LLC) retains authority in the hands of the people responsible for that motor carrier.

These amendments change the definition of "motor carrier" to exclude agents for the purposes of applying for or receiving a PIN. Agents will still be able to use Trucking Online on behalf of a motor carrier, but the PIN number must be given to the agent by responsible officials of the motor carrier rather than by ODOT.
Rules Coordinator: Lauri Kunze—(503) 986-3171

740-015-0020
Definitions

For purposes of OAR chapter 740, division 15, the following definitions apply:

(1) "Agent" means a person or organization appointed or assigned by a Power of Attorney to conduct all business on behalf of a motor carrier.

(2) "Electronic record" means a record created, generated, sent, communicated, received or stored by electronic means through the use of computers.

(3) "Electronic signature" means an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person or organization with the intent to sign the record.

(4) "Electronic transaction" means the use of computers to exchange an electronic record and, in those transactions where an ink on paper signature would also be required under Oregon law, an electronic signature, between a motor carrier and MCTD for the purposes of:

(a) Facilitating access to public records or public information;

(b) Purchasing or selling goods or services;

(c) Transferring funds;

(d) Facilitating the submission of an electronic record or electronic signature required or accepted by MCTD; or

(e) Creating records upon which MCTD or another person or organization will reasonably rely upon and may use for audit purposes, including but not limited to formal communications, notices, certifications and any other record that is issued under a signature.

(5) "Hardcopy" means a document printed on paper.

(6) "MCTD" means the Motor Carrier Transportation Division of the Oregon Department of Transportation.

(7) "Motor carrier" means a for-hire or private carrier, as defined in ORS 825.005, and except for the purposes of OAR 740-015-0040, includes any agent or person authorized by the motor carrier to conduct business on behalf of the motor carrier.

(8) "PIN" means a Personal Identification Number assigned by MCTD to a person or organization to establish a secure means of authenticating the identity of a motor carrier when conducting certain specified electronic transactions with MCTD.

(9) "PIN transaction" means an electronic transaction that requires the use of a PIN assigned by MCTD. A PIN transaction includes but is not limited to the submission of a document or information that is required by law or administrative rule to be "signed" or submitted to MCTD "in writing."

(10) "Record" means a document or information that is customarily printed on paper, which contains information relating to and evidencing the transaction of business between a motor carrier and MCTD.

(11) "Trucking Online" means the MCTD Internet-based electronic transaction program found at: http://www.odot.state.or.us/trucking/online/.

(12) "Unique identifier" means a number, name, symbol or other identifier used singly or in combination by MCTD to uniquely identify a motor carrier, agent or vehicle to MCTD. For example, a driver license number, customer identification number, date of birth, place of birth, mother's maiden name, vehicle license plate number, vehicle identification number, file number, etc.

Stat. Auth.: ORS 184.616, 184.619 & 802.012
Stat. Implemented: ORS 802.012
Hist.: MCTD 5-2003, f. & cert. ef. 10-24-03; MCTD 4-2008, f. & cert. ef. 12-15-08

740-015-0040
Personal Identification Number (PIN); Unique Identifiers

(1) MCTD may require the use of a PIN or other unique identifier for certain electronic transactions.

(2) When a PIN is required, a motor carrier may request a PIN by submitting a completed PIN Request Form (downloaded at http://www.odot.state.or.us/trucking/online/) to MCTD. A PIN Request Form must be signed by an owner, partner, corporate officer, or manager member of a limited liability company and submitted to MCTD by U.S. Mail or facsimile.

(3) Upon receipt of a PIN Request Form, MCTD will assign and e-mail the PIN to the e-mail address provided on the PIN Request Form. MCTD will send, by U.S. mail, an activation notice to the motor carrier's address of record.

(4) MCTD reserves the right to terminate a PIN issued under this rule if:

(a) The PIN is not activated, or used at MCTD's Web site, within a 12-month period;

(b) The Department determines that a transaction was conducted fraudulently; or

(c) The Department determines the PIN holder has not complied with the provisions of division 15 rules, Oregon Revised Statute (ORS) Chapter 825 or ORS 826, or any other Oregon law regarding electronic transactions.

(5) The motor carrier to whom a PIN is assigned is responsible for the security of the PIN and transactions conducted using the PIN.

Stat. Auth.: ORS 184.616, 184.619, 802.012 & 825.212
Stats. Implemented: ORS 802.012 & 825.212
Hist.: MCTD 5-2003, f. & cert. ef. 10-24-03; MCTD 4-2008, f. & cert. ef. 12-15-08

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Employment Department
Chapter 471

Rule Caption: States Employment Department's exemption from Motion for Summary Determination process under the Administrative Procedures Act.
Adm. Order No.: ED 12-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-010-0025
Subject: Rule states that pursuant to OAR 137-003-0580(4), the Employment Department is exempt from Motion for Summary Determination Process under the Administrative Procedures Act.
Rules Coordinator: Janet Orton—(503) 947-1724

471-010-0025
Exemption from Summary Determination

Pursuant to OAR 137-003-0580 (4), the Oregon Employment Department is exempt from Motion for Summary Determination process under the Administrative Procedures Act.

Stat. Auth.: ORS 657.610
Stats. Implemented: ORS 657.610
Hist.: ED 12-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: States that witnesses appearing for the Employment Department who are employees of the department are qualified to testify in hearings as to actions taken by the department by virtue of their employment.
Adm. Order No.: ED 13-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-010-0045
Subject: Stipulates that Employment Department staff called to testify in hearings regarding actions taken by the agency are qualified by virtue of their employment with the agency to testify.
Rules Coordinator: Janet Orton—(503) 947-1724

471-010-0045
Witness Qualification

For the purposes of ORS Chapter 657 any witness appearing for the Employment Department, who is an employee of the department:

(1) Is considered to be a duly authorized agent of the director; and

(2) Is considered, by virtue of their employment, to be qualified to testify in an administrative hearing as to the actions taken by the department that resulted in the proceeding in which they are testifying.

Stat. Auth.: ORS 657.610
Stats. Implemented: ORS 657.610
Hist.: ED 13-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Revised rule to clarify the order in which payments are applied.
Adm. Order No.: ED 14-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Amended: 471-031-0072
Subject: Revised rule to clarify the order in which payments are applied to delinquent tax debts and to limit the definition of legal fees.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0072
Application of Payments

(1) Except as otherwise provided by statute, or directed by a court of competent jurisdiction, payments made to the Employment Department by or on behalf of an employer for taxes; and legal fees, penalties and interest related to taxes; in accordance with the provisions of ORS Chapter 657 shall identified by the Department as either Designated or Undesignated Payments and shall be credited to the employer's account in the following order of priority:

(a) Undesignated Payments; payments received by the Employment Department that are not designated as a payment for a specific quarter or distraint warrant will be identified as an Undesignated Payment and will be credited to:

(A) To the oldest unwarranted unpaid quarter balance in the following order:

(i) Penalties;

(ii) Interest;

(iii) Tax.

(B) When all amounts due in (A) are paid, payments will be then be credited to the most recent unpaid distraint warrant in the following order:

(i) Legal Fees;

(ii) Penalties;

(iii) Interest;

(iv) Tax.

(b) Designated Payments; payments received by the Employment Department that are designated as a payment for a specific quarter or

distraint warrant will be identified as a Designated Payment and will be credited to the specific designated quarter or distraint warrant as follows:

(i) Legal Fees;

(ii) Penalties;

(iii) Interest;

(iv) Tax.

(2) The Director may identify categories of indebtedness for internal accounting procedures and may retire each category separately in the order of priority set forth in section (1) of this rule.

(3) Nothing in this rule shall be construed in any way as abridging or limiting the authority or powers of the Director granted under ORS 657.457, 657.515, 657.517, or 657.610.

(4) The employees listed in OAR 471-031-0145 may act on behalf of the Director for purposes of sections (2) and (3) of this rule.

(5) Notwithstanding any instructions to the contrary by or on behalf of the employer, payments will be applied in the manner specified in this rule.

(6) Credit balances will be treated as payments for purposes of this rule.

(7) Legal Fees are defined as fees attributed to the recording or processing of distraint warrants on behalf of the agency for the purposes of collecting Unemployment Insurance taxes pursuant to ORS 657.396 and search fees attributed to garnishments issued to financial institutions pursuant to Chapter 18.

Stat. Auth.: ORS 657.610
Stats. Implemented: ORS 657.457, 657.505, 657.515, 657.557, 657.642, 657.663 & 657.990
Hist.: ED 5-1996, f. & cert. ef. 8-5-96; ED 14-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Clarifies "good cause" as used in ORS 657.457, 657.552 and 657.663.
Adm. Order No.: ED 15-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Amended: 471-031-0151
Subject: The rule clarifies the term "good cause" as used in ORS 657.457, 657.552 and 657.663. Outlines acceptable documentation to serve as good cause for failure to file reports or pay tax.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0151
Failure to File Reports or Pay Tax — Good Cause

(1) As used in ORS 657.457, 657.552, and 657.663 "good cause" will be found to exist when the employer establishes by satisfactory evidence that factors or circumstances beyond the employer's reasonable control caused the delay in filing the required document or paying the tax due.

(2) In determining "good cause" under section (1) of this rule, the Director or an authorized representative may consider all circumstances, but shall require at a minimum that the employer:

(a) Prior to the date the document or tax was due, gave notice to the Employment Department, when reasonably possible, of the factors or circumstances which ultimately caused the delay;

(b) Filed the required document or paid the tax due within seven days after the date determined by the Director to be the date the factors or circumstances causing the delay ceased to exist; and

(c) Made a diligent effort to remove the cause of the delay and to prevent its recurrence.

(d) Provide an official police report, or other documentation of the criminal act acceptable to the Director or an authorized representative, that was made within 20 days of the incident, or discovery of the incident, if the delay was due to a criminal act by any party.

(3) In applying sections (1) and (2) of this rule, a lack of funds on the part of the employer shall not constitute good cause for failure to pay all taxes when due.

Stat. Auth.: ORS 657
Stats. Implemented: ORS 657.457, 657.552 & 657.663
Hist.: 1DE 2-1984, f. & ef. 9-28-84; ED 15-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Defines "shopping news" as used in ORS 657.080.
Adm. Order No.: ED 16-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0190
Subject: Makes the public aware of the definition of "shopping news" as used in ORS 657.080.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0190
Shopping News

For the purposes of ORS 657.080(1), "shopping news" includes, but is not limited to, publications that consist primarily of classified ads and/or coupons and does not include publications that are primarily phone listings.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 16-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Defines "horticultural commodity" as used in ORS 657.045.
Adm. Order No.: ED 17-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0195
Subject: Makes the public aware of the definition of "horticultural commodity" as used in ORS 657.045.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0195
Horticultural Commodity

(1) For purposes of ORS 657.045(3)(a), "horticultural commodity" means a product resulting from the services performed by a farm worker including: the planting, cultivating, propagating, harvesting, handling, and delivering to storage or to market or to a carrier for transportation to market.

(2) "Farms" include: truck farms, plantations, ranches, nurseries, ranges, orchards, and such greenhouses and other similar structures as are used primarily for the raising of commodities for sale. Greenhouses and similar structures used primarily for purposes such as display, storage for rental of horticultural commodities, and fabrication of horticultural arrangements, do not constitute "farms."

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 17-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Defines "their equipment" as used in ORS 657.047.
Adm. Order No.: ED 18-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0200
Subject: Makes the public aware of the definition of "their equipment" in ORS 657.047.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0200
Ownership of Equipment

For the purposes of ORS 657.047(b), "their equipment" consists of vehicles or equipment independently furnished by the person providing the services, neither leased nor purchased from the for-hire carrier or affiliate entity, unless title to the vehicle or equipment is duly registered with the appropriate state agency under the service provider's name.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 18-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Clarifies the relationship between cafeteria plans and ORS 657.115.
Adm. Order No.: ED 19-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0205
Subject: Outlines the relationship between cafeteria plans and ORS 657.115.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0205
Cafeteria Plans

Employee benefits paid through a cafeteria plan, as defined in the Internal Revenue Code (IRC) Section 125, are not included in wages if listed as excluded in ORS 657.115, even if paid through a payroll deduction.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 19-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Define "risk to the trust fund" as used in ORS 657.507.
Adm. Order No.: ED 20-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0210
Subject: Attempts to clarify questions about the departments authority to demand deposits.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0210
Bond or Deposit

(1) For the purposes of ORS 657.507(1), the director or an authorized representative may demand a bond or deposit to protect the Unemployment Compensation Trust Fund balance when the director or an authorized representative has determined that there is sufficient evidence that a risk exists.

(2) "Risk" is solely determined by the director or an authorized representative and includes circumstances where a principal of an employing entity, who continues to employ workers subject to ORS Chapter 657:

(a) is currently delinquent in filing Unemployment Insurance reports or payment of Unemployment Insurance tax; or

(b) was previously delinquent in filing Unemployment Insurance reports or payment of Unemployment Insurance tax.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 20-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Defines "spouse" as used in ORS 657.
Adm. Order No.: ED 21-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0215
Subject: Defines "spouse" as used in ORS 657 to have the same meaning as defined in HB 2007, passed by the 2007 legislature.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0215
Registered Domestic Partnerships

For the purposes of ORS Chapter 657, "spouse" includes any person in a registered domestic partnership considered valid under the laws of the State of Oregon.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 21-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Franchise must meet an exclusion in 657 when there is payment for services.
Adm. Order No.: ED 22-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0220
Subject: Clarifies the requirement for any individual or business entity under contract as a franchise to meet an exclusion in 657.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0220
Franchisee

(1) A "franchisee" means an individual or business entity that has a franchise license from the owner of a trademark, or trade name permitting another to sell a product, or service under that name or mark.

(2) Individuals or business entities who provide primarily services for pay, and are under contract to provide services as franchisees, must meet the requirements of ORS 657.040 and 670.600 or some other exclusionary provisions of Chapter 657 in order to be excluded from the classification of employee under this Chapter.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 22-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Defines who may be considered an LLC or LLP member in ORS 657.044(b) & (c).
Adm. Order No.: ED 23-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0225
Subject: Clarifies the definition for who may be considered a member of a Limited Liability Company or a Limited Liability Partnership as used in ORS 657.044(b) and (c).
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0225
Limited Liability Company and Limited Liability Partnership Members and Partners

For the purposes of ORS 657.044(b) or (c), members of a limited liability company or limited liability partnership must:

(1) Must hold at least 10% ownership interest in the limited liability company or limited liability partnership; and

(2) must receive a share of the profit or loss commensurate with the percentage of ownership interest; and

(3) must have voting rights in the management of the company.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 23-2008, f. 11-24-08, cert. ef. 12-1-08

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Rule Caption: Clarification of language for the purposes of ORS 657.506.
Adm. Order No.: ED 24-2008
Filed with Sec. of State: 11-24-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 471-031-0230
Subject: The rule clarifies the language in 657.040. The rule allows for exemption with a written contract that meets the requirements outlined in ORS 657.506. Stipulates that the musician operating as a corporation or LLC are employees of that corporation or LLC if the corporation or LLC is registered with the Secretary of State prior to the engagement and independent of the organization engaging the musician's services.
Rules Coordinator: Janet Orton—(503) 947-1724

471-031-0230
Musicians

For purposes of 657.506, notwithstanding ORS 657.040;

(1) The person or organization engaging the services of musicians is the employer of the musicians unless a written contract is executed that meets the requirements of ORS 657.506.

(2) Musicians operating as a corporation or limited liability company are employees of the corporation or limited liability company if the corporation or limited liability company is:

(a) Duly registered with the State of Oregon Secretary of State, prior to the engagement; and

(b) Independent of the organization engaging the services of the musicians.

Stat. Auth. ORS 657.610
Stas. Implemented: ORS 657.610
Hist.: ED 24-2008, f. 11-24-08, cert. ef. 12-1-08

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Occupational Therapy Licensing Board
Chapter 339

Rule Caption: Pain Management CE; OT in Education; Renewal Fees non refundable; Notary for supervision forms deleted.
Adm. Order No.: OTLB 1-2008
Filed with Sec. of State: 11-25-2008
Certified to be Effective: 1-1-09

Notice Publication Date: 9-1-2008
Rules Adopted: 339-020-0015
Rules Amended: 339-010-0023, 339-010-0035, 339-010-0050
Subject: Changes to OAR 339-010-0023 make renewal fees non refundable; a change needed with new online renewals started in 2008 with credit card payments; this rule conforms to other health licensing boards for the online, credit card process.

Changes to OAR 339-010-0034 deleted the requirement that Statement of Supervision must be notarized.

Changes to OAR 339-010-0050 made after over a year of looking at the issues and the need to update the previous rule dealing with Occupational Therapists working in education.

Changes to OAR 339-020-0015 adds a legislative requirement at the 2007 legislative session making it mandatory for Occupational Therapists to complete 7 hours of CE in Pain Management.
Rules Coordinator: Felicia Holgate—(971) 673-0198

339-010-0023
License Renewals

(1) Each applicant for license renewal shall submit to the Board on or before May 1 of each even numbered year a completed license renewal application, CE log and appropriate renewal fee. The renewal fees are non-refundable.

(2) Failure to submit a renewal application, CE log and appropriate fee by May 1 may result in a civil penalty imposed on the applicant.

Stat. Auth.: ORS 675.320(10)(11)
Stats. Implemented: ORS 675.336 & 675.337
Hist.: OTLB 1-2001, f. & cert. ef. 1-12-01; OTLB 1-2004, f. & cert. ef. 6-3-04; OTLB 1-2008, f. 11-25-08, cert. ef. 1-1-09

339-010-0035
Statement of Supervision for Occupational Therapy Assistant

(1) Any person who is licensed as an occupational therapy assistant may assist in the practice of occupational therapy only under the supervision of a licensed occupational therapist.

(2) Before an occupational therapy assistant assists in the practice of occupational therapy, he/she must file with the Board a current statement of supervision of the licensed occupational therapist who will supervise the occupational therapy assistant.

(3) An occupational therapy assistant always requires at least general supervision.

(4) The supervising occupational therapist shall provide closer supervision where professionally appropriate.

(5) The supervisor, in collaboration with the supervisee, is responsible for setting and evaluating the standard of work performed.

Stat. Auth.: ORS 675.320(11), (13) & (14)
Stats. Implemented: ORS 675.210(4)
Hist.: OTLB 2-1986, f. & ef. 6-27-86; OTLB 2-1990, f. & cert. ef. 12-20-90; OTLB 1-1996, f. & cert. ef. 4-16-96; OTLB 1-1999, f. & cert. ef. 10-27-99; OTLB 1-2008, f. 11-25-08, cert. ef. 1-1-09

339-010-0050
Occupational Therapy Services for Children and Youth in Education and Early Childhood Programs regulated by federal laws

(1) Definitions: This rule applies to all occupational therapy practitioners who include both occupational therapists and occupational therapy assistants as defined in OAR 339-010-0005. All other rules regarding Occupational Therapy practitioners apply notwithstanding what is found in these rules as they apply to practitioners in the education setting.

(a) "Children and youth" refers to a child or student determined to be eligible for services under IDEA or Section 504. *Part B* under IDEA describes requirements for the provision of special education services for preschool and school-age children and youth, ages 3 through 21 years. *Part C*, or the early intervention program, focuses on services for infants and toddlers with disabilities and their families. Section 504 and the Americans With Disabilities Act (ADA 1990) define a person with a disability as "any person who has a physical or mental impairment that substantially limits one or more major life activities…" and require a public school system to provide needed accommodations or services.

(b) "Service plans" document the program of services and supports necessary to meet a child's developmental or educational needs under the IDEA. These specify the need for occupational therapy services and include: the individualized family services plan (IFSP) for infants, toddlers and preschoolers; the individualized education plan (IEP) or a Section 504 Plan for school-age youth.

(c) "Educational or developmental goals" are developed collaboratively by a multi-disciplinary early intervention or educational team, which includes an occupational therapist as a related service provider, when areas of occupational performance have been identified.

(d) "Natural environment" refers to the most appropriate setting for the child to develop the skills needed for occupational performance.

(e) "Educational environments" refers to home; community; day care; preschool, or the general and special education settings.

(f) "Evaluation" is the process of gathering information to make decisions about a student's or child's strengths and educational or developmental needs.

(g) "Assessments" are the specific methods or measures used to gather data for the evaluation.

(2) **The Occupational Therapy Process**:

(a) Evaluation: The occupational therapist is responsible for the occupational therapy evaluation.

(A) The occupational therapist selects assessment methods that focus on identifying factors that act as supports or barriers to engagement in occupations. The initial occupational therapy evaluation should include analysis of the child's ability to access the natural or educational environment for learning.

(B) The occupational therapist must participate in decisions about the need for occupational therapy services, development of functional, measurable goals and determining which educational or developmental goals occupational therapy will support.

(C) The occupational therapist determines the types, frequency and duration of interventions, as well as accommodations and modifications of the environment.

(D) Screening to determine the need for an occupational therapy evaluation does not constitute initiation of occupational therapy services.

(b) Intervention: The occupational therapy practitioner may implement occupational therapy services, along a continuum, which may include the following:

(A) Direct intervention is the therapeutic use of occupations and activities with the child present, individually or in groups.

(B) Consultation is collaborative problem solving with parents, teachers, and other professionals involved in a child's program.

(C) The education process is imparting generalized knowledge and information about occupation and activity and does not address an individual child's specific education plan.

(c) Outcomes: The occupational therapist should review the intervention on an ongoing basis and dependent on the child's response, modify as needed.

(3) **Delegation of therapeutic activities**:

(a) The occupational therapy practitioner may instruct others, such as educational or daycare staff, to carry out a specific activity or technique designed to support the child's the performance.

(b) The designated person must be able to demonstrate the technique as instructed, recount the restrictions, safety factors and precautions.

(c) The occupational therapy practitioner is responsible for ongoing monitoring of the trained person and modifying the procedures based on outcomes and other changes.

(d) When considering the delegation of techniques the child's health and safety must be maintained at all times.

(4) **Documentation**:

(a) The occupational therapy practitioner must document evaluation, goals, interventions and outcomes if they are not included in the service plan.

(b) Documentation should reflect the child's current status, progress towards goals, response to interventions, and strategies that were promising or ineffective.

(c) The occupational therapist should utilize a method of data collection that allows for concise and accurate recording of intervention and progress.

(d) The occupational therapy practitioner is responsible for the analysis of data collected to verify progress and the documentation of their own activities to accomplish the goals.

Stat. Auth.: ORS 675.230, 675.240, 675.250, 675.300 & 675.310
Stats. Implemented: ORS 675.210(4), 675.240(1) & (2), 675.250(2) & (3), 675.300(1)(a) & 675.320(11)
Hist.: OTLB 2-1993(Temp), f. & cert. ef. 7-1-93; OTLB 1-1994, f. & cert. ef. 1-24-94; OTLB 1-1999, f. & cert. ef. 10-27-99; OTLB 1-2005, f. & cert. ef. 8-11-05; OTLB 1-2008, f. 11-25-08, cert. ef. 1-1-09

338-020-0015
One-time requirement for CE on Pain Management

(1) After January, 2008, a one-time requirement of 7 points of CE on Pain Management must be completed as part of the 30 points of CE defined in OAR 339-020-0020.

(2) All currently licensed Occupational Therapists and Occupational Therapy Assistants who renew their license in May, 2010 must complete the one-hour online Oregon Pain Commission class and six additional points of CE on Pain Management. Any classes provided by the Pain Commission will count toward the 7 points. Licensees may use any CE points on Pain Management taken between 2006 and their renewal date in May, 2010.

(3) All new applicants for Occupational Therapy and Occupational Therapy Assistants must complete the one-time requirement of 7 points of CE on Pain management (including the one online hour offered by the Pain Commission) prior to their next renewal or within two years of license in Oregon, whichever comes later.

Stat. Auth.: ORS 675.320
Stats. Implemented:
Hist.: OTLB 1-2008, f. 11-25-08, cert. ef. 1-1-09

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Oregon Commission on Children and Families
Chapter 423

Rule Caption: Clarify OAR 412-010-0023(1) that requires 2.0 FTE.
Adm. Order No.: OCCF 3-2008
Filed with Sec. of State: 12-12-2008
Certified to be Effective: 12-12-08
Notice Publication Date: 11-1-2008
Rules Amended: 423-010-0023
Subject: OCCF has determined a clear need to immediately clarify to counties and local commissions on children and families the state's intent regarding funds allocated for staffing local commissions on children and families operations at a level that will provide consistency and leadership to local commissions.
Rules Coordinator: Marsha Clark—(503) 373-1283

423-010-0023
Categorization and Limitation of Local Commission Costs

(1) Basic Capacity:

(a) The State Commission determines a biennial allocation of funds to assist Local Commissions in the costs associated with meeting the intent of the Partnership Agreement and the Components Document. County Basic Capacity allocations may be used for activities in accordance to the limitations in 423-010-0023(5) for costs associated with operating an office, which include functions such as policy and planning, evaluation of state and local outcomes, information systems, fiscal and budget, communications, personnel, reception, general correspondence, contracting processes, mapping systems, designing and assessing strategies, and other related functions of the Local Commission office. Basic Capacity may also be used for costs associated with the monitoring of contracts, quality control, and the measurement of outcomes to determine the efficiency and effectiveness of an activity.

NOTE: Copies of the Partnership Agreement and the Components Document are available from the Agency.

(b) Each county will employ at least 2.0 full-time equivalent (FTE) Local Commission staff, either as employees or contractors, to meet the requirements of ORS 417.760 and 417.775 and OAR 423-010-023(1)(a).

(A) 1.0 FTE of the required 2.0 FTE must be embodied in one person and serve as the Local Commission Director. The remaining required 1.0 FTE may be configured flexibly and must directly support commission work.

(B) The Local Commission Director will:

(i) Be an upper level managerial position within the county structure with overall responsibility for the daily operations of the Local Commission;

(ii) Be responsible for leadership, advocacy and key management to enable the Local Commission to meet the requirements of ORS 417.760 through 417.795.

(iii) Provide information and policy recommendations on the health and wellbeing of the county's children and families directly to the Board of County Commissioners or County Court; and

(iv) Possess the leadership and professional skills necessary to build the Local Commission and meet the requirements of 423-010-0023(1)

(v) Not provide direct services nor be responsible for the management of staff that provide direct services as defined in OAR 423-001-0006(11).

(c) The Executive Committee of the State Commission may waive the 2.0 full-time equivalent staff requirement only when the following criteria have been met:

(A) A plan for staffing is submitted to the Agency that includes a detailed description of how the staffing plan meets the requirements of the Partnership Agreement and accomplishes critical areas of the Components Document and documents in-kind, volunteer assistance or other methods to meet those requirements.

(B) A review is completed by the Agency of past performance of the Local Commission, including meeting timelines, monitoring and compliance requirements, and quality of plans and outcomes.

(C) A written description is provided to the Agency that demonstrates that there is no real or perceived conflict of interest or conflict with ORS 417.775(2) (a), which prohibits Local Commissions from providing direct services.

(D) Letters or other form of written communication that supports the waiver request are provided from community partners from formal and informal systems that work regularly with the Local Commission in accomplishing its work.

(E) Written evidence of the Local Commission recommendation and BOCC support.

(F) If the Local Commission disagrees with the decision of the Executive Committee, it may request reconsideration of the decision at the next regularly scheduled meeting of the Executive Committee. Following that, the Local Commission may appeal the decision to the State Commission at its next regularly scheduled meeting.

(d) Funds remaining in the Basic Capacity allocation after meeting the requirement of 423-010-0023(1)(a) may be used for Community Mobilization or programs or services to children and families that are identified in the Local Plan.

(e) Basic Capacity appropriations cannot be carried from one biennium to the next pursuant to OAR 423-010-0027(7) and (8), but will revert to the State if not obligated or expended at the end of the biennium.

(2) Community Mobilization: Counties may allocate funds for the purposes of community mobilization activities and strategies from locally invested funds as defined in OAR 423-001-006 (20). All community mobilization activities and strategies funded with locally invested funds must use proven practices of effectiveness and outcomes data must be reported for each activity and strategy.

(3) Medicaid (Title XIX): Local Commissions may allocate a combined total of up to 5 percent from Medicaid (Title XIX) claims for reimbursement of documented costs of administering Medicaid (Title XIX). There is no limit to the amount of Medicaid (Title XIX) claims that can be allocated to service providers so long as the Medicaid (Title XIX) earnings are reinvested in the program from which they were earned.

(4) Local Commissions may allocate up to a total of 4 percent of Healthy Start General Fund for contract management functions.

(5) Limitation on Usage:

(a) Consistent with the terms and conditions in the Intergovernmental Agreement, all budget allocations will be directly related to at least one strategy in the Local Plan, meet the purpose and restrictions of each program area and grant stream, and have measurable outcomes.

(b) Service provider contracts: Counties may allocate funds to providers for the cost of services or activities to children and families, however all services or activities must be identified in the Local Plan.

(c) Services and programs funded by another federal or state funding source cannot be funded with OCCF dollars when blending of those funds are not allowed by state or federal agreements or when duplication will occur.

(d) County Indirect/Direct Cost Assessment: Counties may assess direct and indirect charges from the Basic Capacity funding stream at an assessment no higher than 10 percent of the total annual Local Commission allocation from the Agency less funding streams expressly disallowed by state or federal statute or rule. This rule is subject to monitoring and review by the Agency.

(6) A Local Commission may not provide direct services as defined in OAR 423-001-0006(11). However a Local Commission may provide direct services for children, youth or families for a period not to exceed six months under conditions determined in ORS 417.775(2)(a) through (b). The State Commission will not allow an extension beyond six months. Local Commissions not in compliance with this section will be subject to withholding of funds described in OAR 423-010-0027(9).

(7) Agency Approval: Budget allocations effectuated pursuant to the Intergovernmental Agreement and amendments will be subject to Agency review and approval.

Stat. Auth.: ORS 417.705 - 417.797
Stats. Implemented: ORS 417.705 - 417.797
Hist.: CCF 3-1994, f. & cert. ef. 5-18-94; CCF 1-1995, f. & cert. ef. 8-1-95; CCF 1-1997, f. 12-15-97, cert. ef. 12-19-97; OCCF 1-2002, f. & cert. ef. 1-14-02; OCCF 1-2004, f. & cert. ef. 9-15-04; OCCF 3-2007(Temp), f. 5-8-07, cert. ef. 5-11-07 thru 9-7-07; Administrative correction 8-16-07; OCCF 2-2008(Temp), f. & cert. ef. 6-30-08 thru 11-25-08; OCCF 3-2008, f. & cert. ef. 12-12-08

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Rule Caption: To clarify definition of "direct service: and delete unnecessary definition.
Adm. Order No.: OCCF 4-2008(Temp)
Filed with Sec. of State: 12-12-2008
Certified to be Effective: 12-12-08 thru 6-10-09
Notice Publication Date:
Rules Amended: 423-001-0006
Subject: Clarify the definition of "Direct Service: and delete unnecessary definition of "Staff director or director." The duties and responsibilities of the director are detailed in OAR 423-010-0023.
Rules Coordinator: Marsha Clark—(503) 373-1283

423-001-0006
Definitions

As used in OAR chapter 423:

(1) "Agency" means the State Commission acting through the staff of the Oregon Commission on Children and Families as defined in ORS 417.735(6).

(2) "Basic capacity" means an allocation to Local Commissions that provides for the basic functions of a Local Commission office which include the following functions:

(a) Managing resources (includes general office support, fiscal and budget management, program evaluation, and staff development);

(b) Facilitation and coordination of meetings and forums;

(c) Coordinated, comprehensive planning in accordance with ORS 417.775; and

(d) The provision of technical assistance to their communities.

(3) "Best practice" or "proven practice of effectiveness" means research-based or evidence-based programs, core components, and principles that have been shown to reliably produce measurable and sustainable improvements in productivity, efficiency, or effectiveness.

(4) "BOCC" or "Board of County Commissioners" means the governing body of a county as defined in ORS 203.030 and includes a county court as defined in ORS 203.111.

(5) "Budget allocation" means an allocation of funds from the State Commission to the Board of County Commissioners pursuant to an Intergovernmental Agreement per ORS 417.705 through 417.797 and 419A.170.

(6) "Budget distribution" means a budget created by Local Commission staff in a format prescribed by the Agency. The budget distribution demonstrates, by grant stream, the projected budget for all activities proposed by the Local Commission and approved by the Board of County Commissioners.

(7) "Collaborative funding process" means allowing all interested parties to have an opportunity to participate in a funding process intended to use resources in the most effective and efficient manner based on the local coordinated, comprehensive plan.

(8) "Community mobilization" means government and private efforts to increase community awareness and to facilitate the active participation of citizens and organizations in projects and issues that will have positive impact on the well-being of children, families and communities.

(9) "County" means a county or two or more counties, which have combined to provide services to children, youth and families under ORS 417.705 to 417.797 and 419A.170.

(10) "Direct costs" means those costs that can be identified specifically and directly with a particular program or project, such as a particular federal grant or a direct activity or program of the organization.

(11) "Direct Services" means those services provided directly to a child or family or group of children or families to maintain or enhance their well-being. Direct services do not include services that are contracted out to other parties pursuant to ORS 417.775- 417.787 or being the fiscal agent of pass through funds.

(12) "Early Childhood System Planning" means planning developed to describe the system, process and services that families can voluntarily access and that is part of and consistent with the Local Plan. The planning includes goals and strategies to achieve the early childhood benchmarks and intermediate outcomes.

(13) "Expended" means the payment of goods delivered or services rendered or liquidation of an obligation.

(14) "Indirect Costs" means those costs that have been incurred for common or joint purposes and cannot be readily identified with or directly allocated to a particular program or project of the organization. Examples of indirect costs include building and equipment depreciation, rent and facilities maintenance costs, general and administrative expenses, and personnel administration and accounting where those costs are distributed to projects or programs through a formula or cost allocation method.

(15) "Initiatives" means those time-limited activities that a Local Commission undertakes to promote community mobilization.

(16) "Innovative program or practice" means a program or practice that demonstrates success when outcomes are evaluated over time and draws on research-based principles and ideas from best programs and practices.

(17) "Layperson" means a person whose primary income is not derived from offering direct service to children and youth or from administering a program for children or youth.

(18) "Local Commission" means a local commission on children and families appointed pursuant to ORS 417.760.

(19) "Local Plan" means the local coordinated, comprehensive plan for children and families that is developed pursuant to ORS 417.775 and includes identification of connections in state and local planning processes and provisions for a local continuum of social supports. The Local Plan includes planning for the early childhood system, alcohol and drug prevention and treatment, and high-risk juvenile crime prevention, and references mental health and public health service plans.

(20) "Locally invested funds" includes Children, Youth and Families, Great Start and Youth Investment grant streams.

(21) "Oregon Commission on Children and Families (OCCF)" means the totality of the service system described in ORS 417.705 to 417.797, and 419A.170, including the State Commission on Children and Families (ORS 417.730), the State Commission-appointed director and staff (ORS 417.735), the local commissions on children and families (ORS 417.760) and specific program areas.

(22) "Partners for Children and Families" means the formal collaboration among state agencies and affected local agencies that works to combine planning and data requirements and coordinate policies and the provision of services to children and families.

(23) "Perinatal" means the period on or around the time of childbirth.

(24) "Primary health care" for purposes of Healthy Start means linkage and referral to health care resources and assisting families to establish a medical home for primary health care.

(25) "Prenatal" means the period of time from conception to the onset of labor.

(26) "Provider" means a program or service described in ORS 417.705 through 417.797 and 419A.17 that has been approved for funding by the Local Commission and the Board of County Commissioners.

(27) "Provider allocation" means those funds awarded by a county to a public or private agency or person to achieve an outcome within the county's Local Plan.

(28) "State Commission" means the Oregon Commission on Children and Families' appointed members established pursuant to 417.730.

(29) "Services for children and families" does not include services provided by the Department of Education or school districts that are related to curriculum or instructional programs as defined in ORS 417.705.

Stat. Auth.: ORS 417.705 - 417.797
Stats. Implemented: ORS 417.705 - 417.797
Hist.: OCCF 1-2002, f. & cert. ef. 1-14-02; OCCF 1-2004, f. & cert. ef. 9-15-04; OCCF 1-2004, f. & cert. ef. 9-15-04; OCCF 3-2007(Temp), f. 5-8-07, cert. ef. 5-11-07 thru 9-7-07; Administrative correction 9-16-07; OCCF 4-2008(Temp), f. & cert. ef. 12-12-08 thru 6-10-09

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Oregon Health Licensing Agency
Chapter 331

Rule Caption: Establish specific waivers for certification qualification requirements during grandfathering period.
Adm. Order No.: HLA 11-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 10-1-2008
Rules Adopted: 331-810-0038

Subject: Rules clarifying waivers of specific qualification criteria during the grandfathering period are authorized under ORS 675.410(2)(b). Waivers pertain to specific criteria requiring verification of training or direct supervision that pre-dated implementation of the certification program.
Rules Coordinator: Patricia C. Allbritton—(503) 373-2088

331-810-0038
Waivers

If an applicant is unable to provide verification of the experience or supervision required under OAR 331-810-0020, 331-810-0030 or 331-810-0035, the board may consider the following information in determining whether a waiver of verification will be issued:

(1) When the training or direct client services occurred;

(2) Where the training or direct client services occurred;

(3) The reasons for the inability of the applicant to provide training verification or substantiate the required supervision; and

(4) The diligence the applicant used in attempting to provide the training verification or to document supervision.

NOTE: This provision does not disregard or unilaterally exempt the applicant from meeting the education, training and experience required under ORS 675.365; however, it enables the Board to exercise discretion in accepting alternative means of documentation when deemed appropriate, on a case-by-case basis.

Stat. Auth.: ORS 675.375, 675.400, 675.410 & 676.615
Stat. Implemented: ORS 675.375, 675.400 & 675.410
Hist.: HLA 9-2008(Temp), f. & cert. ef. 9-15-08 thru 12-1-08; HLA 11-2008, f. 11-26-08, cert. ef. 12-1-08

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Rule Caption: Clarifies requirements for application documentation, fingerprint and background checks, and strengths identification requirements for individuals seeking licensure.
Adm. Order No.: HLA 12-2008(Temp)
Filed with Sec. of State: 11-28-2008
Certified to be Effective: 12-1-08 thru 4-30-09
Notice Publication Date:
Rules Adopted: 331-030-0005
Rules Amended: 331-030-0000, 331-030-0010
Subject: Temporary rules address requirements for completion of a fingerprint and criminal background check to determine fitness of individuals applying for an authorization issued or renewed by the agency. Amendments pertain to application requirements and procedures for issuing and renewing authorizations to practice. Rules clarify requirements for acceptable documentation and personal identification of applicants to strengthen applicant licensure qualification criteria. These rules are needed to mitigate use of false identification and/or misrepresentation of personal information, to reduce potential agency liability and secure license issuance and renewal procedures.
Rules Coordinator: Patricia C. Allbritton—(503) 373-2088

331-030-0000
Application Requirements

(1) An applicant who has been the subject of any disciplinary action, including the imposition of a civil or criminal penalty, is not considered qualified for an Oregon authorization to practice until the Oregon Health Licensing Agency determines the scope, applicability and finality of the disciplinary action as it relates to the applicant's fitness to be issued an authorization to practice or use a professional title in Oregon. The disciplinary record may include, but not be limited to, actions imposed from the following:

(a) An Oregon health professional regulatory board as defined in ORS 676.160;

(b) A regulatory authority in Oregon or another state;

(c) A regulatory authority in another country or territory.

(2) Pursuant to ORS 181.534, 676.612 and OAR 331-030-005, the agency may require an applicant to complete a fingerprint check through the Oregon Department of Oregon State Police. The agency may also conduct a criminal background check of convictions to determine whether the applicant has been convicted of a crime that may affect the applicant's fitness to practice in accordance with ORS 670.280.

(3) Material misrepresentation or material errors of fact on the application for an examination, or issuance or renewal of an authorization to practice are grounds for disqualification of examination, refusal to issue or revocation of the authorization.

(4) Application for an authorization issued for any program administered by the agency under ORS 676.606 shall be made on forms prescribed and furnished by the agency.

(5) To be accepted and processed, an application must contain:

(a) Applicant's current name, address and telephone number;

(b) Applicant's date of birth;

(c) Applicant's signature and date of application;

(d) Applicant's Social Security number. The agency, at its discretion, may request an applicant to provide evidence of verification of the Social Security card as stipulated in subsection (6) of this rule. If an applicant submits a Social Security card and Evidence of Verification which states "*Valid with INS Authorization*" the applicant must submit the Immigration and Naturalization Services Authorization or a valid United States passport.

(e) Applicant's ethnicity (optional);

(f) Applicant's gender (optional);

(g) Disclosure of any active or inactive disciplinary action, voluntary resignation of a certificate, license, permit or registration or sanction related to authorization imposed upon the applicant by any state or country regulatory authority;

(h) Disclosure of any active or inactive certificate, license, permit or registration issued by Oregon or another state;

(i) Payment for the exact amount of required fees; and

(j) All additional information required by the particular Board, Council or Program for which application is made.

(6) Applicants must list their Social Security number on the form prescribed by the agency at the time of initial application and renewal for certification, licensure, permit or registration. The authority for this requirement is ORS 25.785, 305.385, 42 USC § 405(c)(2)(C)(i), and 42 USC § 666(a)(13).

(7) Failure to provide the Social Security number or INS Authorization or valid U.S. passport, as required in (5)(d) of this rule, will be a basis to refuse to accept the application or to issue an authorization. The Social Security number will be used for child support enforcement and tax administration purposes (including identification) only, unless the applicant authorizes other uses of the number.

(8) OHLA does not accept an Individual Taxpayer Identification Number (ITIN) in lieu of the Social Security Number.

(9) An applicant must provide two or more forms of acceptable original or certified copies of identification issued by a federal, state or local government agency of the United States, or other approved identification listed on the Department of Homeland Security, U.S. Citizenship and Immigration Services Form I-9, Employment Eligibility Verification. Acceptable identification includes, but is not limited to:

(a) U.S. passport;

(b) Driver's license or ID card issued by a state or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address;

(c) ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address;

(d) U.S. Social Security card issued by the Social Security Administration;

(e) Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal.

NOTE: The agency may, at its discretion, require proof of an applicant's legal presence in the U.S., identity, Social Security number or employment eligibility and date of birth.

[Publications: Forms referenced are available from the agency.]
Stat. Auth.: ORS 25.785, 305.385, 42 USC § 405(C)(2)(C)(i), and 42 USC § 666(a)(13), 670.280, 676.605 & 676.615
Stats. Implemented: ORS 25.785, 305.385, 42 USC § 405(C)(2)(C)(i), 42 USC § 666(a)(13), 670.280, 676.605 & 676.615
Hist.: HLO 1-2004, f. & cert. ef. 2-13-04; HLA 12-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

331-030-0005
Fingerprinting, State and Nationwide Criminal Background Checks, Fitness Determinations

(1) The Oregon Health Licensing Agency may conduct and require completion of a fingerprint and criminal background check to determine fitness of individuals applying for an authorization issued or renewed by the agency. These will be provided on prescribed forms provided by the agency. At the discretion of the agency, background checks may be conducted for any of the programs administered by the agency pursuant to ORS 676.606.

(2) Fingerprints may be obtained at a law enforcement office or at a private service acceptable to the agency. The agency will forward fingerprints to the Department of Oregon State Police for checks against state and

national data sources. Any original fingerprint cards will subsequently be destroyed by the department.

NOTE: An applicant must pay the department any fees assessed for conducting the fingerprint service. An applicant must arrange for the report of the fingerprint check to be mailed directly to the Oregon Health Licensing Agency, Regulatory Operations Division.

(3) These rules are to be applied when evaluating the criminal history of all licensees and applicants listed in paragraph (1) of this section, and conducting fitness determinations based upon such history. The fact that the applicant has cleared the criminal history check does not guarantee the granting of an authorization.

(4) Except as otherwise provided in section (1), in making the fitness determination the agency shall consider:

(a) The nature of the crime;

(b) The facts that support the conviction or pending indictment or that indicate the making of the false statement;

(c) The relevancy, if any, of the crime or the false statement to the specific requirements of the subject individual's right to practice in any present or proposed position, services, and employment, that is authorized upon the issuance or renewal of the certificate, license, permit or registration; and

(d) Intervening circumstances relevant to the responsibilities and circumstances of the position, services, employment, certificate, license, permit or registration. Intervening circumstances include but are not limited to:

(A) The passage of time since the commission of the crime;

(B) The age of the subject individual at the time of the crime;

(C) The likelihood of a repetition of offenses or of the commission of another crime:

(D) The subsequent commission of another relevant crime;

(E) Whether the conviction was set aside and the legal effect of setting aside the conviction; and

(F) A recommendation of an employer.

(5) The agency may require fingerprints of any authorization holders or applicant listed in paragraph (1) of this section, who is the subject of a complaint or investigation, under authority of ORS 676.612(3)(c), for the purpose of requesting a state or nationwide criminal records background check.

(6) All background checks shall be requested to include available state and national data, unless obtaining one or the other is an acceptable alternative.

(7) Additional information required. In order to conduct the Oregon and national criminal history check and fitness determination, the agency may require additional information from the authorization holder or applicant as necessary. Information requested may include but is not limited to, proof of identity; residential history; names used while living at each residence; or additional criminal, judicial or other background information.

(8) All Oregon and national criminal history checks, confidentiality, and dissemination of information received, shall be in accordance to and as applicable with ORS 181.534 through 181.560 and OAR 257, division 10.

(9) The agency will permit the individual for whom a fingerprint-based criminal records check was conducted, to inspect the individual's own state and national criminal offender records and, if requested by the subject individual, provide the individual with a copy of the individual's own state and national criminal offender records.

(10) The agency shall determine whether an individual is fit to be granted, hold or renew an authorization, listed in paragraph (1) of this section, based on the criminal records background check, or any false statements made by the individual regarding criminal history of the individual, or any refusal to submit or consent to a criminal records check including fingerprint identification, and any other pertinent information obtained as a part of an investigation. If an individual is determined to be unfit, then the individual may not be granted an authorization. The agency may make fitness determinations conditional upon applicant's acceptance of probation, conditions, or limitations, or other restrictions placed upon the authorization.

(11) The agency may also consider any arrests and court records that may be indicative of a person's inability to perform as an authorization holder with care and safety to the public.

(12) If the agency determines an applicant or authorization holder is unfit, the individual is entitled to a contested case process pursuant to ORS 183. Challenges to the accuracy or completeness of information provided by the Department of Oregon State Police, Federal Bureau of Investigation and agencies reporting information must be made through the department, Federal Bureau of Investigation, or reporting agency and not through the contested case process pursuant to 183.

(13) If the applicant discontinues the application process or fails to cooperate with the criminal history background check the agency considers the application incomplete.

Stat. Auth.: ORS 25.785, 305.385, 42 USC § 405(C)(2)(C)(i), and 42 USC § 666(a)(13), 670.280, 676.605 &676.615

Stats. Implemented: ORS 25.785, 305.385, 42 USC § 405(C)(2)(C)(i), 42 USC § 666(a)(13), 670.280, 676.605 & 676.615

Hist.: HLA 12-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

331-030-0010

Procedure for Issuing and Renewing Certificates, Licenses and Registrations

(1) Subject to ORS 676.612, authorizations issued by the Oregon Health Licensing Agency for all programs administered by the agency under 676.606, shall be issued to qualified applicants after conducting fitness determinations and upon compliance with all requirements established by rules adopted by the agency.

(2) With the exception of temporary or demonstration permits, all authorizations will expire on the last day of the month, two years from the date of authorization was issued.

(3) The authorization will state the holder's name, address, authorization number, expiration date and bear the signature of the holder. The authorization will be mailed to the place of residence or mailing address recorded on the application and substantiated through acceptable identification listed in OAR 331-030-0000.

(4) The agency may mail notice of expiration to the authorization holder, sending the notice to the last known address on file. The authorization holder is responsible for submitting a timely application for renewal whether or not a renewal form was mailed by the agency.

(5) Application for renewal shall be made in advance of the expiration date, and shall be submitted together with the required fee(s) and documentation, as the individual program stipulates for renewal. Payment must be postmarked or received by the agency during regular business hours on or before the expiration date. An authorization may be renewed using the agency's online renewal system accessed at http://www.oregon.gov/OHLA/onlinerenewals.shtml.

(6) An application for renewal and payment received by the agency or postmarked after the expiration date may be assessed delinquent renewal fee(s) according to requirements stipulated in each individual program's rules for certificate, license or registration renewal.

(7) Notwithstanding subsection (1) of this rule, the agency may vary the renewal date of an authorization by giving the applicant written notice of the renewal date being assigned and by making prorated adjustments to the renewal fee.

Stat. Auth.: ORS 676.605 & 676.615

Stats. Implemented: ORS 676.605 & 676.615

Hist.: HLO 1-2004, f. & cert. ef. 2-13-04; HLA 12-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

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Oregon Health Licensing Agency, Board of Cosmetology
Chapter 817

Rule Caption: Clarifies requirements for application documentation, strengthens identification requirements for individuals seeking certification and eliminates interpreter assisted examinations.
Adm. Order No.: BOC 3-2008(Temp)
Filed with Sec. of State: 11-28-2008
Certified to be Effective: 12-1-08 thru 4-30-09
Notice Publication Date:
Rules Amended: 817-030-0005, 817-030-0015, 817-030-0020, 817-030-0040, 817-030-0045, 817-030-0065, 817-035-0030
Rules Suspended: 817-030-0100
Subject: These rules synchronize with agency rules, effective December 1, 2008. Temporary rules address requirements to determine fitness of applicants for an authorization to be issued or renewed by the agency. Amendments pertain to application and examination requirements for issuing and renewing authorizations to practice. Rules clarify requirements for acceptable documentation and personal identification of applicants to strengthen applicant licensure qualification criteria. These rules are needed to mitigate use of false identification and/or misrepresentation of personal information, to reduce potential agency liability and secure licensure issuance and

renewal procedures. The temporary rule repeals the use of interpreter assisted examinations.

Rules Coordinator: Patricia C. Allbritton—(503) 373-2088

817-030-0005
Qualification and Training Requirements

To obtain an Oregon certificate in one or more fields of practice, individuals must complete required application documentation prescribed by the agency or board under OAR 331-030-0000 and 817-030-0015 provide satisfactory evidence of meeting certification requirements, which includes qualifying criteria listed in one of the following certification pathways, and submit payment of required fees.

CERTIFICATION PATHWAY ONE

(1) Graduate from Oregon Licensed Career School: Applicants must meet the education and training requirements in effect at the time of application. Applicants shall complete and pass courses required by the Oregon Department of Education, Private Career Schools, in one or more of the following educational programs offered through an Oregon licensed career school, and must also pass a written and practical examination approved or recognized by the Board of Cosmetology in accordance with OAR 817-030-0040:

(a) Hair design — 1,450 hour course;

(b) Barbering — 1,100 hour course;

(c) Esthetics — 250 hour course;

(d) Nail technology — 350 hour course;

(e) Mandatory completion of a 150 hour safety and infection control course and a 100 hour career development course in addition to any one or more of the approved programs listed in (a) through (d) of this rule. The Board recognizes a final practical examination, prescribed by the Department of Education, Private Career Schools in collaboration with the Board, which establishes standard examination criteria and testing protocols, as its qualifying practical certification examination. Authorized Oregon licensed career school personnel conduct the practical examination.

(2) Non-Credentialed Applicants from Another State or Country: Applicants who have completed schooling requirements established by a regulatory authority in another state or country must submit all required application documentation (OAR 817-030-0015) to the agency for evaluation and approval by the Oregon Department of Education, Private Career Schools (ORS 345.430). Approved applicants will be required to take the Oregon qualifying written and practical examination (OAR 817-030-0040) if the following criteria apply:

(a) Certification or licensure in another state or country was not attained;

(b) Reciprocity requirements listed in subsection (3) of this rule have not been met.

CERTIFICATION PATHWAY TWO

(3) Oregon Certification by Reciprocity: The Board recognizes other states', and at its discretion may recognize other countries', education, examination and licensing requirements. Applicants currently certified or licensed in one or more fields of practices in another state or country will qualify for Oregon certification if requirements of OAR 817-030-0015(1) and (2)(c) and the following criteria have been met:

(a) The applicant shall arrange for the originating regulatory authority to forward directly to the agency a current and original "Affidavit of Licensure" document, signed by an authorized representative of the regulatory authority and affixed with an official seal or stamp to the document. The document may be electronically transmitted to the agency from the originating state. The applicant is responsible for payment of any service fee the originating state may assess for producing the affidavit.

(b) Completion of a state-approved board examination for certification/licensure and graduation from a licensed cosmetology school.

(c) Completion of the Oregon Laws and Rules examination.

(4) Applicants holding current certification/licensure from out-of-state who do not qualify for Oregon certification by means of reciprocity as specified in subsection (3) of this rule must complete and pass the qualifying examination(s) required in OAR 817-030-0005(1) and 817-030-0040.

Stat. Auth.: ORS 690.035, 690.046 & 690.165
Stats. Implemented: ORS 690.035, 690.046 & 690.165
Hist.: BH 2-1978, f. & ef. 11-29-78; BH 1-1981, f. & ef. 10-1-81; BH 4-1984, f. & ef. 12-7-84; BH 1-1988, f. & cert. ef. 7-1-88; BH 2-1990, f. & cert. ef. 10-29-90; BH 1-1992, f. 6-1-92, cert. ef. 7-1-92; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; BH 1-1996, f-5-31-96, cert. ef. 7-1-96; BH 1-1997, f. 7-22-97, cert. ef. 8-1-97; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2002, f. 5-31-02 cert. ef. 6-1-02; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2006, f. & cert. ef. 3-15-06; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-030-0015
Application Requirements

(1) Applicants must meet all of the requirements of OAR 331-030-0000 in addition to the provisions of this rule. Before being authorized to take an examination at any of the agency approved testing locations, the completed application documentation must be on file with the agency. Refer to 817-030-0020.

(2) Applicants must provide, or cause to be delivered to the agency, prescribed documentation verifying training and/or licensure, according to one of the following qualification pathways. Refer to OAR 817-030-0005:

(a) Official transcript/Oregon Career School: completed official transcript, issued by an Oregon licensed career school of barbering, hair design, esthetics or nail technology, and completed original official transcript of practical examination, signed by the authorized school personnel proctoring the Board sanctioned examination, certifying that criteria for the practical examination was met and that the applicant satisfactorily demonstrated minimum competencies established by the Department of Education, Private Career Schools, in collaboration with the Board.

(b) Out-of-state non-credentialed: documentation of schooling and/or training experience, including official transcript from the licensed school mailed or transmitted directly to the agency from the originating state's regulatory authority, work study or apprenticeship records.

(c) Reciprocity: current and original signed and sealed or stamped Affidavit of Licensure document issued upon the request of applicant certified or licensed in another state and mailed directly to the agency by the originating state, and if applicable, verification of a Board-approved examination.

(3) Any Affidavit of Licensure document not mailed directly to the agency from the originating state will invalidate qualification for certification, scheduling and examination.

(4) Application documentation required for an examination and certification must be submitted to the Oregon Health Licensing Agency in English. If documents require translation, a copy of the official document(s), in the original language, must be submitted with the written translation in English.

Stat. Auth.: ORS 676.615, 690.035 & 690.165
Stats. Implemented: ORS 676.615, 690.035 & 690.165
Hist.: BH 2-1978, f. & ef. 11-29-78; BH 1-1981, f. & ef. 10-1-81; BH 4-1984, f. & ef. 12-7-84; BH 1-1988, f. & cert. ef. 7-1-88; BH 2-1990, f. & cert. ef. 10-29-90; BH 1-1992, f. 6-1-92, cert. ef. 7-1-92; Renumbered from 817-030-0010; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; BH 1-1996, f. 5-31-96, cert. ef. 7-1-96; BH 1-1997, f. 7-22-97, cert. ef. 8-1-97; BBH 1-1998, f. 6-24-98, cert. ef. 6-30-98; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2001(Temp), f. 1-31-01, cert. ef. 2-1-01 thru 7-29-01; BOC 3-2001, f. 3-30-01, cert. ef. 4-1-01; BOC 1-2002, f. 5-31-02 cert. ef. 6-1-02; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2006, f. & cert. ef. 3-15-06; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-030-0020
Examination Requirements

(1) The agency will conduct examinations for certification. A schedule of examination dates and times shall be available upon request. The agency reserves the right to alter or adjust examination dates, times and locations as it deems necessary to meet emergency situations and will notify applicants and schools in advance whenever possible.

(2) Applicants may request special examination accommodation according to requirements of OAR 817-030-0080. Special examinations will be scheduled at a date and time determined by the Oregon Health Licensing Agency Director.

(3) Applicants will qualify for examination upon compliance with relevant provisions of OAR 331-030-0000, 817-030-0005 and 817-030-0015. Applicants will not be allowed to take the examination until all requirements for examination have been met. If documentation is incomplete or incorrect, applicants will not be allowed to sit for the examination.

(4) An applicant must provide two or more forms of acceptable original or certified copies of identification issued by a federal, state or local government agency of the United States, or other approved identification listed on the Department of Homeland Security, U.S. Citizenship and Immigration Services Form I-9, Employment Eligibility Verification. Refer to OAR 331-030-0000.

Stat. Auth.: ORS 676.615, 690.065 & 690.165
Stats. Implemented: ORS 676.615, 690.065 & 690.165
Hist.: BH 2-1978, f. & ef. 11-29-78; BH 4-1984, f. & ef. 12-7-84; BH 1-1988, f. & cert. ef. 7-1-88; BH 2-1990, f. & cert. ef. 10-29-90; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; BH 1-1996, f. 5-31-96, cert. ef. 7-1-96 ; BH 1-1997, f. 7-22-97, cert. ef. 8-1-97; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2002, f. 5-31-02 cert. ef. 6-1-02; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2006, f. & cert. ef. 3-15-06; BOC 2-2008, f. 9-15-08 cert. ef. 10-1-08; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-030-0040
Type of Examination

(1) The written examination consists of the following sections: Oregon Laws and Rules, Barbering, Hair Design, Esthetics and Nail Technology. Examinations test the applicant's knowledge of the following subjects:

(a) The basic principals of safety and infection control;

(b) The safety and infection control rules of the Board of Cosmetology;

(c) Chemical use and storage;

(d) Diseases and disorders;

(e) Equipment and tools/implements;

(f) Licensure requirements and regulations;

(g) Standards of practice;

(h) Definitions; and

(i) Practical applications and procedures.

(2) Each section will be scored individually. The passing score for each section is 75 percent or better.

(3) The Board will establish by policy a maximum examination time allowance for each examination section, listed in section (1) of this rule. Maximum examination time allowances shall be published and included in the application for certification packet, posted in the agency Web site and made available upon request.

(4) The examination may be administered using a computerized testing system with touch screen functionality for selecting the candidate's response to multiple-choice question.

(5) The examination is administered in English only, unless an agency approved testing contractor or vendor provides the examination in languages other than English. Examination candidates may be electronically monitored during the course of testing.

(6) The practical examination is a final examination conducted at an Oregon licensed career school of barbering, hair design, esthetics or nail technology, administered at the direction of and in accordance with criteria established by the Department of Education, Private Career Schools. The examination must be documented according to provisions set forth by the Department of Education, Private Career Schools. The Board of Cosmetology recognizes and sanctions the practical examination conducted by licensed career schools in accordance with the Department of Education's criteria and protocols, as its practical competency examination.

(7) In collaboration with the Department of Education, Private Career Schools, the Board or designated staff may periodically review any career school's practical examination procedures and conduct to determine compliance with Department of Education's criteria and to maintain Board recognition of the practical examination.

Stat. Auth.: ORS 676.615, 690.065 & 690.165
Stats. Implemented: ORS 676.615, 690.065 & 690.165
Hist.: BH 2-1978, f. & ef. 11-29-78; BH 1-1983(Temp), f. & ef. 10-4-83; BH 1-1984, f. & ef. 2-13-84; BH 4-1984, f. & ef. 12-7-84; BH 2-1990, f. & cert. ef. 10-29-90; Renumbered from 817-030-0060; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; BH 1-1996, f. 5-31-96, cert. ef. 7-1-96; BH 1-1997, f. 7-22-97, cert. ef. 8-1-97; BBH 1-1998, f. 6-24-98, cert. ef. 6-30-98; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2002, f. 5-31-02 cert. ef. 6-1-02; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2006, f. & cert. ef. 3-15-06; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-030-0045
Sections Which the Applicant Must Pass

(1) An applicant who is a graduate of an Oregon Licensed Career School or applying for certification based on equivalency according to OAR 817-030-0015(2)(a) and (b) must pass the Oregon Laws and Rules section of the examination and one or more of the following fields of practice:

(a) Barbering;

(b) Hair Design;

(c) Esthetics;

(d) Nail Technology.

(2) Applicants failing to successfully complete the examination process and thus failing to obtain a certificate within two years from the date of their most recent examination attempt, will be required to:

(a) Reapply for examination according to OAR 817-030-0015;

(b) Pay the application, examination and original certificate fees; and

(c) Retake all written and practical examination sections qualified for, regardless of a previously passing score.

(3) Individuals, who attained certification but failed a field of practice, must take and pass the failed field of practice and Oregon Laws & Rules (even if previously passed) if two years or more have lapsed since the most recent examination attempt.

(4) Practitioners who completed training in a new field of practice (post initial certification) must take and pass the Oregon Laws & Rules examination in addition to the field of practice examination. Retake of the Oregon Laws & Rules examination is required only if the examination was taken/passed more than two years before the date of application for certification in the new field of practice.

(5) Applicants for certification who fail any part of the examination may apply to retake the failed section(s) twice before being required to obtain recertification of training through an Oregon career school licensed under ORS 345.010 to 345.450.

Stat. Auth.: ORS 676.615, 690.065 & 690.165
Stats. Implemented: ORS 676.615, 690.065 & 690.165
Hist.: BH 2-1978, f. & ef. 11-29-78; BH 4-1984, f. & ef. 12-7-84; BH 2-1990, f. & cert. ef. 10-29-90; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; BH 1-1996, f. 5-31-96, cert. ef. 7-1-96; BH 1-1997, f. 7-22-97, cert. ef. 8-1-97; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2006, f. & cert. ef. 3-15-06; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-030-0065
Procedure if the Applicant Fails

(1) Failed sections of the examination may be retaken at the next available date and time, determined by the agency, as scheduling allows. Retaking a failed examination requires registration and payment of the examination fees.

(2) Opportunity to review failed sections of the examination, conducted by use of the electronic touch screen computer testing system, are provided at the conclusion of each examination question/answer selection, or immediately following conclusion of the entire examination. Review of failed examination sections at a later time or date is prohibited.

(3) Applicants retaking the examination must meet the requirements under OAR 331-030-0000 and 817-030-0020.

Stat. Auth.: ORS 690.065 & 690.165
Stats. Implemented: ORS 690.065 & 690.165
Hist.: BH 2-1978, f. & ef. 11-29-78; BH 1-1983(Temp), f. & ef. 10-4-83; BH 1-1984, f. & ef. 2-13-84; BH 4-1984, f. & ef. 12-7-84; BH 1-1988, f. & cert. ef. 7-1-88; BH 2-1990, f. & cert. ef. 10-29-90; BH 1-1992, f. 6-1-92, cert. ef. 7-1-92; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; BH 1 1996, f. 5-31-96, cert. ef. 7-1-96; BH 1-1997, f. 7-22-97, cert. ef. 8-1-97; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-030-0100
Interpreter Assisted Examinations

(1) An applicant may submit a written request to the agency for a special examination to accommodate their inability to speak or read English.

(2) Following the receipt of an application, an examination date will be scheduled.

(3) The applicant must secure and arrange for an individual to provide translation services and must pay any costs involved.

(4) The applicant must agree to specific provisions concerning the requirements, administration and conduct of the examination before taking the scheduled examination.

(5) Interpreters must meet the following requirements before providing examination interpreting services:

(a) Be registered by an agency or organization approved by the Board.

(b) Be on Board approved list before examination date;

(c) Not be personally affiliated with the test applicant;

(d) Present picture identification at the time of examination.

(6) An agency or organization approved by the Agency must submit the prescribed "Notification for Scheduled Interpreter Assisted Examination" form at least 24 hours before a scheduled examination to confirm the date and time reserved for providing examination interpreting services at the agency office.

(7) Applicants or interpreters will be excluded from the examination if they do not present the proper identification and documentation at the time of scheduled examination.

(8) All interpreter-assisted examinations are conducted at the agency and may be mechanically recorded using an audio or video recording device.

(9) The Board may approve and establish by policy additional examination time beyond published maximum allowances, per examination section listed in OAR 817-030-0040, to accommodate language translation services. Examinations are scheduled in the order in which applications are received in the office and according to available testing dates.

Stat. Auth.: ORS 676.615 & 690.165
Stats. Implemented: ORS 676.615, 690.065 & 690.165
Hist.: BOC 1-2000(Temp), f. 1-31-01, cert. ef. 2-1-01 thru 7-29-01; BOC 3-2001, f. 3-30-01, cert. ef. 4-1-01; BOC 5-2001, f. 11-30-01, cert. ef. 12-1-01; BOC 1-2002, f. 5-31-02 cert. ef. 6-1-02; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2006, f. & cert. ef. 3-15-06; Suspended by BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

817-035-0030
Document Issuance

(1) Pursuant to ORS 690.048, OAR 331-030-0000 and 331-030-0010 an individual will be issued a certificate authorizing the holder to practice barbering, hair design, esthetics or nail technology upon passage of the qualifying examination(s) required in 817-030-0045 and payment of an initial certificate fee for each field of practice.

(2) Certificate, license and registration holders are subject to provisions of OAR 331-030-0010 regarding issuance and renewal of an authorization, and to provisions of 331-030-0020 regarding authorization to practice and requirements for issuance of a duplicate authorization.

Stat. Auth.: ORS 676.615, 690.048, 690.123 & 690.165
Stats. Implemented: ORS 676.615, 690.048, 690.123 & 690.165
Hist.: BH 1-1988, f. & cert. ef. 7-1-88; BH 2-1990, f. & cert. ef. 10-29-90; BH 3-1994, f. 6-23-94, cert. ef. 7-1-94; Renumbered from 817-030-0095; BH 1-1996, f. 5-31-96, cert. ef. 7-1-96; BOC 1-2000, f. 5-12-00, cert. ef. 5-15-00; BOC 1-2004, f. 6-29-04, cert. ef. 7-1-04; BOC 1-2005, f. 6-17-05, cert. ef. 7-1-05; BOC 1-2006, f. & cert. ef. 3-15-06; BOC 3-2008(Temp), f. 11-28-08, cert. ef. 12-1-08 thru 4-30-09

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Oregon Public Employees Retirement System
Chapter 459

Rule Caption: Incorporate necessary updates for plan tax qualification purposes and for clarification.
Adm. Order No.: PERS 14-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 11-26-08
Notice Publication Date: 9-1-2008
Rules Amended: 459-005-0525, 459-005-0535, 459-005-0545
Subject: Amend rules to incorporate necessary updates for plan tax qualification purposes and for clarification.
Rules Coordinator: Daniel Rivas—(503) 603-7713

459-005-0525
Ceiling on Compensation for Purposes of Contributions and Benefits

(1) The purpose of this rule is to assure compliance of the Public Employees Retirement System (PERS) with Internal Revenue Code (IRC) Section 401(a)(17) relating to the limitation on annual compensation allowable for determining contribution and benefits under ORS Chapters 238 and 238A.

(2) Definitions:

(a) "Annual compensation" means "salary," as defined in ORS 238.005 and 238.205 with respect to Chapter 238 and in 238A.005 with respect to Chapter 238A paid to the member during a calendar year or other 12-month period, as specified in this rule.

(b) "Eligible participant" means a person who first becomes a member of PERS before January 1, 1996.

(c) "Employer" means a "public employer" as defined in ORS 238.005(17), for the purposes of this rule as it applies to Chapter 238. For the purposes of this rule as it applies to Chapter 238A, an "employer" means a "participating public employer" as defined in 238A.005(11).

(d) "Noneligible participant" means a person who first becomes a member of PERS after December 31, 1995.

(e) "Participant" means an active or inactive member of PERS.

(3) For eligible participants, the limit set forth in IRC Section 401(a)(17) shall not apply for purposes of determining the amount of employee or employer contributions that may be paid into PERS, and for purposes of determining benefits due under ORS Chapters 238 and 238A. The limit on annual compensation for eligible participants shall be no less than the amount which was allowed to be taken into account for purposes of determining contributions or benefits under former 237.001 to 237.315 as in effect on July 1, 1993.

(4) For noneligible participants, the annual compensation taken into account for purposes of determining contributions or benefits under ORS Chapters 238 and 238A shall be measured on a calendar year basis, and shall not exceed 230,000 per calendar year beginning in 2008.

(a) The limitation on annual compensation will be indexed by cost-of-living adjustments in subsequent years as provided in IRC Section 401(a)(17)(B).

(b) A noneligible participant employed by two or more agencies or instrumentalities of a PERS participating employer in a calendar year, whether concurrently or consecutively, shall have all compensation paid by the employer combined for determining the allowable annual compensation under this rule.

(c) PERS participating employers shall monitor annual compensation and contributions to assure that reports and remitting are within the limits established by this rule and IRC Section 401(a)(17).

(5) For a noneligible participant, Final Average Salary under ORS 238.005(8) with respect to Chapter 238 and under 238A.130 with respect to Chapter 238A shall be calculated based on the amount of compensation that is allowed to be taken into account under this rule.

(6) Notwithstanding section (4) and (5) of this rule, if the Final Average Salary as defined in ORS 238.005(8) with respect to Chapter 238 and as defined in 238A.130 with respect to Chapter 238A is used in computing a noneligible participant's retirement benefits, the annual compensation shall be based on compensation paid in a 12-month period beginning with the earliest calendar month used in determining the 36 months of salary paid. For each 12-month period, annual compensation shall not exceed the amount of compensation that is allowable under this rule for the calendar year in which the 12-month period begins.

(7) With respect to ORS Chapter 238, creditable service, as defined in 238.005(5), shall be given for each month that an active member is paid salary or wages and allowable contributions have been remitted to PERS, or would be remitted but for the annual compensation limit in IRC Section 410(a)(17). With respect to Chapter 238A, retirement credit as determined in 238A.140, shall be given for each month that an active member is paid salary or wages and allowable contributions have been remitted to PERS, or would be remitted but for the annual compensation limit in IRC Section 401(a)(17).

(8) The provisions of this rule are effective on January 1, 2004.

Stat. Auth.: ORS 238.630, 238.650 & 238A.005(16)(c)(I)
Stats. Implemented: ORS 238
Hist.: PERS 4-1995, f. 11-14-95, cert. ef. 12-1-95; PERS 5-1999, f. & cert. ef. 11-15-99; PERS 11-2002, f. & cert. ef. 7-17-02; PERS 31-2004(Temp), f. & cert. ef. 12-15-04 thru 6-1-05; PERS 8-2005, f. & cert. ef. 2-22-05; PERS 19-2005, f. 11-1-05, cert. ef. 1-1-06; PERS 14-2008, f. & cert. ef. 11-26-08

459-005-0535
Annual Benefit Limitation

(1) Applicable Law. This administrative rule shall be construed consistently with the requirements of the Internal Revenue Code (IRC) Section 415(b) and the Treasury regulations and Internal Revenue Service rulings and other interpretation issued thereunder.

(2) Annual Benefit Limitation. The benefits payable to any member for a calendar year, when expressed as an annual benefit, shall not exceed the applicable dollar limitation for that year.

(3) Applicable Dollar Limitation. For purposes of this rule, the "applicable dollar limitation" for each calendar year is the limitation in effect under IRC Section 415(b)(1)(A), with the adjustment described as follows:

(a) Cost-of-Living Adjustments. The limitation under IRC Section 415(b)(1)(A) shall be adjusted for cost of living in accordance with IRC Section 415(d).

(b) Reduction for Retirement Before Age 62. Except as otherwise provided in the paragraphs (A), (B), and (C) of this subsection, if the member's benefit begins before the member reaches 62 years of age, the applicable dollar limitation shall be adjusted as provided for in IRC Section 415(b)(2)(C).

(A) This reduction shall not apply to any member who has at least 15 years of creditable service as a full-time employee of a police department or fire department which is organized and operated by the state or a political subdivision of the state to provide police protection, firefighting services, or emergency medical services for any area within the jurisdiction of the state or political subdivision.

(B) This reduction shall not apply to disability retirement allowances or death benefits.

(C) This reduction shall not apply to any portion of a member's annual benefit that is derived from contributions to purchase service credit, as defined in OAR 459-005-0540, Permissive Service Credit.

(c) Reduction for Less than 10 Years of Membership. Except as provided in paragraphs (A) and (B) of this subsection, if the member has less than 10 years of active membership in PERS, the applicable dollar limitation shall be reduced as provided for under IRC Section 415(b)(5)(A).

(A) For the purposes of this section, a member with less than one year of active membership shall be treated as having one year of active membership.

(B) The reduction under this section shall not apply to disability retirement allowances or death benefits.

(d) Increase for Retirement After Age 65. If the member's benefit begins after the member reaches 65 years of age, the applicable dollar limitation shall be increased as provided for under IRC Section 415(b)(2)(D).

(4) Annual Benefit. For purposes of this rule, the "annual benefit" is the benefit payable to a member under ORS Chapter 238 and the pension program under Chapter 238A for a calendar year, excluding any benefit payable under 238.485 through 238.492, and adjusted as described in this section.

(a) Excludable Benefits. The annual benefit shall not include the portion of the member's benefit that is attributable to:

(A) After-tax member contributions, other than member payments to purchase permissive service credit as defined in OAR 459-005-0540, Permissive Service Credit;

(B) Rollover contributions, if such contributions are permitted;

(C) A transfer of assets from another qualified retirement plan; and

(D) Purchases of permissive service credit, as defined in OAR 459-005-0540, Permissive Service Credit, if all of the member's payments to purchase permissive service credit are treated as annual additions for purposes of 459-005-0545, Annual Addition Limitation, in the year purchased.

(b) Adjustment to Straight Life Annuity. The member's benefit shall be adjusted to an actuarially equivalent straight life annuity beginning at the same age. For purposes of this adjustment, the following values are not taken into account:

(A) The value of a qualified spouse joint and survivor annuity to the extent that the value exceeds the sum of the value of a straight life annuity beginning on the same day, and the value of any post-retirement death benefits that would be payable even if the annuity was not in the form of a joint survivor annuity.

(B) The value of benefits that are not directly related to retirement benefits, such as pre-retirement disability benefits and post-retirement medical benefits.

(C) The value of post-retirement cost of living increases, to the extent they do not exceed the increase provided under IRC Section 415(d) and Treasury Regulation Section 1.415(d)-1.

(5) Interest Rates. The following interest rates shall apply for purposes of adjusting the applicable dollar limitation under section (3) of this rule and the annual benefit under section (4) of this rule.

(a) For purposes of reducing the applicable dollar limitation for retirement before 62 years of age under subsection (3)(b) of this rule, the interest rate shall be the greater of five percent or PERS' assumed earnings rate.

(b) For purposes of determining the portion of a member's benefits attributable to after-tax member contributions under paragraph (4)(a)(A) of this rule, the interest rate shall be the greater of 5 percent or the PERS' assumed earnings rate.

(c) For purposes of adjusting the member's annual benefits under section (4) of this rule (other than the adjustment for after-tax member contributions), the interest rate shall be the greater of five percent or PERS' assumed earnings rate.

(d) For purposes of increasing the applicable dollar limitation for retirement after 65 years of age under subsection (3)(d) of this rule, the interest rate shall be the lesser of five percent or PERS' assumed earnings rate.

(6) Mortality Table. For purposes of adjusting the applicable dollar limitation and annual benefit under sections (3) and (4) of this rule, the mortality table used shall be the table prescribed pursuant to the Internal Revenue Code.

(7) The provisions of this rule are effective on January 1, 2004.

Stat. Auth.: ORS 238.630, 238.650 & 238A.125
Stats. Implemented: ORS 238.005 - 238.715
Hist.: PERS 5-1999, f. & cert. ef. 11-15-99; PERS 3-2000, f. & cert. ef. 3-10-00; PERS 11-2002, f. & cert. ef. 7-17-02; PERS 31-2004(Temp), f. & cert. ef. 12-15-04 thru 6-1-05; PERS 8-2005, f. & cert. ef. 2-22-05; PERS 14-2008, f. & cert. ef. 11-26-08

459-005-0545
Annual Addition Limitation

(1) Applicable Law. This administrative rule shall be construed consistently with the requirements of the Internal Revenue Code (IRC) Section 415(c) and the Treasury regulations and Internal Revenue Service rulings and other interpretations issued thereunder.

(2) Annual Addition Limitation. Except as otherwise provided in this rule, a member's annual additions to PERS for any calendar year after 2007 may not exceed the lesser of the following amounts:

(a) $46,000 (as adjusted under IRC Section 415(d)); or

(b) One hundred percent of the member's compensation for the calendar year (as defined in IRC Section 415(c)(3)).

(3) Annual Additions. For purposes of this rule, the term "annual additions" has the same meaning as under IRC Section 415(c)(2).

(4) Permissive Service Credit. The following special rules shall apply with respect to purchases of permissive service credit, as defined in OAR 459-005-0540, Permissive Service Credit:

(a) If a member's after-tax contributions to purchase permissive service credit are included in the member's annual additions under section (3) of this rule, the member shall not be treated as exceeding the 100 percent of compensation limitation under subsection (2)(b) of this rule solely because of the inclusion of such contributions.

(b) With respect to any eligible participant, the annual addition limitation in section (2) of this rule shall not be applied to reduce the amount of permissive service credit to an amount less than the amount that could be purchased under the terms of the plan as in effect on August 5, 1997. As used in this subsection, the term "eligible participant" includes any individual who became an active member before January 1, 2000.

(5) Purchase of Service in the Armed Forces Under ORS 238.156 or 238A.150. If a member makes a payment to PERS to purchase retirement credit for service in the Armed Forces pursuant to 238.156(3)(c) or 238A.150 and the service is covered under Internal Revenue Code Section 414(u), the following special rules shall apply for purposes of applying the annual addition limitation in section (2) of this rule:

(a) The payment shall be treated as an annual addition for the calendar year to which it relates;

(b) The payment shall not be treated as an annual addition for the calendar year in which it is made; and

(c) The member shall be treated as having received the following amount of compensation for the period of service in the Armed Forces to which the payment relates:

(A) The amount of compensation the member would have received from a participating employer had the member not been in the Armed Forces; or

(B) If the amount in paragraph (A) of this subsection is not reasonably certain, the member's average compensation from the participating employer during the 12-month period immediately preceding the period of service in the Armed Forces (or, if shorter, the period of employment immediately preceding the period of service in the Armed Forces).

(6) The provisions of this rule are effective on January 1, 2004.

Stat. Auth.: ORS 238.630, 238.650 & 238A.370
Stats. Implemented: ORS 238.005 - 238.715
Hist.: PERS 5-1999, f. & cert. ef. 11-15-99; PERS 11-2002, f. & cert. ef. 7-17-02; PERS 31-2004(Temp), f. & cert. ef. 12-15-04 thru 6-1-05; PERS 8-2005, f. & cert. ef. 2-22-05; PERS 14-2008, f. & cert. ef. 11-26-08

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Rule Caption: Clarifies date granting creditable service for leave of absence without pay.
Adm. Order No.: PERS 15-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 11-26-08
Notice Publication Date: 9-1-2008
Rules Amended: 459-010-0010
Subject: Provides that creditable service is granted only for portions of Leave Without Pay (LWOP) that occur before July 11, 1987.
Rules Coordinator: Daniel Rivas—(503) 603-7713

459-010-0010
Leave of Absence Without Pay

(1) Employer/Employee Agreement. An official leave of absence without pay for any purpose must have the following in order to be considered bona fide:

(a) An agreement in writing;

(b) Accordance with the applicable law, rules and regulations;

(c) The duration specifically stated at the time of granting; and

(d) Certification to PERS by the employer granting such leave.

(2) Creditable Service.

(a) A leave of absence without pay occurring on or after July 1, 1987, which constitutes the major fraction of a calendar month:

(A) May not be used to calculate "years of membership" under ORS 238.300; and

(B) May not be used to determine "creditable service" under ORS 238.005 or "retirement credit" under ORS 238.005.

(b) A leave of absence without pay occurring before July 1, 1987, which constitutes the major fraction of a calendar month:

(A) Must be used to calculate "years of membership" under ORS 238.300; and

(B) Must be used to determine "creditable service" under ORS 238.005 or "retirement credit" under 238.005.

(3) Reporting Requirement. Unless otherwise agreed upon by PERS, the employer shall report the following in a format acceptable to PERS:

(a) Any period of leave of absence without pay, which constitutes the major fraction of a calendar month, for each member at the time the leave begins. The reported period of leave of absence without pay must include an end date.

(b) Any amendment or extension to a previously reported period of leave of absence without pay.

(4) A PERS member on an official leave of absence without pay is not considered terminated from service with a participating employer.

(5) An employee on an official leave of absence without pay on the date the employer begins to participate in PERS, shall be considered to be an employee on such date for the purpose of determining eligibility for participation in PERS.

(6) A layoff from employment does not constitute a leave of absence without pay.

Stat. Auth.: ORS 238.650
Stats. Implemented: ORS 238.300
Hist.: PER 8, f. 12-15-55; PERS 12-1998, f. & cert. ef. 12-17-98; PERS 12-2001, f. 12-14-01, cert. ef. 1-1-02; PERS 21-2005, f. & cert. ef. 11-1-05; PERS 15-2008, f. & cert. ef. 11-26-08

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Rule Caption: Modifies effective date used for establishment of retirement benefits.
Adm. Order No.: PERS 16-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 11-26-08
Notice Publication Date: 9-1-2008
Rules Adopted: 459-075-0175
Rules Amended: 459-013-0260
Subject: Currently, a member's effective date of retirement may be the first day of the calendar month in which the member's retirement application is received. If the member submits a retirement application late in the month, PERS faces a shorter timeframe in which to calculate a retirement benefit and issue a benefit payment. This may result in the issuance of an estimated benefit rather than an actual benefit payment. The proposed rule modifications require a member to submit their retirement application before their selected retirement date. This will provide staff an additional month of time to produce the member's benefit and will reduce the frequency of estimated benefit payments.

The rules have a delayed effective date of August 1, 2009.
Rules Coordinator: Daniel Rivas—(503) 603-7713

459-013-0260
Effective Date Used in the Establishment of Service Retirement Benefits

(1) A member's service retirement allowance under ORS 238.300 and 238.305 will be established as of the member's effective date of retirement.

(2) A member's effective date of retirement is the later of:

(a) The first day of the calendar month specified by the member, who is eligible for retirement under the provisions of ORS 238.280 or 238.005(5), on their service retirement application; or

(b) The first of the calendar month following the date an application is received by the Public Employees Retirement System (PERS); or

(c) The first of the calendar month following the date of separation from all employers participating in PERS and in the same controlled group.

(3) For the purpose of this rule, "controlled group" is a group of employers required to be treated as a single employer for the purpose of satisfying the requirements for qualified retirement plans under federal law.

(4) The effective date of this rule is January 1, 2010.

Stat. Auth.: ORS 238.650
Stats. Implemented: ORS 238.300 & 238.305
Hist.: PERS 10-2000, f. 12-15-00 cert. ef. 1-1-01; PERS 20-2005, f. 11-1-05, cert. ef. 11-4-05; PERS 16-2008, f. & cert. ef. 11-26-08

459-075-0175
Effective Date Used in the Establishment of OPSRP Pension Program Benefits

(1) A member's OPSRP pension program benefits under ORS 238A.125 and 238A.180 will be established as of the member's effective date of retirement.

(2) A member's effective date of retirement is the later of:

(a) The first day of the calendar month specified by the member, who is eligible for retirement under the provisions of ORS 238A.160 to 238A.170, on their service retirement application; or

(b) The first of the calendar month following the date an application is received by the Public Employees Retirement System (PERS); or

(c) The first of the calendar month following the date of separation from all employers participating in PERS and in the same controlled group.

(3) For the purpose of this rule, "controlled group" is a group of employers required to be treated as a single employer for the purpose of satisfying the requirements for qualified retirement plans under federal law.

(4) The effective date of this rule is January 1, 2010.

Stat. Auth.: ORS 238A.450
Stats. Implemented: ORS 238A.125 & 238A.180
Hist.: PERS 16-2008, f. & cert. ef. 11-26-08

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Rule Caption: Revise trading restrictions in Oregon Savings Growth Plan.
Adm. Order No.: PERS 17-2008
Filed with Sec. of State: 11-26-2008
Certified to be Effective: 11-26-08
Notice Publication Date: 9-1-2008
Rules Amended: 459-050-0037
Subject: Modifications remove the 90-day restriction on all investment options, with the exception of the International Stock Option, which is reduced to 30 days. The $10,000 daily trade restriction (per option) and the equity wash restriction on the Stable value option will remain in place.
Rules Coordinator: Daniel Rivas—(503) 603-7713

459-050-0037
Trading Restrictions

The purpose of this rule is to establish criteria under which a participant may make trades in the Deferred Compensation Program. The Program is designed for long-term investment and periodic adjustment of asset allocation. Restrictions upon trades are necessary to protect participants and the Program from adverse financial impact attributable to frequent trading. Frequent trading by some participants can lower returns and increase transaction costs for all participants. Frequent trading can trigger the imposition of redemption fees and restrictions by mutual funds within the Program and may cause the Program to be eliminated as an allowable investor in an investment fund.

(1) Definitions. For the purposes of this rule:

(a) "Investment Option" means an investment alternative made available under ORS 243.421.

(b) "Trade" means a purchase or redemption in an investment option for the purpose of moving monies between investment options.

(2) Restrictions. The following restrictions apply to all participants:

(a) A participant may not make a trade that exceeds $100,000.

(b) A purchase that is attributable to a trade may not be redeemed from the International Stock Option for a period of 30 days following the date of the trade.

(c) No trade may move monies directly from the Stable Value Option to the Short-Term Fixed Income Option or the Intermediate Bond Option.

(3) The Deferred Compensation Manager, if necessary to comply with trading restrictions imposed by a participating mutual fund or the Securities and Exchange Commission, may establish additional temporary trading restrictions.

(4) The Deferred Compensation Manager, in the event of extraordinary market conditions, may temporarily suspend any or all trading restrictions established by this rule.

(5) Any action taken by the Deferred Compensation Manager under sections (3) or (4) of this rule must be presented to the Board at its next scheduled meeting. The Board may take action as authorized by ORS 243.401 to 243.507. If the Board does not act, the action(s) taken by the Deferred Compensation Manager shall expire on the first business day following the date of the meeting.

(6) The provisions of this rule are not applicable to trades attributable to the operation of an automatic account rebalancing function offered by the Program.

(7) The trading restrictions provided in this rule are not exclusive. The Board may establish additional restrictions or sanctions as authorized by ORS 243.401 to 243.507.

(8) The effective date of this rule is December 5, 2008.

Stat. Auth.: ORS 243.470
Stats. Implemented: ORS 243.401 - 243.507
Hist.: PERS 4-2007, f. 1-23-07, cert. ef. 5-1-07; PERS 17-2008, f. & cert. ef. 11-26-08

Oregon State Lottery
Chapter 177

Rule Caption: Amends rules specifying number of future drawings for which a player may purchase a ticket.
Adm. Order No.: LOTT 8-2008(Temp)
Filed with Sec. of State: 11-21-2008
Certified to be Effective: 11-23-08 thru 5-16-09
Notice Publication Date:
Rules Amended: 177-046-0020, 177-075-0010, 177-081-0020, 177-083-0020, 177-083-0030, 177-083-0040, 177-085-0015, 177-094-0020
Subject: This rulemaking repeals current language in each of the above game divisions that specifies the number of consecutive drawings for which a player may purchase a ticket and the maximum ticket price, and adopts new provisions in OAR 177-046-0020, 177-081-0020, and 177-094-0020 that authorize the Lottery to determine that limit.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-046-0020
Sale of Lottery Tickets and Shares

(1) **General**: The Director may contract with retailers for the sale of Lottery tickets and shares. Only a retailer under contract with the Lottery may sell Lottery tickets or shares. Nothing in this section shall be construed to prevent a person who lawfully purchases or possesses a Lottery ticket or share from making a gift of such ticket or share to another.

(2) **Retailer Sales Locations**: Unless authorized by the Lottery, Lottery tickets or shares may only be sold by a Lottery retailer at the location listed in the retailer contract.

(3) **Lottery Sales**: The Lottery may designate its agents or employees to sell Lottery tickets or shares directly to the public, either in person or through electronic means.

(4) **Future Drawings**: A player may purchase a ticket or tickets for future consecutive drawings to the extent permitted by the Lottery for each Lottery game.

(4) **Sales Are Final**: Unless otherwise provided in OAR Chapter 177, the sale of all Lottery tickets and shares is final. A player may not return a Lottery ticket or share for a refund of the purchase price or exchange unless the specific game rule provides otherwise. The Lottery is not liable for Lottery tickets or shares that are purchased in error.

(5) **Distribution**: The Director is authorized to arrange for the direct distribution of on-line terminals, ticket stock, and supplies shipped directly from the manufacturer or supplier to an authorized retailer.

Stat. Auth.: ORS 461 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250 & 461.260
Hist.: LOTT 12-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 23-2002, f. & cert. ef. 11-25-02; LOTT 10-2005(Temp), f. & cert. ef. 11-2-05 thru 4-28-06; LOTT 18-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 5-2008, f. 6-30-08, cert. ef. 7-1-08; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-075-0010
Ticket Purchase, Characteristics and Restrictions

(1) **General**: Oregon Megabucks^{SM} is a pari-mutuel lotto game. A player must select an even number set of six different numbers, between 1 and 48 for input into a terminal. Tickets can be purchased either from a terminal operated by a retailer (i.e., a clerk-activated terminal) or from a terminal operated by the player (i.e., a player-activated terminal). If purchased from a retailer, the player may select each set by marking six numbered squares in any one game board on a play slip and submitting the play slip to the retailer, or by requesting "Quick pick" from the retailer. The retailer will then issue a ticket, via the terminal, containing the selected even number set or sets of numbers, each of which constitutes a game play. Tickets can also be purchased from a player-activated terminal by use of a touch screen or by inserting a play slip into the machine. A ticket can contain up to ten game plays lettered A through J.

(2) **Kicker Option**: The player must also choose whether to play "Kicker". Kicker awards larger prizes for correctly selecting three of six, four of six, and five of six numbers.

(3) **Non-Cancellation**: A Megabucks^{SM} ticket may not be voided or cancelled by returning the ticket to the retailer, including tickets that are printed in error. The placing of plays is done at the player's own risk through the On-Line retailer who is acting on behalf of the player in entering the player's plays.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210
Hist.: SLC 11-1985(Temp), f. & ef. 10-24-85; SLC 6-1986, f. & ef. 3-5-86; SLC 12-1986, f. 5-28-86, ef. 6-1-86; LC 16-1988, f. & cert. ef. 6-2-88; LC 10-1989(Temp), f. 4-25-89, cert. ef. 4-30-89; LC 11-1989, f. & cert. ef. 7-6-89; LC 9-1990, f. 7-20-90, cert. ef. 8-5-90; LC 2-1991, f. & cert. ef. 7-24-91; LC 6-1993, f. & cert. e.f 7-2-93; LC 3-1995, f. & cert. ef. 4-27-95; LOTT 8-2001(Temp), f. & cert. ef. 5-18-01 thru 11-9-01; LOTT 11-2001, f. & cert. ef. 8-7-01; LOTT 16-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 27-2002, f. & cert. ef. 11-25-02; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-081-0020
Price

The price of a ticket shall be determined by the amount of money a player chooses to wager on the game play selected, multiplied by the number of drawings in which the ticket will be played.

(1) Price — Clerk-Operated Terminal: The price of a ticket for a single drawing purchased through a clerk-operated terminal shall range from a minimum of $1.00 to a maximum of $7.00 in $.50 increments.

(2) Price — Player-Operated Terminal: The price of a ticket for a single drawing purchased through a player-operated terminal shall range from a minimum of $1.00 to a maximum of $7.00 in $1.00 increments. When a player requests a Quick Pick from a player-operated terminal the only wager possible is $1.00.

(3) Tickets for Multiple Drawings: A player may purchase a ticket for a single drawing or for up to the maximum permitted by the Lottery. The price of a ticket is determined by multiplying the number of drawings in which the ticket will be played by the total wager for each drawing. The minimum ticket price for a ticket containing consecutive drawings is $2.00 ($1 x 2 consecutive drawings = $2). A game slip indicating a price of less than $1.00 or a price greater than that permitted by the Lottery shall be automatically rejected by the terminal.

(4) Whole Dollar Amounts: Notwithstanding sections (1) through (3) of this rule, the price of a ticket for consecutive drawings purchased through a player-operated terminal must be in whole dollar amounts. For example, a $1.50 wager placed for two consecutive drawings equals a viable $3.00 total game play wager.

Stat. Auth.: OR Const. Art. XV Sec. (4) & ORS 461
Stats. Implemented: ORS 461.210, 461. 220, 461.240 & 461. 250
Hist.: LOTT 2-2000, f. 3-31-00, cert. ef. 4-3-00; LOTT 17-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 28-2002, f. & cert. ef. 11-25-02; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-083-0020
Price

(1) **Ticket Price for a Single Drawing**: A player may purchase a ticket for a single drawing. The price of a ticket for a single drawing is $2.

(2) **Ticket Price for Consecutive Drawings**: The price of a ticket for consecutive drawings is a minimum of $4.

Stat. Auth.: ORS 461 & OR Const., Art. XV, §4(4)
Stats. Implemented: ORS 461.210
Hist.: LOTT 4-2006, f. 3-23-06, cert. ef. 4-9-06; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-083-0030
Ticket Purchase, Characteristics, and Restrictions (Lucky Lines)

(1) Hours of Purchase: Lucky Lines^{SM} tickets may be purchased everyday of the year during the hours of operation of the Lottery's On-Line game system and a Lottery On-Line retailer's business hours of operation.

(2) Ticket Purchase: Tickets may be purchased either from a clerk-operated terminal or from a player-operated terminal. To play Lucky Lines^{SM}, a player must:

(a) Complete a play slip for input into a clerk-operated terminal or player-operated terminal; or

(b) Request a Quick Pick from a clerk or by using a player-operated terminal; and

(c) Pay the ticket price.

(3) Play Slip: Completing a play slip:

(a) A player must choose a game play by one of two methods:

(A) A player must select one number out of a group of four numbers in each of the eight fields; or

(B) The player may select the numbers using the Quick Pick option.

(b) A player must indicate if the game play is for consecutive drawings.

(4) Clerk-Operated Terminal: Purchasing a ticket from a clerk-operated terminal:

(a) The player may complete a game slip and submit it with the price of the ticket to the clerk. The clerk will use the terminal to issue a ticket to the player with the player's game plays; or

(b) Without using a game slip, the player may request that a clerk electronically use the terminal's Quick Pick number selection. Upon pay-

ment of the price of the ticket to the clerk, the clerk will use the terminal to issue a ticket to the player with the player's Quick Pick game plays.

(c) The placing of game plays is done at the player's own risk through the On-Line retailer who is acting on behalf of the player in entering the player's plays.

(5) Player-Operated Terminal: A player may purchase a ticket from a player-operated terminal by following the instructions appearing on the screen of the terminal either by:

(a) Completing a game slip, inserting it into the terminal, and paying the price of the ticket into the terminal. The terminal will issue a ticket to the player with the player's game plays; or

(b) The player may use the terminal's Quick Pick number selection without using a game slip by following the instructions appearing on the terminal screen and paying the price of the ticket. The terminal will issue a ticket to the player with the player's Quick Pick game plays.

Stat. Auth.: ORS 461 & OR Const., Art. XV, §4(4)
Stats. Implemented: ORS 461.210
Hist.: LOTT 4-2006, f. 3-23-06, cert. ef. 4-9-06; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-083-0040
Cancellation of Tickets

(1) **General**: A player may cancel a Lucky Lines[SM] ticket for a single drawing or consecutive drawings. To cancel a ticket, a player must follow the procedure in OAR 177-046-0060.

(2) **Refund**: In the event that a ticket is canceled in accordance with OAR 177-083-0040(1) and 177-046-0060, the player shall be entitled to a refund from the retailer equal to the cost shown on the player's ticket.

Stat. Auth.: ORS 461 & OR Const., Art. XV, §4(4)
Stats. Implemented: ORS 461.210
Hist.: LOTT 4-2006, f. 3-23-06, cert. ef. 4-9-06; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-085-0015
Game Description

(1) Powerball is a five out of fifty-five numbers plus one out of forty-two numbers on-line lottery game, drawn every Wednesday and Saturday, which pays the Grand Prize, at the election of the player made in accordance with these rules or by a default election made in accordance with these rules, either on an annuitized pari-mutuel basis or as a single lump sum payment of the total amount held for this prize pool on a pari-mutuel basis. Except as provided in the rules, all other prizes are paid on a set lump sum basis.

(2) To play Powerball, a player shall select five different numbers, between 1 and 55 and one additional number between 1 and 42, for input into a terminal. The additional number may be the same as one of the first five numbers selected by the player.

(3) Tickets can be purchased either from a terminal operated by a retailer (i.e., a clerk-activated terminal) or from a terminal operated by the player (i.e., a player-activated terminal). If purchased from a retailer, the player may select a set of five numbers and one additional number by marking six numbered squares in any one game board on a play slip and submitting the play slip to the retailer, or by requesting "Quick Pick" from the retailer. The retailer will then issue a ticket, via the terminal, containing the selected set or sets of numbers, each of which constitutes a game play. Tickets can be purchased from a player-activated terminal by use of a touch screen or by inserting a play slip into the machine.

(4) It is the sole responsibility of the player to verify the accuracy of the game play or plays and other data printed on the ticket. A ticket may not be voided or canceled by returning the ticket to the retailer or to the Lottery, including tickets that are printed in error. No ticket shall be returned to the Lottery for credit. The placing of plays is done at the player's own risk through the on-line retailer.

(5) The winning numbers for the Powerball game shall be determined at a drawing conducted under the supervision of the MUSL Board. The MUSL Board shall determine the frequency of Powerball game drawings. Winning numbers shall be selected at random with the aid of mechanical drawing equipment. The Lottery Director shall designate a Drawing Manager who shall review and randomly observe the drawings conducted by the MUSL Board.

Stat. Auth.: ORS 461.250 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 6-1993, f. & cert. ef. 7-2-93; LC 1-1994, f. 1-27-94, cert. ef. 2-1-94; LC 7-1997, f. 10-30-97, cert. ef. 11-2-97; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

177-094-0020
Price

(1) General: The minimum price of a ticket for a single drawing is $2.

(2) Consecutive Drawings: The price of a ticket for play in consecutive drawings shall be the price of a ticket for a single drawing ($2.00) multiplied by the number of consecutive drawings in which the ticket will be played. The minimum ticket price for consecutive drawings is $4.00 ($2 x 2 consecutive drawings = $4).

(3) Game Boards: A game slip contains five boards. Each of the five boards may be used by a player to purchase a single ticket. Therefore, a game slip may be used to purchase up to five tickets. Any game slip indicating a total ticket purchase price greater than that permitted by the Lottery shall be automatically rejected by the terminal.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461
Hist.: LOTT 11-2000, f. & cert. ef. 12-1-00; LOTT 18-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 29-2002, f. & cert. ef. 11-25-02; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09

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Rule Caption: Clarifies Director's authority to end Scratch-it[SM] ticket games, repeals, general end-of-game rule.
Adm. Order No.: LOTT 9-2008
Filed with Sec. of State: 11-21-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 177-050-0100
Rules Amended: 177-050-0025, 177-050-0027
Rules Repealed: 177-046-0150
Subject: The Oregon Lottery® repealed OAR 177-046-0150 in the Lottery Games General Operating rules and adopted a new rule in the Scratch-it[SM] ticket games operating rules, division 50, that clarifies the Director's authority to end a Scratch-it[SM] ticket game and establishes the time frames for claiming a prize and returning unsold Scratch-it[SM] tickets when a game ends.

OAR 177-050-0025 and OAR 177-050-0027 are amended to update references to the new rule.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-050-0025
Payment of Prizes

(1) **Director's Determination**: The Director shall determine the official ending date of a Scratch-it[SM] ticket game.

(2) **Notice**: The Director shall announce the official ending date of each Scratch-it[SM] ticket game by any reasonable means, which may include: Notice on the Lottery's website, media advertisements, or notice through Lottery retail sales sites.

(3) **Last Date to Claim a Prize**: In accordance with ORS 461.250(7), the last date to claim a prize is one calendar year from the official ending date of the game, unless the Lottery Commission defines a shorter time period to claim a prize in a particular Scratch-it[SM] ticket game. A prize must be claimed by the close of business on the last date to claim a prize and if not claimed by that date is an unclaimed prize. If the final date of the claim period falls on a weekend or a Lottery holiday, the last date to claim a prize extends to the close of the next Lottery business day.

(4) **Unsold Returns**: To receive a credit after a game has ended for unsold Scratch-it[SM] tickets in any ticket pack activated by the retailer, the retailer must return the unsold tickets to the Lottery within one calendar year from the official ending date of that game. Upon a showing of good cause by the retailer, the Director may authorize credit for unsold Scratch-it[SM] tickets returned beyond this one-year period.

Stat. Auth.: ORS 461, OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250, 461.260
Hist.: SLC 4-1985(Temp), f. & ef. 1-29-85; SLC 8-1985, f. & ef. 6-21-85; SLC 4-1986, f. & ef. 2-25-86; SLC 27-1986, f. & ef. 11-24-86; LC 7-1987, f. & ef. 4-29-87; LC 4-1990, f. & cert. ef. 4-3-90; LC 8-1993, f. 9-22-93, cert. ef. 10-18-93; LOTT 15-2001, f. & cert. ef. 12-3-01; LOTT 13-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 24-2002, f. & cert. ef. 11-25-02; LOTT 10-2005(Temp), f. & cert. ef. 11-2-05 thru 4-28-06; LOTT 18-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 4-2007(Temp), f. 11-8-07, cert. ef. 11-12-07 thru 5-9-08; LOTT 1-2008, f. 3-21-08, cert. ef. 3-31-08; LOTT 9-2008, f. 11-21-08, cert. ef. 12-1-08

177-050-0027
Ticket Validation Requirements

(1) **General**: Besides meeting all of the other requirements in OAR Chapter 177 and as may be printed on each ticket, the following validation requirements apply to Scratch-it[SM] game tickets.

(2) **Requirements**: Except as provided in section (3) of this rule and OAR 177-050-0025(3), to be a valid Scratch-it^{SM} game ticket, all of the following requirements must be met:

(a) Play Symbols: Where applicable, each of the play symbols must have a play symbol caption underneath, and each play symbol must agree with its play symbol caption.

(b) Legibility: Where applicable, each of the play symbols and play symbol captions must be present in its entirety and be legible.

(c) Specifications: Each of the play symbols and its play symbol caption must be printed according to game specifications.

(d) Completeness of Information: The game number, pack number, ticket number, bar code, bar code number, and VIRN number must be present and all information must correspond with the Lottery's computer records.

(e) Printing Order: The play symbols, play symbol captions, game number, pack-ticket number, and VIRN number must be right-side-up and not reversed in any manner.

(f) Pack-Ticket Number: The ticket must have exactly one pack-ticket number.

(g) VIRN: The VIRN number of an apparent high-tier winning ticket must appear on the Lottery's official record of winning ticket VIRN numbers, and a ticket with that VIRN number must not have been paid previously.

(h) Artwork: Each of the following must correspond to the artwork on file at the Lottery: Play symbols on the ticket, play symbol captions, pack-ticket numbers, display printing, game numbers, retailer validation code, and ticket VIRN number.

(i) Multi-Page Tickets: In the case of Scratch-it^{SM} tickets consisting of multiple pages designed to remain intact, the individual pages must not be detached from each other. Such separated multi-page tickets will be considered damaged tickets.

(3) **Lost, Damaged, or Destroyed Tickets for Prizes Greater than $600**: If a player of a Scratch-it^{SM} prize of more than $600 cannot submit an intact winning ticket because a Scratch-it^{SM} game retailer lost, damaged, or destroyed the ticket while attempting to perform validation procedures on the game ticket, a prize claim based on the lost, damaged, or destroyed ticket may still be validated as set forth in OAR 177-050-0025(3), provided the claim is made before the end of the one year claim period after the end of the game as described in OAR 177-050-0100.

(a) Payment Process: When a prize payment is authorized by the Director under this section, the prize payment shall be validated as set forth in OAR 177-050-0025(3).

(b) Payment Restriction: Payments of prize claims submitted under this section are restricted to the prize amount.

(4) **Damaged Tickets**: Notwithstanding OAR 177-046-0090 and section (2) of this rule, the Director may pay the prize on a winning Scratch-it^{SM} ticket that is inadvertently or accidentally damaged so that it cannot be validated either through the Lottery's central computer system or because it is missing information required under section (2) of this rule, if the ticket is readable and is validated as a winning ticket by the Lottery's Security Section. For purposes of this rule, a Scratch-it^{SM} ticket is unreadable if there is insufficient information remaining on the ticket for the Lottery's Security Section to reconstruct and validate the ticket.

(a) Validation Process: When a prize payment is authorized by the Director under this section, the prize payment shall be validated as follows:

(A) Evidence: The player shall obtain, complete, and sign a winner claim form and a claim affidavit furnished by the Lottery. The player shall submit the two completed forms along with the damaged ticket, (including, but not limited to, all pages of a game book in the player's possession) to the Lottery at the addresses listed in section OAR 177-050-0025(1)(b), either by mail (registered mail is recommended) or in person at the Lottery's Headquarters in Salem during Lottery business hours.

(B) Investigation: The Assistant Director for Security will conduct an investigation to determine if the claim and winning game ticket are valid.

(C) Director's Determination: Based upon all the facts and information available, the Director shall make a determination whether prize payment is warranted and authorized. The Director may require that such determination be made on the last day of the one-year claim period following the end of the game, as described in OAR 177-050-0100. If the prize claim period expires on a weekend or on a holiday when the Lottery is closed, the claim period will be extended to end at the close of the next Lottery business day. Following validation, the Lottery shall issue the prize payment in the usual course of Lottery business.

(D) Payment of Prize: Upon the Director's determination that the ticket submitted under this section is a valid, winning ticket, and that the player is the proper person to whom a prize is payable, the Lottery shall present or mail a check to the player in payment of the appropriate prize amount less any applicable tax withholding.

(E) Notification of Denial: If the ticket is determined to be invalid or a non-winning ticket or the claim is invalid, the claim shall be denied and the player notified.

(b) Payment Restriction: Payment of a prize claim submitted under this section is restricted to the prize amount less any applicable tax withholding.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.250
Hist.: LC 7-1987, f. & ef. 4-29-87; LC 4-1988, f. & cert. ef. 1-26-88; LC 4-1990, f. & cert. ef. 4-3-90; LC 6-1993, f. & cert. e.f 7-2-93; LC 7-1995, f. & cert. ef. 7-7-95; LC 6-1996, f. 5-30-96, cert. ef. 6-1-96; LC 1-1997, f. 1-31-97, cert. ef. 2-1-97; LOTT 15-2001, f. & cert. ef. 12-3-01; LOTT 13-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 24-2002, f. & cert. ef. 11-25-02; LOTT 13-2004(Temp), f. & cert. ef. 11-29-04 thru 5-27-05; LOTT 3-2005, f. 4-27-05, cert. ef. 4-28-05; LOTT 10-2005(Temp), f. & cert. ef. 11-2-05 thru 4-28-06; LOTT 18-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 4-2007(Temp), f. 11-8-07, cert. ef. 11-12-07 thru 5-9-08; LOTT 1-2008, f. 3-21-08, cert. ef. 3-31-08; LOTT 9-2008, f. 11-21-08, cert. ef. 12-1-08

177-050-0100
Official End of Scratch-it^{SM} Ticket Games and Last Date to Claim a Prize or to Receive Credit for Unsold Scratch-it^{SM} Tickets

(1) Director's Determination: The Director shall determine the official ending date of a Scratch-it^{SM} ticket game.

(2) Notice: The Director shall announce the official ending date of each Scratch-it^{SM} ticket game by any reasonable means, which may include: Notice on the Lottery's website, media advertisements, or notice through Lottery retail sales sites.

(3) Last Date to Claim a Prize: In accordance with ORS 461.250(7), the last date to claim a prize is one calendar year from the official ending date of the game, unless the Lottery Commission defines a shorter time period to claim a prize in a particular Scratch-it^{SM} ticket game. A prize must be claimed by the close of business on the last date to claim a prize and if not claimed by that date is an unclaimed prize. If the final date of the claim period falls on a weekend or a Lottery holiday, the last date to claim a prize extends to the close of the next Lottery business day.

(4) Unsold Returns: To receive a credit after a game has ended for unsold Scratch-it^{SM} tickets in any ticket pack activated by the retailer, the retailer must return the unsold tickets to the Lottery within one calendar year from the official ending date of that game. Upon a showing of good cause by the retailer, the Director may authorize credit for unsold Scratch-it^{SM} tickets returned beyond this one-year period.

Stat. Auth.: ORS 461 & Or. Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.020, 461.210, 461.220, 461.230, 461.240, 461.250, 461.260
Hist.: LOTT 9-2008, f. 11-21-08, cert. ef. 12-1-08

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Rule Caption: Describes new Lottery Raffle game and creates the game's operating rules.
Adm. Order No.: LOTT 10-2008
Filed with Sec. of State: 11-21-2008
Certified to be Effective: 12-1-08
Notice Publication Date: 11-1-2008
Rules Adopted: 177-069-0000, 177-069-0010, 177-069-0020, 177-069-0030, 177-069-0040, 177-069-0050
Subject: These rules describe a new Lottery game, the Lottery Raffle game, and set forth the game's operating rules.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-069-0000
Game Description

(1) **General**: A Lottery raffle is a lottery game in which a specified number of Lottery raffle game tickets, as determined by the Lottery, are available for purchase. A unique sequential identifying number(s) is printed on each Lottery raffle ticket. Each unique number represents a chance for a prize in a particular Lottery raffle drawing. Players win prizes by matching the number(s) on the player's Lottery raffle ticket to the numbers drawn by the Lottery during the Lottery raffle drawing.

(2) **Prizes**: The prizes and the prize structure for each Lottery raffle are determined by the Lottery and will be posted on the Lottery's Website at www.oregonlottery.org while the Lottery raffle tickets for a particular Lottery raffle are being sold. The odds of winning a prize will vary depending on the number of Lottery raffle tickets sold for the particular Lottery raffle. The Lottery may advertise the prize structure by any reasonable means. All prizes will be awarded regardless of the number of Lottery raf-

fle tickets sold unless the Lottery raffle drawing is suspended by the Lottery Director in accordance with OAR 177-046-0140.

(3) **Determination of Winners**: A player wins a prize in a Lottery raffle game when during a raffle drawing the Lottery selects the unique sequential identifying number on the player's Lottery raffle ticket as a winning number for a prize.

(4) **Sales Location**: A Lottery raffle ticket may only be sold by and purchased from a Lottery On-Line retailer, or at the Lottery Headquarters in Salem.

(5) **Ticket Price**: The price of a Lottery raffle ticket will be set by the Lottery for each Lottery raffle drawing held by the Lottery. A player may purchase more than one Lottery raffle ticket. A Lottery raffle ticket may represent a single play or multiple plays at the Lottery's discretion. If the Lottery raffle ticket represents multiple plays, each play will have a unique sequential identifying number printed on the Lottery raffle ticket.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.240, 461.250, 461.260
Hist.: LOTT 10-2008, f. 11-21-08, cert. ef. 12-1-08

177-069-0010
Ticket Purchase, Characteristics, and Restrictions

(1) Availability of Lottery Raffle Tickets: The Lottery may periodically announce the availability of Lottery raffle tickets which will be available for limited sales periods. A Lottery raffle ticket may then be purchased during the hours of operation of the Lottery's On-Line game system and a Lottery On-Line retailer's business hours of operation. When all the Lottery raffle tickets are sold for a particular Lottery raffle game, no more tickets will be available for purchase for that Lottery raffle game. The Lottery will close sales of Lottery raffle tickets at a date and time determined by the Lottery. The Lottery may extend this date at its discretion. If the Lottery extends the sales date, it may advertise that fact by any reasonable means.

(2) Ticket Purchase: A Lottery raffle ticket may be purchased either from a clerk-operated terminal or from a player-operated terminal.

(a) Clerk-Operated Terminal: A player may purchase a Lottery raffle ticket from a clerk-operated terminal by requesting that the clerk use the clerk-operated terminal to issue a Lottery raffle ticket(s). Upon payment of the price of the ticket(s) to the clerk, the clerk will use the terminal to issue the requested number of Lottery raffle tickets purchased by the player.

(b) Player-Operated Terminal: A player may purchase a Lottery raffle ticket from a player-operated terminal by following the instructions appearing on the screen of the terminal and inserting payment for the ticket(s). Upon payment for the ticket(s), the terminal will issue the number of Lottery raffle tickets purchased by the player.

(3) Ticket Sales: Lottery raffle tickets are sold in numerical order through the On-Line computer system. A player does not select the unique identifying number(s) on the Lottery raffle ticket. A player purchasing a Lottery raffle ticket will be issued the next sequentially available number determined by the Lottery's central computer system.

(4) Player's Risk: The purchase of a Lottery raffle ticket is done at the player's own risk either through the On-Line retailer who is acting on behalf of the player in entering the player's request to purchase a Lottery raffle ticket, or the player's purchase of a Lottery raffle ticket by operation of a player-operated terminal.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.240, 461.250, 461.260
Hist.: LOTT 10-2008, f. 11-21-08, cert. ef. 12-1-08

177-069-0020
Cancellation of Lottery Raffle Tickets

A Lottery raffle ticket once issued cannot be cancelled by a player or a retailer.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.240, 461.250, 461.260
Hist.: LOTT 10-2008, f. 11-21-08, cert. ef. 12-1-08

177-069-0030
Lottery Raffle Drawing

(1) **General**: A Lottery raffle drawing will be held at such date, time, place, and in such manner as is determined by the Lottery. A Lottery raffle drawing will be conducted only after sales for the particular Lottery raffle game are closed. During each drawing for each available prize, the Lottery will randomly select a Lottery raffle ticket number(s) as a winner from all the tickets sold for that drawing. Selection of a ticket's number as a winning number removes that number from selection in the Lottery raffle drawing for any other remaining prize(s). An unsold Lottery raffle ticket number is not eligible for selection as a winning ticket number. To select a winning Lottery raffle ticket number(s), Lottery personnel, or their authorized agents, may conduct a manual or electronic drawing, or may use any other selection procedure as determined by the Lottery that ensures a random selection of a winning Lottery raffle ticket number(s) for the prize(s) in the particular Lottery raffle game.

(2) **Suspension of Play**: If all available tickets for a Lottery raffle game are not sold before purchases are disabled prior to the scheduled drawing time, the Lottery may suspend the Lottery raffle drawing in accordance with OAR 177-046-0140. The Lottery will advertise the suspension of a Lottery raffle drawing by any reasonable means. At the discretion of the Director, the Lottery may hold a replacement Lottery raffle drawing, or provide a refund for each Lottery raffle ticket purchased and which is presented to the Lottery or a Lottery retailer by a player. Submission of the Lottery raffle ticket is the sole method for claiming a refund under this section.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.240, 461.250, 461.260
Hist.: LOTT 10-2008, f. 11-21-08, cert. ef. 12-1-08

177-069-0040
Ticket Validation Requirements

(1) General: For a Lottery raffle ticket to be valid and eligible to receive prize payment, the ticket must be validated in accordance with the provisions of OAR Chapter 177, including but not limited to OAR 177-070-0035.

(2) Claiming a Prize: A Lottery raffle ticket is the only proof of a game play and the submission of a winning Lottery raffle ticket to the Lottery is the sole method of claiming a prize.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.240, 461.250, 461.260
Hist.: LOTT 10-2008, f. 11-21-08, cert. ef. 12-1-08

177 069 0050
Prizes

(1) General: A prize for a winning Lottery raffle ticket is determined by the selection of that ticket's unique sequential identifying number as a winning number for a prize in the Lottery raffle drawing for which the Lottery raffle ticket is purchased.

(2) Payment: Lottery raffle prizes will be paid in accordance with OAR 177-070-0025. All Lottery raffle prizes consisting of money will be paid in a single lump sum less applicable taxes and withholding.

(3) Lottery's Determination: The Director's decision regarding the determination of whether a Lottery raffle ticket is a winning ticket, or the determination of the rightful owner or owners of a prize, or of any other dispute or matter arising from payment or awarding of prizes, is final and binding on all parties.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210, 461.220, 461.240, 461.250, 461.260
Hist.: LOTT 10-2008, f. 11-21-08, cert. ef. 12-1-08

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Rule Caption: Update division 85 Powerball® Rules, adopt changes by national Powerball® organization, housekeeping and insert trademarks.
Adm. Order No.: LOTT 11-2008
Filed with Sec. of State: 11-21-2008
Certified to be Effective: 1-4-09
Notice Publication Date: 11-1-2008
Rules Amended: 177-085-0000, 177-085-0005, 177-085-0010, 177-085-0015, 177-085-0020, 177-085-0025, 177-085-0030, 177-085-0035, 177-085-0040, 177-085-0045, 177-085-0050, 177-085-0065
Subject: The Oregon State Lottery has amended the above referenced administrative rules. The amendments update the Powerball® rules to reflect changes in the administration of the game including changes in the probability of winning and Power Play® multipliers. These changes are necessary to implement changes to the Powerball® game. In addition, several of the amendments are for general housekeeping purposes including inserting registered trademarks.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-085-0000
Purpose

These rules establish the procedures and requirements for playing Powerball®, a lotto game operated by the Multi-State Lottery (hereinafter referred to as "MUSL"), of which the Oregon State Lottery is a member.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.210
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 2-1992(Temp),

f. & cert. ef. 4-17-92; LC 6-1992, f. & cert. ef. 6-23-92; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0005
Definitions

The following definitions apply unless the context requires a different meaning.

(1) "**Drawing**" means the formal process of selecting winning numbers which determine the number of winners for each prize level of the game.

(2) "**Game Board**" or "Boards" means that area of the play slip which contains two sets of numbered squares to be marked by the player, the first set containing fifty-nine squares, numbered one through fifty-nine, and the second set containing thirty-nine squares, numbered one through thirty-nine.

(3) "**Game Ticket**" or "Ticket" means a ticket produced by a terminal which contains the caption Powerball®, one or more lettered game plays followed by the drawing date, the price of the ticket, a six digit retailer number and a serial number that is compatible with the Lottery's on-line operating system.

(4) "**Lottery**" means the Oregon State Lottery.

(5) "**Match 5 Bonus Prize**" means the bonus money won when a Grand Prize has reached a new high level and bonus prize monies have been declared by the Product Group under these rules. The Match 5 Bonus Prize does not include the original amount declared for the Match 5 Prize. For the purposes of the Match 5 Bonus Prize, Match 5 means matching five of the numbers drawn from the first set containing fifty-nine numbers.

(6) "**MUSL**" means the Multi-State Lottery Association

(7) "**MUSL Board**" means the governing body of the MUSL which is comprised of the chief executive officer of each Party Lottery.

(8) "**Party Lottery**" means a state lottery or lottery of a political subdivision or entity that participates in the Multi-State Lottery (MUSL) and, in the context of these Powerball® Product Group rules, which has joined in selling the Powerball® game.

(9) "**Play**" means the six numbers, the first five from a field of fifty-nine numbers and the last one from a field of thirty-nine numbers which appear on a ticket as a single lettered selection and are to be played by a player in the game.

(10) "**Play Slip**" or "**Game Slip**" means the paper used in marking a player's game plays and containing one or more boards.

(11) "**Product Group**" means a group of lotteries which has joined together to offer a product pursuant to the terms of the Multi-State Lottery Agreement and the Group's own rules.

(12) "**Quick Pick**" means the random selection by the computer system of two-digit numbers that appear on a ticket and are played by a player in the game.

(13) "**Retailer**" means a person or entity authorized by the Lottery to sell lottery tickets.

(14) "**Set Prize**" means all prizes except the Grand Prize that are advertised to be paid by a single lump sum payment and, except in instances outlined in these rules, will be equal to the prize amount established by the MUSL Board for the prize level.

(15) "**Winning Numbers**" means the six numbers, the first five from a field of fifty-nine numbers and the last one from a field of thirty-nine numbers, randomly selected at each drawing, which shall be used to determine winning plays contained on a game ticket.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 10-1996, f. & cert. ef. 9-4-96; LC 7-1997, f. 10-30-97, cert. ef. 11-2-97; LC 9-1997(Temp), f. & cert. ef. 11-7-97; LOTT 2-1998, f. & cert. ef. 5-28-98; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 4-2003(Temp), f. & cert. ef. 4-15-03 thru 10-10-03; LOTT 10-2003, f. & cert. ef. 6-30-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0010
Ticket Price

(1) A Powerball® ticket shall cost one dollar (USA $1) per play.

(2) An offer to buy and an offer to sell a Powerball® ticket shall be made only at a location which has a retailer contract with the Lottery or only by a method which is approved by the Lottery.

(3) The Lottery shall not directly and knowingly sell a Powerball® ticket or combination of tickets to any person or entity which would guarantee said purchaser a Grand Prize win.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.240
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 2-1992(Temp), f. & cert. ef. 4-17-92; LC 6-1992, f. & cert. ef. 6-23-92; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0015
Game Description

(1) General Information: Powerball® is a five out of fifty-nine numbers plus one out of thirty-nine numbers on-line lottery game, drawn every Wednesday and Saturday, which pays the Grand Prize, at the election of the player made in accordance with these rules or by a default election made in accordance with these rules, either on an annuitized pari-mutuel basis or as a single lump sum payment of the total cash amount held for this prize pool on a pari-mutuel basis. Except as provided in the rules, all other prizes are paid as a single lump sum payment.

(2) Selection of Numbers: To play Powerball®, a player shall select five different numbers, from one through fifty-nine and one additional number from one through thirty-nine, for input into a terminal. The additional number may be the same as one of the first five numbers selected by the player, as long as it is from one through thirty-nine.

(3) Purchase of Tickets: Tickets can be purchased either from a terminal operated by a retailer (i.e., a clerk-activated terminal) or from a terminal operated by the player (i.e., a player-activated terminal). If purchased from a retailer, the player may select a set of five numbers and one additional number by marking six numbered squares in any one game board on a play slip and submitting the play slip to the retailer, or by requesting "Quick Pick" from the retailer. The retailer will then issue a ticket, via the terminal, containing the selected set or sets of numbers, each of which constitutes a game play. Tickets can be purchased from a player-activated terminal by use of a touch screen or by inserting a play slip into the machine. Tickets may be purchased for up to four consecutive drawings.

(4) Player's Responsibility: It is the sole responsibility of the player to verify the accuracy of the game play or plays and other data printed on the ticket. A ticket may not be voided or canceled by returning the ticket to the retailer or to the Lottery, including tickets that are printed in error. No ticket shall be returned to the Lottery for credit. The placing of plays is done at the player's own risk through the On-Line retailer, who when entering the play or plays is acting on behalf of the player.

(5) Determination of Winning Numbers: The winning numbers for the Powerball® game shall be determined at a drawing conducted under the supervision of the MUSL Board. The MUSL Board shall determine the frequency of Powerball® game drawings. Winning numbers shall be selected at random with the aid of mechanical drawing equipment or a random number generator. The Lottery Director shall designate a Drawing Manager who shall review and randomly observe the drawings conducted by the MUSL Board.

Stat. Auth.: ORS 461.250 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.220
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 6-1993, f. & cert. ef. 7-2-93; LC 1-1994, f. 1-27-94, cert. ef. 2-1-94; LC 7-1997, f. 10-30-97, cert. ef. 11-2-97; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 8-2008(Temp), f. 11-21-08, cert. ef. 11-23-08 thru 5-16-09; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0020
Prize Claims

A ticket, subject to the validation requirements set forth in these rules, is the only proof of a game play or plays and the submission of a winning ticket to the Lottery or an authorized retailer as required by these rules is the sole method of claiming a prize or prizes. A play slip or a copy of a ticket has no pecuniary or prize value and does not constitute evidence of ticket purchase or of numbers selected. A terminal produced paper receipt has no pecuniary or prize value and does not constitute evidence of ticket purchase or of numbers selected.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.250
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0025
Prize Pool

(1) Prize Pool: The prize pool for all prize categories shall consist of 50 percent of each drawing period's sales, including any specific statutorily-mandated tax on a Party Lottery to be included in the price of a lottery

ticket, after funding the prize reserve accounts to the amounts established by the Product Group. Any amount remaining in the prize pool at the end of the Powerball® game shall be carried forward to a replacement game or expended in a manner as directed by the Product Group in accordance with state law.

(2) Prize Reserve Accounts: An amount equal to up to two percent of a Party Lottery's sales, including any specific statutorily-mandated tax on a Party Lottery to be included in the price of a lottery ticket, shall be deducted from the Party Lottery's Grand Prize Pool and placed in trust in one or more prize reserve accounts until the Party Lottery's share of the prize reserve accounts reaches the amounts designated by the Product Group. Once the Party Lottery's share of the prize reserve accounts exceeds the designated amounts, the excess shall become part of the Grand Prize pool. Any amount remaining in a prize reserve account at the end of the Powerball® game shall be carried forward to a replacement prize reserve account or expended in a manner as directed by the Product Group in accordance with state law.

(3) Expected Prize Payout Percentages: The Grand Prize shall be determined on a pari-mutuel basis. Except as provided in these rules, all other prizes awarded shall be paid as set lump sum prizes with the following expected prize payout percentages: [Table not included. See ED. NOTE.]

(a) Division of Grand Prize Among Winners: The prize money allocated to the Grand Prize category shall be divided equally by the number of game plays winning the Grand Prize.

(b) Set Prizes: The prize pool percentage allocated to the set prizes (the single lump sum prizes of $200,000 or less) shall be carried forward to subsequent draws if all or a portion of it is not needed to pay the set prizes awarded in the current draw. If the total of the set prizes awarded in a drawing exceeds the percentage of the prize pool allocated to the set prizes, then the amount needed to fund the set prizes awarded shall be drawn from the following sources, in the following order:

(A) The amount allocated to the set prizes and carried forward from previous draws, if any;

(B) An amount from the Set Prize Reserve Account, if available, not to exceed $25,000,000.00 per drawing.

(c) Lack of Sufficient Prize Funds: If, after these sources are depleted, there are not sufficient funds to pay the set prizes awarded, then the highest set prize shall become a pari-mutuel prize. If the amount of the highest set prize, when paid on a pari-mutuel basis, drops to or below the next highest set prize and there are still not sufficient funds to pay the remaining set prizes awarded, then the next highest set prize shall become a pari-mutuel prize. This procedure shall continue down through all set prize levels, if necessary, until all set prize levels become pari-mutuel prize levels. In that instance, the money available from the funding sources listed in this rule shall be divided among the winning plays in proportion to their respective prize percentages.

(d) Match 5 Bonus Prize: The prize money allocated to the Match 5 Bonus Prize shall be divided equally by the number of game plays winning the Match 5 prize when a game play wins the new high jackpot amount.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)

Stat. Implemented: ORS 461.220

Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 17-1988(Temp), f. & cert. ef. 6-2-88; LC 18-1988, f. & cert. ef. 6-28-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 4-1993, f. & cert ef. 4-2-93; LC 11-1995, f. 10-30-95, cert. ef. 11-1-95; LC 10-1996, f. & cert. ef. 9-4-96; LC 7-1997, f. 10-30-97, cert. ef. 11-2-97; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0030

Probability of Winning

The following table sets forth the probability of winning and the probable distribution of winners in and among each prize category, based upon the total number of possible combinations in Powerball®: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)

Stats. Implemented: ORS 461.220

Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 7-1997, f. 10-30-97, cert. ef. 11-2-97; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0035

Prize Payment

(1) Selection of Payment Type: Grand prizes shall be paid, at the election of the player made no later than 60 days after validation of the prize, with either a per winner annuity or single lump sum payment. If the payment election is not made by the player within 60 days after validation, then the prize shall be paid as an annuity prize. The election to take the single lump sum payment may be made at the time of validation of the prize claim or within 60 days thereafter. An election made after validation is final and cannot be revoked, withdrawn or otherwise changed.

(2) Share of the Grand Prize: Shares of the Grand Prize shall be determined by dividing the amount available in the Grand Prize pool equally among all winners of the Grand Prize.

(3) Lump Sum Payment: Winner(s) who elect a lump sum payment shall be paid their share(s) in a single lump sum payment. (Application of the MUSL annuity factor generally is anticipated to result in the Grand Prize winner who elects a single lump sum payment receiving an amount that roughly approximates one-half of the advertised jackpot amount. The actual single lump sum payment amount will vary as a function of the MUSL annuity factor determined as described in subsection (4)(a) of this rule.)

(4) Annuity Payment: The annuitized option prize shall be determined by multiplying a winner's share of the Grand Prize pool by the MUSL annuity factor.

(a) The MUSL annuity factor is determined by the best total securities price obtained through a competitive bid of qualified, pre-approved brokers made after it is determined that the prize is to be paid as an annuity prize or after the expiration of 60 days after the winner becomes entitled to the prize.

(b) Neither MUSL nor the party lotteries shall be responsible or liable for changes in the advertised or estimated annuity prize amount and the actual amount purchased after the prize payment method is actually known to MUSL. In certain instances announced by the Product Group, the Grand Prize shall be a guaranteed amount and shall be determined pursuant to subsection (11) of this rule. If individual shares of the cash held to fund an annuity are less than $250,000, the Product Group, in its sole discretion, may elect to pay the winners their share of the amount held in the Grand Prize pool.

(5) Initial and Annual Payments: Except as may be controlled by statute, all annuitized prizes shall be paid annually in thirty payments with the initial payment being made directly with available funds, to be followed by twenty-nine payments funded by the annuity. All annuitized prizes shall be paid annually in thirty graduated payments (increasing each year) by a rate as determined by the Product Group. Prize payments may be rounded down to the nearest $1,000. Annual payments after the initial payment shall be made by the lottery on the anniversary date of the first payment or if such date falls on a non-business day, then the first business day following the anniversary date of the first payment. Funds for the initial payment of an annuitized prize or the lump sum payment prize shall be made available by MUSL for payment by the Party Lottery which sold the winning ticket by the 15th calendar day (or the next banking day if the fifteenth day is a holiday) following the drawing.

(6) Lack of Available Funds: If necessary, when the due date for the payment of a prize occurs before the receipt of sufficient funds in the prize pool trust to pay the prize, then the transfer of funds for the payment of the full lump sum payment amount may be delayed pending receipt of funds from the party lotteries. A state may elect to make the initial payment from its own funds after validation, with notice to MUSL.

(7) Death of Winner: In the event of the death of a lottery winner during the annuity payment period, the Product Group, in its sole discretion, upon the petition of the estate of the lottery winner (the "Estate") or the persons identified on the winner's Beneficiary Designation form (BDF), whichever is applicable, to the state lottery of the state in which the deceased lottery winner purchased the winning ticket, and subject to applicable federal, state, or district laws, may make payment to the Estate or the designated beneficiary of the discounted present value of the annuitized prize payments. If the Product Group makes such a determination, then securities and/or amounts held to fund the deceased lottery winner's annuitized prize may be distributed to the Estate or the persons on the BDF. The identification of the securities, if any, to fund the annuitized prize shall be at the sole discretion of the Product Group.

(8) Low-Tier Prizes: All low-tier prizes (all prizes except the Grand Prize) shall be paid directly through the Lottery that sold the winning ticket. The Lottery may begin paying low-tier prizes after receiving authorization to pay from the MUSL central office.

(9) Rounding of Grand Prize Payments: Annuitized payments of the Grand Prize or a share of the Grand Prize may be rounded to facilitate the purchase of an appropriate funding mechanism. Breakage on an annuitized Grand Prize win shall be added to the first payment to the winner or winners. Prizes other than the Grand Prize which, under these rules, may become single-payment, pari-mutuel prizes, may be rounded down so that prizes can be paid in multiples of whole dollars. Breakage resulting from rounding these prizes shall be carried forward to the prize pool for the next drawing.

(10) Roll Over of Grand Prize: If the Grand Prize is not won in a drawing, the prize money allocated for the Grand Prize shall roll over and be added to the Grand Prize pool for the following drawing. If a new high Grand Prize is not won in a drawing, the prize money allocated for the Match 5 Bonus Prizes shall roll over and be added to the Match 5 Bonus Prize pool for the following drawing.

(11) Minimum Grand Prizes and Increases: The Product Group may offer guaranteed minimum Grand Prize amounts or minimum increases in the Grand Prize amount between drawings or make other changes in the allocation of prize money where the Product Group finds that it would be in the best interest of the game. If a minimum Grand Prize amount or a minimum increase in the Grand prize amount between drawings is offered by the Product Group, then the Grand Prize amount shall be determined as follows.

(a) All Winners Select Annuity: If there are multiple Grand Prize winners during a single drawing, each selecting the annuitized option prize, then a winner's share of the guaranteed annuitized Grand Prize shall be determined by dividing the guaranteed annuitized Grand Prize by the number of winners.

(b) Mix of Lump Sum and Annuity: If there are multiple Grand Prize winners during a single drawing and at least one of the Grand Prize winners has elected the annuitized option prize, then the best bid submitted by MUSL's pre-approved qualified brokers shall determine the cash pool needed to fund the guaranteed annuitized Grand Prize.

(c) No Winners Select Annuity: If no winner of the Grand Prize during a single drawing has elected the annuitized option prize, then the amount of the cash in the Grand Prize pool shall be an amount equal to the guaranteed annuitized amount divided by the average annuity factor of the most recent three best quotes provided by MUSL's pre-approved qualified brokers submitting quotes.

(d) Changes in Allocation of Prizes: In no case shall quotes be used which are more than two weeks old, and if less than three quotes are submitted, then MUSL shall use the average of all quotes submitted. Changes in the allocation of prize money shall be designed to retain approximately the same prize allocation percentages, over a year's time, set out in these rules. Minimum guaranteed prizes or increases may be waived if the alternate funding mechanism set out in OAR 177-085-0025(3)(b) or (c) becomes necessary.

(12) One Prize per Board: The holder of a winning ticket may win only one prize per board in connection with the winning numbers drawn, and shall be entitled only to the prize won by those numbers in the highest matching prize category.

(13) Claim Expires in One Year: Claims for all prize categories, including the Grand Prize, shall be submitted within one year after the date of the drawing in accordance with these rules.

(14) New High Grand Prize: When the Grand Prize reaches a new high annuitized amount, through a procedure as determined by the Product Group, the maximum amount to be allocated to the Grand Prize pool from the Grand Prize percentage shall be the previous high amount plus $25 million (annuitized) or as otherwise set by the Product Group. Any amount of the Grand Prize percentage which exceeds the $25 million (annuitized) increase shall be added to the Match 5 Bonus Prize Pool. The Match 5 Bonus prize pool is hereby created, and shall accumulate until the Grand Prize is won, at which time the Match 5 Bonus prize pool shall be divided equally by the number of game boards winning the Match 5 prize. If there are no Match 5 winners on the draw when the new high Grand Prize is won, then the Match 5 Bonus prize pool shall be divided equally by the number of game plays winning the Match 4+1 prize.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.20
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 3-1989(Temp), f. & cert. ef. 1-23-89; LC 6-1989, f. 2-28-89, cert. ef. 3-2-89; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 8-1992, f. & cert. ef. 7-23-92; LC 4-1993, f. & cert. ef. 4-2-93; LC 10-1996, f. & cert. ef. 9-4-96; LC 7-1997, f. 10-30-97, cert. ef. 11-2-97; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 4-2003(Temp), f. & cert. ef. 4-15-03 thru 10-10-03; LOTT 10-2003, f. & cert. ef. 6-30-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0040
Ticket Validation

To be a valid ticket and eligible to receive a prize, a Powerball® ticket shall satisfy all the requirements established by the Lottery for validation of winning tickets sold through its on-line system and any other validation requirements adapted by the MUSL Board, the Product Group, and published as the Confidential MUSL Minimum Game Security Standards. The Lottery and MUSL shall not be responsible for tickets which are altered in any manner. When a winning ticket is submitted to the Lottery for validation along with the Lottery's completed claim form, and the Lottery has initiated the validation procedures, the Lottery retains possession of the winning ticket and claim form.

Stat. Auth.: ORS 461.250 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.250
Hist.: LC 6-1988 (Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LC 1-1994, f. 1-27-94, cert. ef. 2-1-94; LC 10-1996, f. & cert. ef. 9-4-96; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0045
Ticket Responsibility

Until such time as a signature is placed in the area designated for signature, a ticket is owned by the bearer of the ticket. MUSL, the Product Group, and the Lottery are not responsible for lost or stolen tickets.

Stat. Auth.: ORS 461.250 & OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.250
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 16-1988, f. & cert. ef. 6-2-88; LC 10-1996, f. & cert. ef. 9-4-96; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0050
Ineligible Players

(1) **MUSL Restrictions**: A ticket or share issued by the MUSL or any of its party lotteries shall not be purchased by, and a prize won by any such ticket or share shall not be paid to:

(a) A MUSL employee, officer, or director;

(b) A contractor or consultant under agreement with the MUSL to review the MUSL audit and security procedures;

(c) An employee of an independent accounting firm under contract with MUSL to observe drawings or site operations and actually assigned to the MUSL account and all partners, share-holders, or owners in the local office of the firm; or

(d) An immediate family member (parent, stepparent, child, stepchild, spouse, or sibling) of an individual described in subsections (a) through (c) of this section and residing in the same household.

(2) **Local Lottery Restrictions**: Those persons designated by a party lottery's law as ineligible to play its game shall also be ineligible to play Powerball® in that party lottery's jurisdiction.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461.250
Hist.: LC 6-1988(Temp), f. & cert. ef. 1-26-88; LC 9-1988, f. & cert. ef. 2-23-88; LC 12-1990, f. & cert. ef. 10-2-90; LC 1-1992, f. 2-25-92, cert. ef. 4-19-92; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

177-085-0065
Power Play

(1) General: Power Play® is an optional, limited extension of the Powerball® Game described in OAR Division 85. The Lottery Director, in the Lottery Director's sole discretion and based on agreements with MUSL, is authorized to initiate and terminate the Power Play® option.

(2) Set Prizes Only: Power Play® multiplies the amount of any of the cash Set Prizes (the cash prizes normally paying $3 to $200,000) won in a drawing. The Grand Prize jackpot is not a Set Prize and will not be multiplied. Match 5 Bonus Prizes are awarded independent of the Power Play® option and are not multiplied by the Power Play® multiplier.

(3) Power Play® Purchase: A qualifying Power Play® option play is any single Powerball® Play for which the player selects the Power Play® option on either the Play Slip or by selecting the Power Play® option through a clerk-activated or player-activated terminal, pays one extra dollar for the Power Play® option play, and which is recorded at the Party Lottery's central computer as a qualifying play.

(4) Qualifying Play: A qualifying play which wins one of the seven lowest lump sum Set Prizes (excluding the Match 5 prize) will be multiplied by the number selected (either 2, 3, 4, or 5), in a separate random Power Play® drawing announced during the official Powerball® drawing show. The announced Match 5 prize, for players selecting the Power Play®

option, shall be multiplied by five unless a higher limited promotional multiplier is announced by the Product Group.

(5) Selection of Multiplier: MUSL will conduct a separate random Power Play® drawing and announce results during each of the regular Powerball® drawings held during the promotion. During each Power Play® drawing, a single number (2, 3, 4, or 5) shall be drawn. The Product Group may change one or more of these multiplier numbers for special promotions from time to time.

(6) Power Play® Prize Pool: The prize pool for all prize categories shall consists of up to 49.5 percent of each drawing period's sales, including any specific statutorily mandated tax on a Party Lottery to be included in the price of a lottery ticket, after the Powerball® prize reserve accounts are funded to the amounts set by the Product Group. Any amount remaining in the prize pool at the end of the Powerball® game shall be carried forward to a replacement game or expended in a manner as directed by the Product Group in accordance with state law.

(7) Power Play® Prize Reserve Accounts: An additional one-half percent of sales, including any specific statutorily mandated tax on a Party Lottery to be included in the price of a lottery ticket, may be collected and placed in the rollover account or in trust in one or more prize reserve accounts until the prize reserve accounts reach the amounts designated by the Product Group.

(8) Power Play® Payout: Except as provided in these rules, all prizes awarded shall be paid as lump sum set prizes. Instead of the Powerball® set prize amounts, qualifying Power Play® option plays will pay the amounts shown below when matched with the Power Play® number drawn: [Table not included. See ED. NOTE.]

(9) Probability of Prize Increase: The following table sets forth the probability of the various Power Play® numbers being drawn during a single Powerball® drawing, except that the Power Play® number for the Match 5 prize will be at least five (5X); setting the probability of the 5X being drawn at 1 in 1. The Product Group may elect to run limited promotions that may increase the multiplier numbers. [Table not included. See ED. NOTE.]

(11) Prize Pool Carried Forward: The prize pool percentage allocated to the Power Play® set prizes shall be carried forward to subsequent draws if all or a portion of it is not needed to pay the set prizes awarded in the current draw.

(12) Pari-Mutuel Prizes —All Prize Amounts: If the total of the original Powerball® set prizes and the multiplied Power Play® set prizes awarded in a drawing exceeds the percentage of the prize pools allocated to the set prizes, then the amount needed to fund the set prizes (including the multiplied set prizes) awarded shall be drawn from the following sources, in the following order:

(a) The amount allocated to the set prizes and carried forward from previous draws, if any;

(b) An amount from the Powerball® Set-Prize Reserve Account, if available in the account, not to exceed twenty-five million dollars ($25,000,000) per drawing; and

(c) If, after these sources are depleted, there are not sufficient funds to pay the set prizes awarded (including multiplied prizes), then the highest set prize (including the multiplied prizes) shall become a pari-mutuel prize. If the amount of the highest set prize, when paid on a pari-mutuel basis, drops to or below the next highest set prize and there are still not sufficient funds to pay the remaining set prizes awarded, then the next highest set prize, including the multiplied prize, shall become a pari-mutuel prize. This procedure shall continue down through all set prizes levels, if necessary, until all set prize levels become pari-mutuel prize levels. In that instance, the money available from the funding sources listed in this rule shall be divided among the winning plays in proportion to their respective prize percentages. In rare instances, where the Powerball® set prize amount may be funded but the money available to pay the full multiplier may not be available due to an unanticipated number of winners, the Product Group may announce pari-mutuel shares of the available pool for the Power Play® payment only.

(13) Prize Payment: All Power Play® prizes shall be paid in one lump sum. The Lottery may begin paying Power Play® prizes after receiving authorization to pay from the MUSL central office.

(14) Prizes Rounded: Prizes, which under these rules may become pari-mutual prizes, may be rounded down so that prizes can be paid in multiples of whole dollars. Breakage resulting from rounding these prizes shall be carried forward to the prize pool for the next drawing.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461
Hist.: LOTT 3-2001(Temp), f. 3-1-01, cert. ef 3-2-01 thru 8-29-01; LOTT 10-2001, f. 5-25-01, cert. ef. 5-29-01; LOTT 9-2002(Temp), f. 9-4-02, cert. ef. 10-6-02 thru 3-31-03; LOTT 1-2003, f. & cert. ef. 2-3-03; LOTT 7-2005(Temp), f. 8-8-05, cert. ef. 8-28-05 thru 2-23-06; LOTT 23-2005, f. 12-21-05, cert. ef. 12-31-05; LOTT 11-2008, f. 11-21-08, cert. ef. 1-4-09

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Oregon State Treasury
Chapter 170

Rule Caption: New Rules Affecting Collateralization of Public Funds.
Adm. Order No.: OST 6-2008
Filed with Sec. of State: 11-28-2008
Certified to be Effective: 11-28-08
Notice Publication Date: 11-1-2008
Rules Adopted: 170-040-0090, 170-040-0100
Subject: Rule 170-040-0090 requires weekly filing of Treasurer Reports when a bank depository is required to collateralize at 110%.

Rule 170-040-0100 requires submission of a new Treasurer Report when a bank depository's net worth decreases by 10% or more or when its capitalization level decreases.
Rules Coordinator: Sally Wood—(503) 378-4990

170-040-0090
Weekly Reporting Requirement for Bank Depositories at 110% Collateralization

Bank depositories ordered to collateralize their public funds deposits at 110% by the State Treasurer are required to submit a new Treasurer Report weekly. The weekly reporting requirement shall remain in effect until such time as the bank depository no longer holds public funds deposits over the FDIC limit or the State Treasurer removes the 110% collateralization requirement.

Stat. Auth.: ORS 295.018(1) and 295.061(3)
Stats. Implemented: ORS 295
Hist.: OST 5-2008(Temp), f. & cert. 10-2-08 thru 3-30-09; OST 6-2008, f. & cert. ef. 11-28-08

170-040-0100
Reporting Requirement for Bank Depositories with Decreased Net Worth and /or Capitalization Level

A bank depository that files reports with the State Treasurer according to ORS 295.061(1) is required to submit a new Treasurer Report to the State Treasurer within 10 business days of:

(1) The date on which the bank depository's net worth is reduced by an amount greater than 10 percent of the amount shown on its most recent Treasurer Report.

(2) The date on which a bank depository ceases to be well capitalized and becomes adequately capitalized or undercapitalized, or ceases to be adequately capitalized and becomes undercapitalized.

Stat. Auth.: ORS 295.061(2)(a) & 295.061(2)(b)
Stats. Implemented: ORS 295
Hist.: OST 6-2008, f. & cert. ef. 11-28-08

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Parks and Recreation Department
Chapter 736

Rule Caption: Amend existing ATV rules to allow beach access permit for Class I all-terrain vehicle (ATV) used by individual with disabilities.
Adm. Order No.: PRD 10-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 10-1-2008
Rules Amended: 736-004-0062
Subject: Amend the existing rule to allow Class I all-terrain vehicle (ATV) access with a permit for access needs of individuals with disabilities including those sections normally closed to motorized vehicles.
Rules Coordinator: Joyce Merritt—(503) 986-0756

736-004-0062
Ocean Shores Operating Permit

(1) A person may not operate a Class I all-terrain vehicle on the ocean shore unless the person obtains an Ocean Shores ATV Operating Permit from OPRD.

(2) The operator must have, in addition to the Ocean Shores ATV Operating Permit, a current ATV Safety Education Card issued under ORS 390.570 and the vehicle must have a current operating permit (ATV decal affixed to the vehicle) issued under ORS 390.580.

(3) The Ocean Shores ATV Operating Permit is to be used only to meet the access needs of:

(a) Persons with disabilities, as defined by ORS 174.107; or who have proof of motor vehicle disabled placard, or both;

(b) Emergency response or emergency aid workers during the course of their work; or

(c) Biologists, wildlife monitors, or other natural resources workers during the course of their work.

(4) Ocean Shores ATV Operating Permits issued under subsection (3)(a) will allow use in those areas open to motorized vehicle use. However, upon request from an individual with a disability, OPRD may issue such a permit for sections closed to motorized use if the Director or his designee determines that such use:

(a) Is a reasonable accommodation of the individual's access needs; and

(b) Does not significantly impact environmentally or culturally sensitive areas or create a safety hazard to the public.

(5) Permits issued under this section shall specify length of time, area of operation and access points.

(6) Class I ATV's shall not be operated in a careless manner on the Ocean Shore Recreation Area.

(7) Unless otherwise posted Class I ATV's shall not be operated on the Ocean Shore in excess of 25 mph in open sections and 10 mph in closed sections.

Stat. Auth.: ORS 390.180, 390.585
Stats. Implemented: ORS 390.729
Hist.: PRD 4-2007, f. & cert. ef. 4-13-07; PRD 8-2008, f. & cert. ef. 10-15-08; PRD 10-2008, f. & cert. ef. 12-15-08

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Rule Caption: Amend to make minor changes to General Park Area Rules re: metal detecting, found property, hunting at Wapato Access (Willamette River Greenway), and management title change updates.
Adm. Order No.: PRD 11-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 6-1-2008
Rules Amended: 736-010-0040, 736-010-0055
Subject: Amend to clarify use of metal detectors on park property.

Amend to increase the limit for found property from $20 to $100 in accordance with ORS 98.005.

Amend to clarify that hunting us allowed rather than permitted with an actual permit, and to extend hunting exclusion for Wapato Access to full river miles length of the access.

Amend to update management titles to align with new management organizational structure.
Rules Coordinator: Joyce Merritt—(503) 986-0756

736-010-0040
Visitor Conduct

(1) Fires in park areas shall be confined to:

(a) Park camp stoves or fireplaces provided for such purpose;

(b) Portions of beach areas designated as permissible for fires; or

(c) Portable stoves used in established campsites, picnic areas, or beach areas where fires are allowed.

(2) Every fire shall be extinguished before its users leave the park area. No fire shall be allowed to cause personal injury or damage to private property or park resources.

(3) The park manager may restrict or prohibit fires due to high fire hazard conditions.

(4) A person may not mutilate, deface, damage, or remove any property, structure or facility of any kind in a park area, except as provided in OAR 736-010-0055.

(5) A person shall leave garbage, recyclables, sewage or waste in a park area only in the designated containers provided.

(6) A person many not dispose of garbage, recyclables, sewage, or waste generated by activities conducted outside a park area in a park area, with the exception of recreational vehicle sewage and gray water holding tank contents to be disposed of in designated dump stations.

(7) A person may not remove items from containers designated for recyclables, garbage, sewage or waste without authorization of the park manager.

(8) A person may not engage in the following activities in park areas:

(a) Use or operation of any noise producing machine, vehicle, device or instrument in a manner that may disturb other park area visitors;

(b) Use of a public address system or similar device without written permission of the park manager;

(c) Possessing, discharging, or causing to be discharged, any firecracker, explosives, torpedoes, rockets, fireworks or other substances without the written permission of the park manager;

(d) Use of a metal detector or similar device without a written permit from the department in any property not listed on the "Detecting Allowed" list, published on the OPRD website;

(e) Obstructing, harassing or interfering with a park employee or peace officer in the performance of their duties;

(f) Entering or occupying any building, facility or portion of a park area that has been closed to public access;

(g) Blocking, obstructing or interfering with vehicular or pedestrian traffic on any road, parking area, trail, walkway, pathway or common area;

(h) Occupying or interfering with access to any structure, office, lavatory or other facility in a manner which interferes with the intended use of such a structure or facility;

(i) Fighting; or promoting, instigating or encouraging fighting or similar violent conduct which would threaten the physical well being of any person in the park area;

(j) Smoking in any areas where the Oregon Indoor Clean Air Act, ORS 433.835 to 433.875; prohibits smoking;

(k) Activities or conduct which constitutes a public nuisance or hazard;

(l) Public indecency as defined in ORS 163.465;

(m) Base-jumping, hang gliding, paragliding or similar activities are not allowed in park areas without a written permit from the park manager. The use of hang gliders is allowed at Cape Kiwanda State Natural Area;

(n) Discharging any firearm, bow and arrow, slingshot, pellet gun, or other weapon capable of injuring humans or wildlife or damaging property, except in those park area locations and for those purposes specified in OAR 736-010-0055(7);

(o) Placing a sign, marker or inscription of any kind, except in designated areas within a park area, without written permission from the park manager;

(9) A person may not distribute circulars, notices, leaflets, pamphlets or written or printed information of any kind within a park area unless they have first obtained permission from the park manager and reported their name, address and number of leaflets to be distributed.

(10) A person may not operate a concession, solicit, sell or offer for sale, peddle, hawk or vend any goods, wares, merchandise, food, liquids or services in a park area without prior written authorization from the park manager.

(11) All money or goods, having a value of $100 or more and found by the public in park areas, must be turned over to the park manager. All found money or goods will be disposed of according to department policy adopted in accordance with ORS 98.005.

(12) The director or designee may close rock formations and cliffs within a park area to descending, scaling or technical rock climbing.

(13) The director or designee may close lakes, streams or waterfalls to kayaking, boating, diving or swimming when the park manager has determined the activity to be a danger to participants.

(14) A person using a park area shall pay rates as established in OAR chapter 736, division 15 for use of selected facilities or the purchase of services or products.

Stat. Auth.: OAR 390.124
Stats. Implemented: ORS 390.111, 163.465, 433.835 - 433.875 & 498.006
Hist.: 1 OTC 17, f. 12-20-73; 1 OTC 23, f. 2-19-74; 1 OTC 56 (Temp), f. & ef. 4-4-75; 1 OTC 59, f. 8-1-75, ef. 8-25-75; 1 OTC 74, f. & ef. 4-30-76; 1 OTC 22-1979 (Temp), f. & ef. 9-24-79; 1 OTC 2-1980, f. & ef. 1-4-80; PR 9-1981, f. & ef. 4-6-81; PR 5-1983, f. & ef. 3-30-83; PR 3-1984, f. & ef. 3-5-84; PR 1-1990, f. & cert. ef. 5-14-90; PR 4-1991, f. 4-30-91, cert. ef. 5-13-91; PR 8-1993, f. & cert. ef. 5-11-93; PR 13-1993, f. 7-12-93, cert. ef. 8-2-93; PR 7-1996, f. 8-14-96, cert. ef. 8-15-96; PRD 4-2000, f. & cert. ef. 4-5-00; Renumbered from 736-010-0045, 736-010-0070, 736-010-0125, 736-015-0045 & 736-015-0067, PRD 4-2005, f. & cert. ef. 5-5-05; PRD 8-2007, f. & cert. ef. 8-28-07; PRD 11-2008, f. & cert. ef. 12-15-08

736-010-0055
Cultural, Historic, Natural and Wildlife Resources

(1) A person may not disturb or remove any archaeological, cultural, or historical material from a park area, unless authorized by the director as defined in ORS 390.235.

(2) A person may not, except with the written permission of the park director or park manager:

(a) Dig up, or remove any soil, rock, or fossil materials;

(b) Roll any stones, logs or other objects that may endanger a person or damage park resources; or

(c) Pick, cut, mutilate or remove plants or natural resources of any type from any park area, except as allowed by sections (3) to (5) and (7) of this rule.

(3) A person may collect limited-souvenirs of agate and gem stone rock materials within the boundaries of Succor Creek State Recreation Area away from the developed public use areas and roadways of the park under the following conditions:

(a) No commercial digging, quarrying, or removal of rock is allowed;

(b) No excavating or rock collecting is allowed within a distance of 500 feet from any developed public use picnic area or campground, or 200 feet from an improved highway or park road within the park area; or within the area of an archeological site;

(c) Excavation is restricted to standard hand tools including a hand pick, shovel, or hammer;

(d) The use of mechanical excavators including, but not limited to bulldozers, backhoes, scoops, tractors, or the use of other power tools to excavate or remove materials is prohibited;

(e) Excavation of rock or soil materials around the root zone of trees and shrubs is prohibited.

(4) Notwithstanding section (2) or (3), a person must comply with existing state and federal rules and regulations concerning mining or the protection of public archeological features or artifacts on the state and federal lands of this area.

(5) A person may gather for personal consumption berries, fruits, mushrooms, or similar edibles. A person may not uproot living plants, and roots, tubers, flowers, and stems may not be collected except with a written permit and only for scientific collection or research purposes, or by a Native American for personal consumption as part of their traditional cultural heritage. Driftwood may be taken in small amounts in accordance with OAR 736-026-0010.

(6) A person may not give or offer food items to any wildlife within a park area except when authorized by the park manager.

(7) A person may not hunt, pursue, trap, kill, injure, or molest any wildlife or disturb their habitats within a park area, except under the following provisions:

(a) In those park areas where hunting and trapping is allowed, a person must comply with the rules and regulations of the Oregon Department of Fish and Wildlife.

(b) In those park areas where hunting is allowed, dogs being used for hunting game birds or unprotected wildlife or being trained for hunting or tracking shall be in the handler's control at all times.

(c) Seasonal hunting of waterfowl is allowed in the following park areas:

(A) Bowers Rock State Park;

(B) That portion of Elijah Bristow State Park located north of the main channel of the Middle Fork of the Willamette River;

(C) Portions of Fort Stevens State Park adjacent to Trestle Bay as posted;

(D) That portion of La Pine State Park located on the northeast boundary, beginning 4,135 feet down river from the Deschutes River Home Sites #6 bridge (survey point at N43 46.989, W121 31.015) to a point 950 feet up river of the Fall River confluence (survey point at N43 47.204, W121 30.705);

(E) That portion of Willamette Mission State Park located on Grand Island in Yamhill County;

(F) That portion of Government Island State Recreation Area including the perimeter of both Government and Lemon Islands, not above the mean high water mark as posted;

(G) That portion of Rooster Rock State Park which includes Sand Island as well as the bank which runs parallel to the south of the island. Hunting will not be allowed during the special waterfowl hunting season which starts in September as posted;

(H) That portion of Benson State Recreation Area at Dalton Point, north of I-84, starting 300' east of the boat ramp running to the eastern most tip of the property at river mile 134 as posted;

(I) That portion of Starvation Creek State Park, north of I-84, river mile 159.6 to 160.2 as posted;

(J) That portion of Mayer State Park including the entire Salisbury Slough area and the pond 800' Northwest of the boat ramp as posted.

(d) Seasonal hunting of game wildlife is allowed within Deschutes River State Recreational Area south of the stream gauge cable crossing line and parallel extensions of the cable crossing line to the east and west park boundaries.

(e) Seasonal hunting of deer is allowed in portions of La Pine State Recreation Area north of the east-west power line road, approximately one mile north of the campground booth.

(f) Seasonal hunting of upland game birds is allowed in Succor Creek State Park, except within 500 feet of camping areas located near the Succor Creek Bridge and posted Safety Zones.

(g) Trapping is allowed only by permit from the department in Bowers Rock State Park, Deschutes State Recreation Area, Elijah Bristow State Park, and Willamette Mission State Park.

(h) Hunting is allowed with shotguns or bows and arrows only, during authorized seasons in all Willamette River Greenway Corridor parcels, except in those parcels described below, where all hunting is prohibited:

(A) Wapato Access (Virginia Lake), River Mile 17.0-18.0, Multnomah Channel, Right bank when facing downstream;

(B) Crown Zellerbach, River Mile 21.3, Main Channel, Left Bank when facing downstream;

(C) Merrell (Mary S. Young State Park), River Mile 23.6, Main Channel, Left Bank when facing downstream;

(D) Willamette Shores, Inc. (Mary S. Young State Park), Main Channel, River Mile 24.0, Main Channel, Left Bank when facing downstream;

(E) Meldrum Bar Park (City of Gladstone) River Mile 24.2-24.4, Main Channel, Right Bank when facing downstream;

(F) Hattan-Fisher, River Mile 24.3, Main Channel, Left Bank when facing downstream;

(G) Dahl Park (City of Gladstone) River Mile 24.7, Main Channel, Right Bank when facing downstream;

(H) Coalca Landing, River Mile 30.7, Main Channel, Right Bank when facing downstream;

(I) Lang, River Mile 30.7, Main Channel, Left Bank when facing downstream;

(J) Pete's Mountain Landing, River Mile 30.8, Main Channel, Left Bank when facing downstream;

(K) Peach Cove Landing, River Mile 31.5, Main Channel, Left Bank when facing downstream;

(L) Brandborg, River Mile 32.0, Main Channel, Left Bank when facing downstream;

(M) Asche, River Mile 34.1, Main Channel, Left Bank when facing downstream;

(N) Molalla River State Park, River mile 34.6-36.1, Main Channel, Right Bank when facing downstream;

(O) Willamette Meridian Landing, River Mile 37, Main Channel, Left Bank when facing downstream;

(P) French Prairie Access, River Mile 41.0, Main Channel, Right Bank when facing downstream;

(Q) Parrett Mountain Access, River Mile 45.5-46.0, Main Channel, Left Bank when facing downstream;

(R) Hess Creek Landing, River Mile 53, Main Channel, Left Bank when facing downstream;

(S) San Salvador Access, River Mile 56.7, Main Channel, Right Bank when facing downstream;

(T) Lincoln Access, River Mile 76.2-77.0, Main Channel, Left Bank when facing downstream;

(U) Lincoln Access (Doak's Ferry) River Mile 77.6, Main Channel, Left Bank when facing downstream;

(V) Darrow Rocks Access, River Mile 78.1, Main Channel, Left Bank when facing downstream;

(W) Ross Island Sand & Gravel (Salem Waterfront), River Mile 82.8, Main Channel, Right Bank when facing downstream;

(X) Hall's Ferry Access, River Mile 91.3, Main Channel, Right Bank when facing downstream;

(Y) Springfill Access, River Mile 113.8, Main Channel, Left Bank when facing downstream;

(Z) Takenah Landing (City of Albany), River Mile 118.5, Main Channel, Left Bank when facing downstream (Closed only for 500 feet west of parking area);

(AA) Jasper Bridge, River Mile 195.2, Middle Fork, Right Bank when facing downstream;

(BB) Minshall, Eller, River Mile 119.9, Main Channel, Left Bank when facing downstream;

(CC) Jones, Lanham, River Mile 120.1, Main Channel, Left Bank when facing downstream;

(DD) F. Schmidt, P. Schmidt, River Mile 120.3, Main Channel, Left Bank when facing downstream;

(EE) Truax Island Access, River Mile 168.7, Main Channel, Left Bank when facing downstream (closed only for 500 feet west of parking area);

(FF) Marshall Island Access (Banton), River Mile 168.7, Main Channel, Left Bank when facing downstream;

(GG) Log Jam Access, River Mile 194.4-194.8, Middle Fork, Left Bank when facing downstream;

(HH) Pengra Access, River Mile 195.2, Middle Fork, Right Bank when facing downstream;

(II) Cougar Mountain Access, River Mile 15.5, Coast Fork, Right Bank when facing downstream; and

(JJ) Lynx Hollow Access, River Mile 17.2, Coast Fork, Left Bank when facing downstream (Closed except for 100 foot strip along riverbank);

(i) Trapping is allowed only with written authorization from the department in the Willamette River Greenway Corridor parcels closed to hunting, as listed above. Trapping is allowed in all other Willamette River Greenway Corridor parcels.

Stat. Auth.: ORS 390.124
Stats. Implemented: ORS 390.111, 498.002 & 498.006
Hist.: 1 OTC 2-1980, f. & ef. 1-4-80; PR 9-1981, f. & ef. 4-6-81; PR 10-1991, f. & cert. ef. 6-18-91; Renumbered from 736-015-0065, 736-015-0072, 736-015-0080, 736-015-0090, 736-015-0095, 736-015-0100, 736-015-0130, 736-015-0135, 736-015-0150 & 736-015-0160, PRD 4-2005, f. & cert. ef. 5-5-05; PRD 11-2008, f. & cert. ef. 12-15-08

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Rule Caption: Amend and repeal administrative rules governing general provisions related to public contracting.
Adm. Order No.: PRD 12-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 10-1-2008
Rules Amended: 736-146-0010, 736-146-0012, 736-146-0015, 736-146-0020, 736-146-0050, 736-146-0060, 736-146-0070, 736-146-0080, 736-146-0090, 736-146-0100, 736-146-0110, 736-146-0120, 736-146-0130, 736-146-0140
Rules Repealed: 736-146-0025, 736-146-0030, 736-146-0040
Subject: Existing rules being amended for housekeeping updates in accordance with instructions of ORS 279A.065(5)(b), and to:

Remove independent contractor status for Personal Services Contracts; Remove section of of procedural language governing internal files; Remove extraneous section on Contract Administration Definitions.
Rules Coordinator: Joyce Merritt—(503) 986-0756

736-146-0010
Application

The Oregon Parks and Recreation Department adopts OAR 137-046-0100 through 137-046-0480 (effective January 1, 2008), the Department of Justice Model Rules, General Provisions Related to Public Contracting including the additional provision provided in these rules.

Stat. Auth.: ORS 279A.070
Stats. Implemented: ORS 279A.070, 279A.065
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0012
Definitions

(1) "Contract Administration" means all functions related to a given contract between OPRD and a contractor from the time the contract is awarded until the work is completed and accepted or the contract is terminated, payment has been made, and disputes have been resolved.

(2) "Designated Procurement Officer" (DPO) means the individual designated and authorized by the Director of the Oregon Parks and Recreation Department to perform certain procurement functions described in these rules.

Stat. Auth.: ORS 279A.070
Stats. Implemented: ORS 279A.070, 279A.065
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0015
Special Approvals for Public Contracts When Required

(1) When Attorney General legal sufficiency approval is required under ORS 291.047, the Oregon Parks and Recreation Department (OPRD) must seek legal approval.

(2) When OPRD contracts for services normally provided by another contracting agency or for services for which another contracting agency has statutory responsibilities, OPRD is required to seek the other contracting agency's approvals. Examples of these special approvals include, but are not limited to:

(a) Oregon Department of Administrative Services (DAS), State Services Division, Risk Management for providing tort liability coverage;

(b) DAS, State Services Division, Publishing and Distribution for printing services;

(c) DAS, State Data Center for telecommunications services;

(d) Office of the Treasurer, Debt Management Division, for bond counsel and financial advisory services (bond counsel services also require the approval of the Attorney General);

(e) DAS Enterprise Information Strategy and Policy Division for information-system related services.

(3) The Attorney General has sole authority to contract for attorney services. Exceptions may be granted in writing on a case-by-case basis only by the Attorney General.

(4) The Secretary of State Audits Division has sole authority to contract for financial auditing services. Exceptions may be granted in writing on a case-by-case basis only by the Secretary of State Audits Division.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.140(2)
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0020
Reporting Requirements for Personal Services Contracts

The Department of Administrative Services (DAS) State Procurement Office maintains an electronic reporting system called the Oregon Procurement Information Network (ORPIN) and a report form for reporting personal services contracts. OPRD must submit this report form to the DAS State Procurement Office for each contract and subsequent contract amendment. The report form must include OPRD's name, not-to-exceed amount of the contract, the name of the contractor, the duration of the contract, and its basic purpose. OPRD will use the OPRIN system for reporting personal services contracts, including architectural, engineering and land surveying services contracts and related services contracts pursuant to ORS 729A.140(2)(h)(A)(I) unless directed otherwise by DAS State Procurement Office.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.140(h)(A)
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0050
Contract Administration; General Provisions

(1) OPRD conducts procurements for goods or services, including architectural, engineering, land surveying and related services, and public improvements, pursuant to ORS 279A.050 and 279A.075.

(2) OPRD must appoint, in writing, a contract administrator as an OPRD representative for each contract. The contract administrator may delegate in writing a portion of the contract administrator's responsibilities to a technical representative for specific day-to-day administrative activities for each contract.

(3) OPRD must maintain a procurement file for procurements exceeding the intermediate procurement threshold for goods or services; the informal selection threshold for architectural, engineering, and land surveying services; and the intermediate procurement threshold for public improvements pursuant to OAR 137-047-0270, 137-048-0210, and 137-049-0160, respectively:

(a) Each procurement file must contain:

(A) Documentation required by law and the DOJ Model Rules;

(B) An executed contract, if awarded;

(b) OPRD must maintain procurement files, including all documentation, for a period not less than six years, except for 10 years beyond each contract's expiration date for architectural, engineering, and land surveying services and related services or for another period in accordance with another provision of law.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0060
Payment Authorization of Cost Overruns for Goods or Services including Architectural, Engineering and Land Surveying Services and Related Services Contracts

(1) Payments on contracts that exceed the maximum contract consideration require approval from OPRD's designated procurement officer and may require approval from the Department of Justice pursuant to OAR 137-045-0010 et seq. Approval may be provided if there is compliance with all of the following:

(a) The original contract was duly executed and, if required, approved by the Attorney General.

(b) The original contract has not expired, been terminated, or been reinstated under OAR 736-147-0070 as of the date written approval to increase the contract amount is granted.

(c) The cost overrun is not associated with any change in the statement of work set out in the original contract.

(d) The cost overrun arose out of extraordinary circumstances or conditions encountered in the course of contract performance that were reasonably not anticipated at the time the original contract or the most recent amendment, if any, was signed. Such circumstances include but are not limited to cost overruns that:

(A) Address emergencies arising in the course of the contract that require prompt action to protect the work already completed.

(B) Comply with official or judicial commands or directives issued during contract performance.

(C) Ensure that the purpose of the contract will be realized;

(e) The cost overrun was incurred in good faith, results from the good faith performance by the contractor, and is no greater than the prescribed hourly rate or the reasonable value of the additional work or performance rendered.

(f) Except for the cost overrun, the contract and its objective are within the statutory authority of OPRD and OPRD currently has funds available for payment under the contract.

(g) An officer or employee of OPRD has presented a written report to OPRD's designated procurement officer within 60 days of the discovery of the overrun that states the reasons for the cost overrun and demonstrates to the satisfaction of OPRD's designated procurement officer that the original contract and the circumstances of the overrun satisfy the conditions stated above.

(h) OPRD's designated procurement officer approves in writing the payment of the overrun, or such portion of the overrun amount as OPRD's designated procurement officer determines may be paid consistent with the conditions of this rule. If OPRD's designated procurement officer has signed the contract, or has immediate supervisory responsibility over performance of the contract, that person must designate an alternate delegate to grant or deny written approval of payment.

(2) OPRD must obtain an Attorney General's approval of the contract amendment, if such approval is required by ORS 291.047, before making any overrun payment.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0070
Ethics in Public Contracting – Policy

Oregon public contracting is a public trust. OPRD and contractors involved in public contracting must safeguard this public trust.

Stat. Auth.: ORS 244.010 - 244.400, 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 244.010 - 244.400, 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0080
Ethics in Selection and Award of Public Contracts

(1) OPRD officers, employees or agents involved in the process of the selection and award of public contracts must carefully review the provisions of ORS 244.040.

(2) OPRD officers, employees and agents are prohibited from soliciting or receiving gifts, which means something of economic value given to a public official or the public official's relative without an exchange of valuable consideration of equivalent value, including the full or partial forgiveness of indebtedness, and which is not extended to others who are not public officials or the relatives of public officials on the same terms and conditions; and something of economic value given to a public official or the public official's relative for valuable consideration less than that required from others who are not public officials.

(3) OPRD officers, employees and agents are prohibited from using their official position for personal or financial gain.

(4) OPRD officers, employees and agents are prohibited from using confidential information gained in the course of the screening and selection procedures for personal or financial gain.

Stat. Auth.: ORS 244.010 - 244.400, 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 244.010 - 244.400, 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0090
Ethics in Appointments to Advisory Committees

OPRD's designated procurement officer or a delegate may appoint procurement advisory committees to assist with specifications, procurement decisions, and structural change that can take full advantage of evolving procurement methods as they emerge within various industries, while preserving competition pursuant to ORS 279A.015.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0100
Non-retaliation

Retaliation against anyone who complies with the Public Contracting Code and rules in this division related to ethics is prohibited. Any officer, employee or agent of OPRD or contractor who engages in retaliation action will be subject to penalties pursuant to ORS 279A.990, 244.350 to 244.400 and related rules. Also, any contractor who engages in a retaliation action may be debarred.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0110
Ethics in Specification Development

(1) OPRD and contractors must not develop specifications that primarily benefit a contractor, directly or indirectly, to the detriment of OPRD or the best interest of the state.

(2) OPRD must not develop specifications that inhibit or tend to discourage public contracting with qualified rehabilitation facilities (QRF) under ORS 279.835 through 279.855 and OAR 125-055-0005 through 125-055-0045 where those specifications inhibit or tend to discourage the acquisition of QRF-produced goods or services without reasonably promoting the satisfaction of bona fide, practical procurement needs of OPRD.

(3) OPRD and contractors must not develop specifications that inhibit or tend to discourage public contracting under other public procurement laws or policies of OPRD.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0120
Ethics in Sole Source

OPRD may not select a sole-source procurement pursuant to ORS 279B.075 and avoid a competitive procurement if the purpose of the selection is to primarily benefit the contractor, directly or indirectly, to the detriment of OPRD or the best interest of the state.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279B.075, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0130
Fragmentation

A procurement may not be artificially divided or fragmented so as to constitute a small procurement, pursuant to ORS 279B.065, or an intermediate procurement, pursuant to ORS 279B.070.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279B.065
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

736-146-0140
Ethics in OPRD and Contractor Communications

(1) Research Phase. OPRD is encouraged to conduct research with contractors who can meet the state's needs. This research includes but is not limited to:

(a) Meetings;

(b) Industry presentations; and

(c) Demonstrations with contractors that, in OPRD's discretion, may be able to meet OPRD's needs.

(2) OPRD must document the items discussed during the research phase of solicitation development. The research phase ends the day of a solicitation release or request for a quote pursuant to an intermediate procurement, unless the solicitation or intermediate procurement provides for a different process that permits on-going research.

(3) Solicitation and Contracting Phase. Any communication between OPRD and contractors regarding a solicitation, that occurs after the solicitation release or request for a quote and before the award of a contract, must only be made within the context of the solicitation document or intermediate procurement requirements.

(4) Communication may allow for discussions, negotiations, addenda, contractor questions, and OPRD's answers to contractor questions about terms and conditions, specifications, amendments, or related matters. During this phase, telephone conversations and meetings must be documented in the procurement file. Written inquiries regarding the solicitation should be responded to by OPRD in writing.

(5) A record of all material communications regarding the solicitation by interested contractors must be made a part of the procurement file pursuant to OAR 736-146-0030.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 12-2008, f. & cert. ef. 12-15-08

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Rule Caption: Amend, adopt and repeal administrative rules governing general provisions for public procurement for goods and services.
Adm. Order No.: PRD 13-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 10-1-2008
Rules Adopted: 736-147-0040, 736-147-0070
Rules Amended: 736-147-0010, 736-147-0030, 736-147-0050, 736-147-0060
Rules Repealed: 736-147-0020
Subject: Existing rules being amended for minor housekeeping updates as required by ORS 279.065(5)(b) and to:
Remove Life Cycle Costing provision;
Add provision for price agreements;
Add reinstatement of expired or terminated contracts to facilitate the contracting process.
Rules Coordinator: Joyce Merritt—(503) 986-0756

736-147-0010
Application

The Oregon Parks and Recreation Department adopts OAR 137-047-0000 through 137-047-0810 (effective January 1, 2008) with the exception of OAR 137-047-0270(4), the Department of Justice Model Rules, Public Procurements for Goods or Services General Provisions including the additional provisions provided in these rules.

Stat. Auth.: ORS 279A.065
Stats. Implemented: ORS 279B.015
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 13-2008, f. & cert. ef. 12-15-08

736-147-0030
Emergency Procurements Process

(1) The Director of OPRD or person designated under ORS 279A.075, may authorize OPRD personnel to award a public contract for goods and services as an emergency procurement pursuant to the requirements of ORS 279B.080. Emergency contracts are exempt from Department of Justice legal sufficiency review under OAR 173-045-0070 as set out in subsection (3)(b)of this rule.

(2) Pursuant to the requirements of this rule, OPRD may, in its discretion, enter into a public contract without competitive solicitation if an emergency exists. Emergency means circumstances that could not have been reasonably foreseen that create a substantial risk of loss, damage, interruption of services or threat to public health or safety that requires prompt execution of a contract to remedy the condition.

(3) For contracts above $5,000, when entering into an emergency contract, OPRD must:

(a) Encourage competition that is reasonable and appropriate under the circumstances;

(b) Award contract within sixty (60) days following the event triggering the need for an emergency contract unless an extension has been granted by the Director of OPRD or person designated;

(c) Have a written report prepared and signed by an executive of OPRD who is responsible for oversight of the public contract within ten (10) business days after execution of the public contract, said report to contain:

(A) A concise summary of the circumstances that constitute the emergency and the character of the risk of loss, damage, interruption of services, or threat to public health or safety created or anticipated to be created by the emergency circumstances;

(B) A statement of the reason or reasons why the prompt execution of the proposed public contract was required to deal with the risk created or anticipated to be created by the emergency circumstances;

(C) A brief description of the services or goods to be provided under the public contract, together with its anticipated cost; and

(D) A brief explanation of how the public contract, in terms of duration, services, or goods provided under it, was restricted to the scope reasonably necessary to adequately deal only with the risk created or anticipated to be created by the emergency circumstances.

(d) Maintain a copy of report described in (c) of this rule in OPRD's emergency public contract file and provide a copy of the report to the Attorney in Charge, Business Transactions Section, Department of Justice, within thirty (30) days after preparing the report; (e) Provide a summary of the contract on the Oregon Procurement Information Network (ORPIN) maintained by the DAS State Procurement Office.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.080
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 13-2008, f. & cert. ef. 12-15-08

736-147-0040
Price Agreements

(1) OPRD may create price agreements designed for the exclusive use of OPRD or use DAS multi-agency price agreements. OPRD may create price agreements for the purposes of minimizing paper work, achieving continuity of product, securing a source of supply, reducing inventory, combining requirements for volume discounts, standardization among agencies, and reducing lead time for ordering.

(2) If OPRD conducts a purchase of goods or services pursuant to a DAS or OPRD price agreement, OPRD does not need to undertake an additional competitive solicitation.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A
Hist.: PRD 13-2008, f. & cert. ef. 12-15-08

736-147-0050
Mandatory Use Contracts

(1) For the purposes of this rule, a Mandatory Use Contracts means a public contract, DAS price agreement, or other agreement that OPRD is required to use for the procurement of goods and services.

(2) If DAS State Procurement Office establishes a price agreement that is designated mandatory for state agency use, OPRD must procure applicable goods and services pursuant to the Mandatory Use Contract unless otherwise specified in the contract, allowed by law or these rules.

(3) OPRD is exempted from Mandatory Use Contracts for acquisition of the following, regardless of dollar amount:

(a) Goods or services from another government public agency, provided that a formal written agreement is entered into between the parties;

(b) Goods or services from the federal government pursuant to ORS 279A.180;

(c) Personal property for resale through student stores operated by public educational contracting agencies; and

(d) Emergency purchases declared by a contracting agency pursuant to ORS 279B.080.

(4) If a DAS price agreement is not mandatory, the designated procurement officer or other designated person will decide whether to contract pursuant to the price agreement based on what best meets the business needs of OPRD.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279B.090
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 13-2008, f. & cert. ef. 12-15-08

736-147-0060
Amendments for Intermediate Goods or Services Procurements

OPRD may amend a public contract awarded as an intermediate procurement in accordance with OAR 137-047-0800, but the cumulative amendments shall not increase the total contract price to a sum that is greater than 25 percent of the original contract price, except:

(1) OPRD may amend a public contract awarded as an intermediate procurement in accordance with OAR 137-047-0800 over the 25 percent cumulative amount but not exceeding the $150,000 threshold with written approval from the OPRD Designated Procurement Officer based upon a determination of the best interests of the state.

(2) OPRD may amend a public contract awarded as an intermediate procurement in accordance with OAR 137-047-0800 over the 25 percent cumulative amount exceeding the $150,000 threshold with written approval from the OPRD Designated Procurement Officer and Department of Justice based upon a determination of the best interests of the state.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070, 279A.140
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 13-2008, f. & cert. ef. 12-15-08

736-147-0070
Reinstatement of Expired or Terminated Contracts

(1) If OPRD enters into a contract for goods or services and that contract subsequently expires or is terminated, OPRD may reinstate the contract subject to the following:

(a) The type or aggregated value (including all amendments) of the contract, after reinstatement, falls under OPRD procurement authority in accordance with law, the Department of Justice Model Rules and these rules;

(b) OPRD may reinstate and amend for time only;

(c) The purpose must be for:

(A) Fulfillment of its term, up to the maximum time period provided in the contract; or

(B) Completion of a deliverable, provided:

(i) The deliverable, including but not limited to goods, services, or work, was defined in the contract as having a completion date or event; and

(ii) OPRD documents the uncompleted work as of the date of the reinstatement of the expired contract in the procurement file.

(d) The expired or terminated contract was previously properly executed; and

(e) The failure to extend or renew the contract in a timely manner was due to unforeseen circumstances, unavoidable conditions or any other occurrence outside the reasonable control of OPRD or the contracting party.

(2) If the type or aggregated value (including all amendments) of the contract after reinstatement will exceed OPRD's procurement authority, then OPRD may reinstate and amend for time only, and OPRD must submit a written justification demonstrating the satisfaction of the requirements for reinstatement, as set forth in subsections (1) (a-e) of this rule.

(3) OPRD may amend an expired contract for time only in accordance with section (1) of this rule. OPRD may amend the contract purposes other than time in accordance with OAR 137-047-0800.

(4) If OPRD reinstates and amends an expired contract for time, pursuant to this rule, OPRD may compensate the contracting party for work performed in the interim between the expiration of the original contract and the effective date of the reinstatement and amendment.

(5) Once a contract is reinstated, it is in full force and effect as if it had not expired or terminated.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A
Hist.: PRD 13-2008, f. & cert. ef. 12-15-08

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Rule Caption: Amend administrative rules governing consultant selection for architectural, engineering, land surveying, and related services contracts.
Adm. Order No.: PRD 14-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 10-1-2008
Rules Amended: 736-148-0010, 736-148-0020
Subject: Existing rules being amended for housekeeping updates as required by ORS 279A.065(5)(b).
Rules Coordinator: Joyce Merritt—(503) 986-0756

736-148-0010
Application

The Oregon Parks and Recreation Department adopts OAR 137-048-0100 through 137-048-0320 (effective January 1, 2008), the Department of Justice Model Rules, Consultant Selection: Architectural, Engineering, Land Surveying, and Related Services Contracts including the additional provisions provided in these rules.

Stat. Auth.: ORS 279A.065
Stats. Implemented: ORS 279A.065
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 14-2008, f. & cert. ef. 12-15-08

736-148-0020
Price Agreement Selection Process

Consultants for price agreements must be selected, and Oregon Parks and Recreation Department (OPRD) must obtain architectural, engineering, land surveying and related services by selecting a consultant or consultants in the following manner:

(1) When OPRD selects more than one consultant in accordance with the price agreement solicitation process under OAR 137-048-0130(1), OPRD must identify objective criteria in the solicitation document and the price agreement to be used in assigning particular architectural, engineering land surveying or related services to the most qualified consultant.

(2) Design-Build contracts involve the provision of both design and construction services for public improvements under one contract. Under most circumstances, Design-Build contracts are mixed contracts with the predominate purpose of the contract involving construction of the public improvement. If the predominate purpose of the contract is to obtain architectural, engineering, land surveying and related aervices, selection may proceed under this division and shall not be considered a Design-Build project.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279C.110, 279C.115
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 14-2008, f. & cert. ef. 12-15-08

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Rule Caption: Amend existing administrative rule that governs general provisions related to public service contracts for construction services.
Adm. Order No.: PRD 15-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 10-1-2008
Rules Amended: 736-149-0010
Subject: Existing rules being amended for housekeeping updates as required by ORS 279A.065(5)(b).
Rules Coordinator: Joyce Merritt—(503) 986-0756

736-149-0010
Application

The Oregon Parks and Recreation Department adopts OAR 137-049-0100 through 137-049-0910 (effective January 1, 2008), the Department of Justice Model Rules, General Provisions Related to Public Contracts for Construction Services.

Stat. Auth: ORS 279A.065
Stats. Implemented: ORS 279A.065
Hist.: PRD 1-2007, f. & cert. ef. 2-7-07; PRD 15-2008, f. & cert. ef. 12-15-08

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Real Estate Agency
Chapter 863

Rule Caption: Create a new division and update existing licensing rules for real estate brokers.
Adm. Order No.: REA 5-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Adopted: 863-014-0000, 863-014-0003, 863-014-0038, 863-014-0042
Rules Ren. & Amend: 863-015-0005 to 863-014-0005, 863-015-0010 to 863-014-0010, 863-015-0015 to 863-014-0015, 863-015-0020 to 863-014-0020, 863-015-0030 to 863-014-0030, 863-015-0035 to 863-014-0035, 863-015-0040 to 863-014-0040, 863-015-0050 to 863-014-0050, 863-015-0055 to 863-014-0055, 863-015-0060 to 863-014-0060, 863-015-0061 to 863-014-0061, 863-015-0062 to 863-014-0062, 863-015-0063 to 863-014-0063, 863-015-0065 to 863-014-0065, 863-015-0070 to 863-014-0070, 863-015-0075 to 863-014-0075, 863-015-0076 to 863-014-0076, 863-015-0080 to 863-014-0080, 863-015-0085 to 863-014-0085, 863-015-0095 to 863-014-0095, 863-015-0100 to 863-014-0100, 863-015-0160 to 863-014-0160
Subject: Real estate broker license rules were moved ("renumbered") from division 15 to this new division to help applicants, licensees and the Agency more easily find and use licensing rules, These rules only cover licensing requirements for real estate brokers, principal real estate brokers and sole practitioners. Renumbered rules were amended to provide clarity. New rules were added for application and purpose of the division and for definitions. A rule for sole practitioner real estate broker was added for clarity. A rule addressing the waiver of experience requirements and procedure was added.
Rules Coordinator: Laurie Skillman—(503) 378-4630

863-014-0000
Application and Purpose

(1) This division sets forth the requirements and process for licensing real estate brokers, sole practitioners, and principal real estate brokers, as those terms are defined in ORS 696.010.

(2) The purpose of this division is to specify the requirements for obtaining the desired real estate license.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0003
Definitions

As used in this division, unless the context requires otherwise, the following definitions apply:

(1) "Agency" is defined in ORS 696.010.

(2) "Board" means the Real Estate Board established pursuant to ORS 696.405.

(3) "Branch office" is defined in ORS 696.010.

(4) "Commissioner" is defined in ORS 696.010.

(5) "Incapacitated" means the physical or mental inability to perform the professional real estate activities described in ORS 696.010.

(6) "Licensed Name" means the name of a real estate licensee as it appears on the current, valid real estate license issued to the licensee pursuant to ORS 696.020.

(7) "Principal broker" means "principal real estate broker," as defined in ORS 696.010.

(8) "Real estate activity," "professional real estate activity," and "real estate business" mean "professional real estate activity" as defined in ORS 696.010.

(9) "Real estate broker" is defined in ORS 696.010 and includes a principal real estate broker and a sole practitioner, as those terms are defined in 696.010, unless the context requires otherwise.

(10) "Real estate licensee" and "licensee" mean a "real estate licensee" as defined in ORS 696.010, unless the context requires otherwise.

(11) "Registered business name" is defined in ORS 696.010.

(12) "Sole Practitioner" is defined in ORS 696.010. A sole practitioner engages in professional real estate activity under the individual's licensed name or under a registered business name.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0005
Education

(1) The required courses of study for a real estate broker's license, sole practitioner's license, or principal real estate broker's license must be designed pursuant to the Guidelines for Oregon Private Real Estate Schools and Instructional Guidelines and approved by the commissioner.

(2) The commissioner may at any time reevaluate an approved course or instructor. If the commissioner finds there is basis for consideration of revocation of the approved course or the instructor, the commissioner shall give notice by ordinary mail to the coordinator of that provider or instructor of a hearing on the possible revocation of an approved course at least 20 days prior to the hearing.

(3) The commissioner may deny or revoke approval of a program, course, activity, or instructor, but that decision may be appealed to the commissioner within 20 days of the date of mailing the notice of denial or revocation and is subject to the contested case hearing provisions of the Oregon Administrative Procedures Act, ORS Chapter 183.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; Renumbered from 863-015-0005, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0010
License Application Form and Content

(1) Applicants for a real estate broker's license, sole practitioner's license, and principal real estate broker's license must submit a license application in writing on an Agency-approved form with all information provided by the applicant and verified by the applicant.

(2) The license application must contain:

(a) The applicant's legal name, mailing address, and phone number;

(b) If the applicant is to be associated with a principal real estate broker, the name of the principal real estate broker who will supervise the applicant's professional real estate activity;

(c) The place or places, including the street address, city, and county where the business will be conducted; and

(d) If the applicant will be associated with a principal real estate broker, the principal broker's authorization for the applicant to use the principal broker's registered business name.

(3) Every license application must be accompanied by the license fee authorized by ORS 696.270. At all periods of the year, the fee for all licenses issued is as authorized by 696.270. That is, the Agency does not pro-rate license fees.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; Renumbered from 863-015-0010, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0015
Background Check Application and Fingerprint Card

(1) An applicant for real estate broker, sole practitioner, or principal real estate broker license must submit to a background check, except an applicant who is currently licensed as a real estate broker, sole practitioner, principal real estate broker or real estate property manager or who is eligible for renewal of such licenses. The background check includes a criminal background check as provided in OAR chapter 863, division 005. The applicant must apply for the background check in writing on an Agency-approved form with all information provided by the applicant and verified by the applicant.

(2) The background check application must include, but is not limited to, the following information:

(a) The applicant's legal name, residence address, and telephone number;

(b) The applicant's date and place of birth;

(c) The applicant's Social Security Number;

(d) Whether the applicant:

(A) Has ever been convicted of or is under arrest, investigation, or indictment for a felony or misdemeanor;

(B) Has ever been refused a real estate license or any other occupational or professional license in any other state or country;

(C) Has ever had any real estate license or other occupational or professional license revoked or suspended; or

(D) Has ever been fined or reprimanded as such a licensee; and

(e) Any other information the commissioner considers necessary to evaluate the applicant's trustworthiness and competency to engage in professional real estate activity in a manner that protects the public interest.

(3) As part of any application submitted under section (2) of this rule, the applicant must submit one completed fingerprint card on the form prescribed by the Oregon State Police and FBI and an additional fee sufficient to recover the costs of processing the applicant's fingerprint information and securing any criminal offender information pertaining to the applicant.

(4) The Agency must receive the background check application, fingerprint card, and processing fee before it will issue a license.

(5) As provided in ORS 181.540, all fingerprint cards, photographs, records, reports, and criminal offender information obtained or compiled by the Agency are confidential and exempt from public inspection. The commissioner will keep such information segregated from other information on the applicant or licensee and maintain such information in a secure place.

(6) If the Agency determines that additional information is necessary in order to process the application, the Agency may request such information in writing, and the applicant must provide the requested information in order to complete the application. If the applicant fails to provide the requested information, the Agency may determine that the application is incomplete, which will result in termination of the application.

(7) An applicant who has otherwise qualified for licensing may not be considered for any real estate license until the background check process and review has been completed, including but not limited to the Agency's receipt of criminal offender information from the Oregon State Police, other regulatory or law enforcement agencies, and the FBI. If an individual who has had a successfully completed background check process and review does not successfully complete the remaining portions of the entire licensing application process within twelve months from the date of the successfully completed background check process and review, the successfully completed background check process and review is no longer valid.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 4-2003(Temp), f. 12-18-03, cert. ef. 1-1-04 thur 6-29-04; REA 3-2004, f. 4-28-04 cert. ef. 5-3-04; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0015, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0020
Examinations

(1) In addition to any other licensing eligibility requirements, a license applicant must pass a real estate examination that includes subject matter determined by the Board.

(2) An applicant may apply for an examination whether or not the Agency has finished processing the applicant's fingerprint card and back-

ground check or has received documentation on the applicant's licensing educational courses. However, the Agency will not consider an applicant for a license until the Agency has completed such processing and review.

(3) A real estate licensee who was licensed as a salesperson before July 1, 2002 must apply for and pass a real estate broker examination in order to be licensed as a principal real estate broker.

(4) An applicant must apply for an examination by submitting to the Agency:

(a) An Agency-approved license examination application form; and

(b) An examination application fee authorized by ORS 696.270.

(5) If a real estate license has not been active for two or more consecutive years, before applying to reactivate such license under OAR 863-014-0065, the licensee must apply for and pass a reactivation examination. To apply for the reactivation examination, the licensee must submit to the Agency:

(a) An Agency-approved license reactivation examination application form; and

(b) The examination application fee authorized by ORS 696.270.

(6) Examination fees are not refundable if an applicant:

(a) Fails to appear for a scheduled examination;

(b) Fails to cancel or reschedule an examination appointment at least two business days before the appointment; or

(c) Fails to pass an examination.

(7) If an applicant for a real estate broker license examination passes both the national and the state portions of an examination but is not issued a license within one year from the date of the examination:

(a) The applicant is no longer qualified for the license on the basis of the examination; and

(b) The applicant must reapply for the examination as required by this rule.

(8) An applicant who passes only one portion of a license examination must reapply for and pass the remaining portion within 12 months of the examination date of the passed portion in order to qualify for a license on the basis of the examination.

(9) In lieu of the national portion of the examination required in this rule, the Board may accept an applicant's passing results of the national portion of a broker examination taken in another state if:

(a) The examination was taken after November 1, 1973 and the license issued as a result of that examination has not been expired for more than one year; or

(b) The examination was taken within the 12 months before the application date and the Agency has received the required forms and fees; and

(c) The applicant provides the Agency with the applicant's certified license history from the state where such examination was taken.

Stat. Auth.: ORS 696.385, 696.425 & 183.335
Stats. Implemented: ORS 696.020, 696.022 & 696.425
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 3-2004, f. 4-28-04, cert. ef. 5-3-04; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2005(Temp), f. 6-9-05, cert. ef. 7-1-05 thru 12-26-05; Administrative correction 1-20-06; REA 2-2007(Temp), f. & cert. ef. 3-21-07 thru 9-16-07; REA 4-2007, f. & cert. ef. 9-26-07; Renumbered from 863-015-0020, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0030
License Issue, Term, Form, and Inspection

(1) The Agency will issue a real estate license to an applicant after determining that the applicant meets the license requirements contained in ORS 696.022 and 696.790 and receiving:

(a) The license application form required by OAR 863-014-0010; and

(b) The fees authorized by ORS 696.270.

(2) A licensee may engage in professional real estate activities allowed for that license by ORS Chapter 696 and OAR chapter 863 from the date the license is issued until the license expires, becomes inactive, or is revoked, surrendered, or suspended.

(3) A licensee may hold only one of the following Oregon real estate licenses at any time:

(a) Real estate broker;

(b) Principal real estate broker;

(c) Sole practitioner; or

(d) Property manager.

(4) The license expiration date is the last day of the month of a licensee's birth month.

(5) The license term is not more than 24 months plus the number of days between the date the license is issued or renewed and the last day of the month of the licensee's birth month.

(6) The license will include the following information:

(a) The licensee's legal name;

(b) The license number, effective date, and expiration date;

(c) The name under which the licensee conducts real estate business or the registered business name;

(d) The licensee's business address;

(e) The seal of the Real Estate Agency; and

(f) Any other information the Agency deems appropriate.

(7) Each license must be available for inspection in the licensee's principal place of business. If a licensee is associated with a principal real estate broker, the principal broker must make the license available for inspection in the licensee's principal place of business, which is:

(a) The principal broker's principal place of business; or

(b) A branch office.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2007(Temp), f. & cert. ef. 3-21-07 thru 9-16-07; REA 4-2007, f. & cert. ef. 9-26-07; Renumbered from 863-015-0030, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0035
Real Estate Broker Licensing Requirements

(1) To be eligible for a real estate broker's license, an individual must:

(a) Submit a complete license application and background check application as required by OAR 863-014-0010 and 863-014-0015;

(b) Pass the licensing examination required by OAR 863-014-0020;

(c) Pay the licensing fees authorized by ORS 696.270; and

(d) Successfully complete the required courses of study for real estate broker licensing as prescribed by the commissioner.

(2) If the applicant's qualifications are based wholly or partially upon an active real estate license held in another state, the applicant must furnish with the application a certification of active licensing from the other state's licensing agency.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0035, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0038
Sole Practitioner Licensing Requirements

(1) To be eligible for a sole practitioner's license, an individual must:

(a) Submit a complete license application and background check application as required by OAR 863-014-0010 and 863-014-0015;

(b) Pass the licensing examination required by OAR 863-014-0020;

(c) Pay the licensing fees authorized by ORS 696.270;

(d) Successfully complete the required courses of study for real estate broker licensing as prescribed by the Commissioner; and

(e) Provide proof satisfactory to the Commissioner that the applicant has met the requirements contained in ORS 696.022 for a sole practitioner.

(2) If the applicant's qualifications are based wholly or partially upon an active real estate license held in another state, the applicant must furnish with the application a certification of active licensing from the other state's licensing agency.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0040
Principal Real Estate Broker Licensing Requirements

(1) Except as allowed by OAR 863-014-0042 concerning waiver of experience requirements, to be eligible for a principal real estate broker's license, an individual must:

(a) Submit a complete license application and background check application as required by OAR 863-014-0010 and 863-014-0015;

(b) Pass the licensing examination required by OAR 863-014-0020;

(c) Pay the licensing fees authorized by ORS 696.270;

(d) Successfully complete the required course of study for principal real estate broker licensing as prescribed by the Agency; and

(e) Provide proof satisfactory to the Agency that the applicant has met the requirements contained in ORS 696.022 for a principal real estate broker.

(2) If the applicant's qualifications are based wholly or partially upon an active real estate license held in another state, the applicant must furnish with the application a certification of active licensing from the other state's licensing agency.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 2-2005(Temp), f. 6-9-05, cert. ef. 7-1-05 thru 12-26-05; Administrative correction 1-20-06; Renumbered from 863-015-0040, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0042
Waiver of Experience Requirements

(1) If an applicant for a principal real estate broker's license or a sole practitioner's license has met all requirements for such license except for the experience requirement, the applicant may petition the Real Estate Board for a waiver of the three-year experience requirement contained in ORS 696.022, OAR 863-014-0038, and 863-014-0040. The petition must contain sufficient information to allow the Board to determine whether the applicant qualifies for a waiver as allowed by this rule.

(2) The applicant must file a petition to waive the experience requirement on an Agency-approved form with the Agency no later than 21 days before the scheduled Real Estate Board meeting at which the applicant wishes the Board to act.

(3) The Board may issue a waiver if the applicant:

(a) Has graduated from a four-year college or university with a degree in real estate in a curriculum approved by the Commissioner, and the applicant has held an active license as a real estate broker for a period of at least one year; or

(b) Has a two-year community college associate degree in real estate in a curriculum approved by the Commissioner, has held an active license as a real estate broker for a period of at least two years and, if the applicant is applying for a principal real estate broker license, the applicant has completed the course of study for principal real estate brokers as required by OAR 863-014-0040; or

(c) Has had real estate-related experience equivalent to at least three years of active experience as a real estate licensee and provides written details about the nature of such experience.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0050
License Renewal

(1) A real estate license expires if a licensee fails to renew the license on or before the license expiration date. A real estate licensee may not engage in any professional real estate activity after a license expires.

(2) The Agency will renew an active or inactive real estate license to an active real estate license status for the term prescribed in OAR 863-014-0030 when the Agency has received the following:

(a) The renewal fee authorized by ORS 696.270; and

(b) An Agency-approved renewal application form requesting active license status that includes certification that the licensee has met the real estate continuing education renewal requirements for active license status under OAR 863-014-0055.

(3) The Agency will renew an active or inactive real estate license to an inactive real estate license status for the term prescribed in OAR 863-014-0030, when the Agency has received the following:

(a) The renewal fee authorized by ORS 696.270; and

(b) An Agency-approved renewal application form requesting inactive status.

(4) The Agency will renew an expired real estate license to an active or inactive license status under the following conditions:

(a) The licensee applies for a license renewal on a agency-approved renewal application form requesting active or inactive license status within one year of the date the license expired;

(b) The Agency has received both the renewal fee and a late fee authorized by ORS 696.270; and

(c) If the licensee renews to an active license status, the Agency has received an Agency-approved renewal application form that includes certification that the licensee met the real estate continuing education renewal requirements under OAR 863-014-0055.

(5) When the Agency renews an expired license, the renewed license is effective as of the renewal date. The renewal is not retroactive, and the expired license retains the status of expired until the renewal date.

(6) A license that is renewed under this rule expires two years from the date of the original expiration date.

(7) A real estate license that has expired for more than one year is lapsed, as defined in ORS 696.010.

(8) A license may not be renewed if it is lapsed, surrendered, suspended, or revoked. Except as provided in 863-014-0075, the former licensee must reapply and meet all the licensing qualifications required of new license applicants.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 3-2004, f. 4-28-04 cert. ef. 5-3-04; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2007(Temp), f. & cert. ef. 3-21-07 thru 9-16-07; REA 4-2007, f. & cert. ef. 9-26-07; Renumbered from 863-015-0050, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0055
Continuing Education

(1) To renew an active license, a licensee must certify that the licensee has completed at least 30 clock-hours of real estate oriented continuing education during the preceding two license years.

(a) A licensee must complete 15 clock-hours of continuing education in one or more of the following required topics:

(A) Trust Accounts;
(B) Misrepresentation;
(C) Anti-Trust;
(D) Rule and Law Update;
(E) Property Management;
(F) Commercial Brokerage and Leasing;
(G) Real Estate Taxation: Federal, State, and Local;
(H) Agency;
(I) Fair Housing;
(J) Contracts;
(K) Property Evaluation;
(L) Brokerage Management;
(M) Land;
(N) Business Ethics; or
(O) Compliance Review.

(b) A licensee must complete the remaining 15 hours in any combination of the above course topics or in other elective real estate oriented continuing education courses.

(c) Courses related to personal skills, such as time management, and routine meetings and luncheons are not considered real estate oriented continuing education courses and do not qualify as such.

(d) Courses must be a minimum of one clock-hour in length. A clock-hour is measured in 60-minute increments, excluding meal or rest breaks.

(e) Credit will not be given for repeating a continuing education course with the same content during a two-year renewal period.

(2) Licensees must complete a standard Certificate of Attendance developed by the Agency for each course completed by a licensee. "Certifying licensee" means a principal real estate broker or sole practitioner who certifies on an Agency-approved form that a licensee completed the continuing education requirements.

(3) In completing the standard Certificate of Attendance, the certifying licensee must decide:

(a) Whether a continuing education course meets the continuing education requirements; and

(b) Whether to classify the course as a required topic or an elective topic.

(4) A certifying licensee may approve continuing education courses completed outside of Oregon. However, for courses completed outside of Oregon, the number of approved credit hours must reflect the clock-hours of course content related to the practice of real estate in Oregon. Credit hours will not be approved for courses with content specific to another state or jurisdiction.

(5) The certifying licensee must retain the Certificate of Attendance in its records as prescribed in OAR 863-015-0260. The certifying licensee must produce a copy of the Certificate of Attendance if the associated licensee or the Agency so requests.

(6) Principal real estate brokers and sole practitioners must:

(a) Self-certify that they have completed their continuing education requirements;

(b) Retain their Certificate of Attendance as prescribed in OAR 863-015-0260; and

(c) Produce a copy of the Certificate of Attendance if the Agency so requests.

(7) Providing false information on an Agency license renewal form or Certificate of Attendance or falsely certifying such information is prima facie evidence of a violation of ORS 696.301.

(8) In certifying a continuing education course, the certifying licensee must consider the totality of the information provided and the class content and may consider additional criteria including, but not limited to:

(a) Evidence of the instructor's qualifications to teach the course;

(b) Whether the course content is current and accurate, the learning objectives for the course, and whether the course content fulfills the learning objectives;

(c) Whether the course includes ways of measuring learning outcome, such as a final examination; and

(d) Whether students get to evaluate the course and instructor.

(9) A real estate broker first licensed on or after July 1, 2002 must complete a commissioner-approved course entitled "Advanced Real Estate

Practices" before the first active renewal of the real estate broker's license or before the first license reactivation following an inactive first renewal. This requirement does not apply to sole practitioners or principal brokers. An approved Advanced Real Estate Practices course satisfies the continuing education requirements for a licensee's renewal.

(10) Certifying licensees may approve continuing education courses completed through alternative delivery methods. "Alternative delivery" means presentation of continuing education material in a method other than classroom lecture, including but not limited to correspondence, and electronic means such as satellite broadcast, videotape, computer disc, and Internet.

(a) In addition to the certification criteria in section (8), in determining whether to certify an alternative delivery method course, the certifying licensee may consider:

(A) Whether the course offers operational or electronic security measures;

(B) The students' ability to interact with an instructor or access other resources to support their learning;

(C) Whether the learning environment and technical requirements are explained to students in advance of the course; and

(D) Whether the course includes a proctored final examination.

(b) In determining the number of credit hours to approve for an alternative delivery course, the certifying licensee may consider:

(A) The number of questions in the examination, with a minimum standard of 10 questions per hour of credit;

(B) The number of pages for Internet, Computer-Based Training, CD-ROM, and book courses, with a minimum standard of 10 pages per hour of credit; and

(C) The clock hours elapsed for videocassette, audiotape, or teleconference courses.

(11) Continuing education course sponsors may:

(a) State in their advertising that the licensee's principal broker must approve the continuing education requirements, e.g., course content, topics, and hours; and

(b) Complete the following information on a Certificate of Attendance:

(A) Real estate licensee's name;

(B) Continuing education course title and date of completion;

(C) Instructor's name and location of course; and

(D) Method of course delivery and whether a final examination was administered.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.174 & 696.301
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2004(Temp), f. & cert. ef. 1-15-04 thru 6-25-04; REA 3-2004, f. 4-28-04 cert. ef. 5-3-04; Renumbered from 863-015-0055, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0060
Limited Licenses

If the commissioner issues an individual a limited license under ORS 696.130, the licensee must apply in writing for an unrestricted license after the period of limitation.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2005(Temp), f. 6-9-05, cert. ef. 7-1-05 thru 12-26-05; Suspended by REA 3-2005(Temp), f. 7-18-05, cert. ef. 7-22-05 thru 12-26-05; Administrative correction 1-20-06; Renumbered from 863-015-0060, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0061
Affiliated and Subsidiary Organizations

(1) Affiliated organizations are two or more organizations whose controlling ownership interests are owned by the same licensee, licensees, entity, or entities.

(2) A subsidiary organization is one in which the majority of the voting stock or controlling ownership interest is owned by another organization.

(3) Affiliated or subsidiary business organizations may use the same principal broker, provided that the individual registering the business name submits proof satisfactory to the commissioner that the principal real estate broker or brokers involved actually manages and controls each affiliated and subsidiary organization.

(4) As used in this rule, controlling ownership interest(s) means owning 51 percent or more.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0061, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0062
Mailing Address, Address Change, Service of Notice

(1) Each real estate licensee must maintain on file with the Agency a current mailing address and notify the Agency within 10 calendar days of a change of address.

(2) A forwarding address is effective as a "current mailing address" when the Agency receives notice of the forwarding address by the United States Postal Service.

(3) Agency notice by mail, whether registered, certified, or regular, to the real estate licensee's current mailing address on file with the Agency constitutes service.

(4) This rule applies regardless of license status.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0062, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0063
Real Estate License Transfers, Principal Brokers' Responsibilities, Authority to Use Registered Business Name

(1) As used in this rule:

(a) "Authorized licensee" means a licensee who has authority over the use of a registered business name;

(b) "License transfer form" means a completed and signed Agency-approved form that does one of the following:

(A) Transfers a real estate broker license to a receiving principal broker in order to become associated with the receiving principal broker, or

(B) Authorizes a real estate licensee to use a registered business name to conduct professional real estate activity.

(c) "Sending principal broker" means the principal real estate broker with whom an active real estate broker license is associated before the license transfer;

(d) "Receiving principal broker" means the principal real estate broker with whom an active real estate broker license will be associated after the license transfer.

(2) The licensee must provide the following information on a license transfer form:

(a) The name, mailing address, and license number of the licensee who is transferring the license or documenting the authorized use of a registered business name;

(b) The current status of the license, whether active or inactive;

(c) If the real estate broker is associated with a sending principal broker, certification that the real estate broker provided written notice of the transfer to the sending principal broker, and that such notice was provided before the date the transfer form is submitted to the Agency, including:

(A) The date of personal service of such notice; or

(B) The date a certified letter was delivered by the post office to the sending principal broker's address;

(d) If the form is used to authorize the use of a different registered business name, certification that the licensee provided written notice of such change to the authorized licensee for the current registered business name, and that such notice was provided before the date the license transfer form is submitted to the Agency, including:

(A) The date of personal service of such notice; or

(B) The date a certified letter was delivered to the authorized licensee's address;

(e) If applicable, the receiving principal broker's registered business name, street address, and registered business name identification number;

(f) If applicable, the street address, registered business name identification number, and the registered business name under which the real estate licensee will be authorized to conduct professional real estate activity; and

(g) The receiving broker's or authorized licensee's name, license number, telephone number, date, and signature.

(3) The Agency will transfer the license of an active real estate broker associated with a sending principal broker to a receiving principal broker when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

(4) The Agency will transfer the license of an active sole practitioner or principal real estate broker to a receiving principal broker when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

(5) The Agency will transfer the license of an inactive real estate licensee, who has been inactive for a period of 30 days or less, to a receiving principal broker when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

(6) The Agency will change a real estate license category when the license is transferred under sections (4) and (5) of this rule and will not require a fee payment for changing the license category when the Agency receives the following:

(a) A license transfer form;

(b) The transfer fee authorized by ORS 696.270; and

(c) An Agency-approved form to change the license category.

(7) A principal real estate broker with whom a licensee is associated remains responsible for the licensee's professional real estate activity until the Agency receives one of the following:

(a) The licensee's real estate license;

(b) An Agency-approved form submitted by the principal real estate broker terminating the relationship with the licensee under OAR 863-014-0065; or

(c) A license transfer form and fee.

(8) If a principal real estate broker with whom a real estate broker is associated voluntarily gives the license to the real estate broker named in the license, the principal real estate broker remains responsible for the licensee's subsequent professional real estate activity until the Agency receives one of the following:

(a) The licensee's real estate license;

(b) An Agency-approved form submitted by the principal real estate broker terminating the relationship with the licensee under OAR 863-014-0065;

(c) An Agency-approved form submitted by the licensee terminating the relationship with the principal real estate broker under OAR 863-014-0065; or

(d) A license transfer form and fee.

(9) The Agency will document the registered business name under which a real estate licensee is authorized to conduct professional real estate activity when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 4-2007, f. & cert. ef. 9-26-07; Renumbered from 863-015-0063, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0065
Inactive License, Change License Status to Active, Change License Category, License Reactivation

(1) A real estate licensee whose license is on inactive status may not engage in professional real estate activity.

(2) The commissioner may reprimand, suspend, revoke, or impose a civil penalty against an inactive licensee under ORS 696.301.

(3) The Agency will change an active real estate license to inactive license status when the Agency actually receives the following:

(a) The license;

(b) A request by the licensee submitted on an Agency-approved form to change the license status to inactive; or

(c) An Agency-approved form submitted by the licensee terminating the relationship with the principal real estate broker under this rule.

(4) The Agency will change the status of an active real estate broker who is associated with a principal real estate broker to inactive status when the Agency receives one of the following:

(a) The real estate broker license, submitted by the licensee;

(b) The real estate broker license, submitted by the principal real estate broker;

(c) An Agency-approved form, submitted by the principal real estate broker, terminating the principal real estate broker's relationship with the real estate broker; or

(d) An Agency-approved form submitted by the real estate broker terminating the relationship with the principal real estate broker.

(5) An inactive real estate licensee may renew such license under OAR 863-014-0050.

(6) For a period of 30 days after a real estate broker license becomes inactive, the licensee may change such license status from inactive to active and transfer the license to a principal real estate broker under OAR 863-014-0063.

(7) Except as provided in section (8) of this rule, for a period of 30 days after the real estate license becomes inactive, the licensee may change such license category to an active sole practitioner or active principal real estate broker only if:

(a) The licensee is qualified for such licenses; and

(b) The licensee submits to the Agency:

(A) An Agency-approved application form to change the license category and to change the license status to active,

(B) A license transfer form under OAR 863-014-0064, if applicable, and

(C) Payment of the transfer fee authorized by ORS 696.270.

(8) If the licensee under section (7) of this rule is changing license category to a principal real estate broker and has never been licensed as a principal real estate broker, the licensee must submit to the Agency:

(a) An Agency-approved broker license application form; and

(b) The licensing fee authorized by ORS 696.270.

(9) If a license has not been on active status for two or more consecutive years, before applying for reactivation of such license under sections (10) and (11) of this rule:

(a) The licensee must submit to the Agency:

(A) An application for licensing reactivation examination; and

(B) The examination fee authorized by ORS 696.270; and

(b) The licensee must pass the reactivation examination.

(10) After the 30-day period specified in sections (6) and (7) of this rule, and subject to the examination requirements in section (9) of this rule, a licensee may change the license status from inactive to active only by submitting to the Agency:

(a) An application for license reactivation; and

(b) Payment of the reactivation fee authorized by ORS 696.270.

(11) Subject to the examination requirements in section (9) of this rule, if an inactive licensee renews a license and maintains inactive status under section (5) of this rule, the licensee may, within 60 days of the date of renewal, change the license status to active by submitting to the Agency:

(a) An Agency-approved application for license reactivation that includes certification that the licensee met the real estate continuing education renewal requirements under OAR 863-014-0055; and

(b) Payment of the active renewal fee authorized by ORS 696.270, less the amount of the inactive renewal fee already paid by the licensee.

(12) The change of license status, transfer, or change of license category under sections (6) and (7) of this rule, or the reactivation of a license under sections (10) and (11) of this rule, are effective when the Agency actually receives all required forms and fees.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-1991, f. & cert. ef. 11-4-91; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0081; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 3-2004, f. 4-28-04 cert. ef. 5-3-04; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2007(Temp), f. & cert. ef. 3-21-07 thru 9-16-07; REA 4-2007, f. & cert. ef. 9-26-07; Renumbered from 863-015-0065, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0070
License Surrender

(1) A real estate licensee may surrender the licensee's license to the commissioner on an Agency-approved form. Upon surrender, the license is terminated, and the licensee's rights under the surrendered license are terminated. The commissioner retains continuing jurisdiction to investigate the professional real estate activity conducted under the license and to take disciplinary action against the former licensee under ORS Chapter 696 and its implementing rules.

(2) A surrendered license may not be renewed. The former licensee must reapply and meet all the licensing qualifications required of new license applicants.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REC 21, f. 7-5-67; REC 23, f. 7-3-69, ef. 9-1-69; REC 28, f. 11-1-70, ef. 1-1-71; REC 31, f. 8-6-71, ef. 9-9-71; REC 46, f. & ef. 1-22-76; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 3-1980, f. 10-20-80, ef. 11-1-80; REC 1-1981, f. 10-30-81, ef. 11-1-81; REC 5-1984, f. 6-18-84, ef. 7-1-84; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0085; Renumbered from 863-015-0070, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0075
Reissuing Suspended License

(1) The Agency may reissue an unexpired real estate license that has been suspended by order of the commissioner if the licensee makes a written request to the Agency that such license be reissued and pays the required fee within 30 days after the close of the suspension period.

(2) If the licensee fails to act within 30 days, the license becomes inactive and may be reactivated only pursuant to OAR 863-014-0065.

(3) If the license expires before the request for reissuance, the Agency will renew the license within the 30-day period only pursuant to OAR 863-014-0050.

(4) A license reissued under this rule is effective for licensing purposes when the Agency receives all required forms and fees.

(5) If the license has had a status other than active for two or more consecutive years, the licensee must comply with the reactivation requirements of OAR 863-014-0065.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REC 1-1981, f. 10-30-81, ef. 11-1-81; REC 5-1984, f. 6-18-84, ef. 7-1-84; REA 3-1989, f. 12-13-89, cert. ef. 2-1-90; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0086; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0075, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0076
Signature Requirements

(1) Subject to ORS 84.001 to 84.061, the Agency may, but is not required to, accept any electronic or facsimile signature created, generated, sent, communicated, received, or stored regarding licensing documents including, but not limited to, background check applications, examination applications, license applications, license change forms, and license surrender forms.

(2) The Agency may require an individual to submit an original signature on any document.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0076, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0080
Nonresident License Recognition

(1) As used in ORS 696.265 and this rule, unless the context requires otherwise:

(a) "Nonresident real estate broker" means an individual residing in another state or country who is licensed by that state or country to transact professional real estate activity and whose license authorizes that individual to employ, engage, or otherwise supervise other real estate brokers or salespersons.

(b) "Nonresident real estate salesperson" means an individual residing in another state or country who is licensed by that state or country to transact professional real estate activity.

(c) "Nonresident licensee" means either a nonresident real estate broker or a nonresident real estate salesperson.

(d) "State or country of residence" means, presumptively, the state or country where an individual's resident license is located.

(2) An individual who is not a resident of Oregon, is actively engaged in professional real estate activity in his or her state or country of residence, and has been duly licensed by that state or regulatory agency within that country, may obtain an Oregon nonresident license if the applicant's state or county of residence:

(a) Allows an Oregon real estate broker to be licensed in that state or country under terms and conditions similar to those prescribed in ORS 696.255 and 696.265; and

(b) Is capable of assisting and does assist the commissioner in the commissioner's review of real estate transactions and management of rental real estate for enforcement to protect Oregon consumers affected by the nonresident licensees' professional real estate activity.

(3) An applicant for a nonresident license must provide fingerprints and criminal offender information in the same manner as required of a resident licensee under ORS 696.022. The nonresident license application must be accompanied by a background check application, fingerprint card, and processing fees as prescribed by OAR 863-014-0015. The applicant must furnish with the nonresident license application proof that the applicant holds an active and valid license issued by the state or country of residence.

(4) An applicant for a nonresident license must sign and file with the Agency an affidavit stating that the applicant has reviewed and is familiar with ORS Chapter 696 and its implementing rules and agrees to be bound by them.

(5) For a nonresident real estate salesperson who is a resident of a state requiring salespersons to work under licensed real estate brokers, the license issued by that state's Real Estate Agency must contain the business name and business address of the broker under whose license the salesperson works. The Agency will mail the Oregon license to the broker at the broker's business address.

(6) If the Agency requests, nonresident licensees must produce in the Agency's office any and all records of professional real estate activity conducted in Oregon. The nonresident licensee, by applying for and accepting the nonresident license, authorizes the Agency to inspect and examine any transaction escrow records, trust account records, and other records of professional real estate activity, wherever maintained.

(7) With respect to nonresident real estate salespersons who are residents of a state or country requiring salespersons to work under licensed real estate brokers, all advertising (including business signs, business cards, agreements, and other documents) used by those salespersons must contain the name and business address of the nonresident real estate broker.

(8) The commissioner may suspend or revoke, reprimand, deny a license to, or refuse to renew a license to a nonresident real estate licensee upon any of the grounds in ORS 696.301 or if the state or country of residence has suspended, revoked, denied, or refused to renew the individual's license or has limited the license in any way.

(9) Except as otherwise provided in reciprocity agreements entered into pursuant to section (10) below, or except as provided at the commissioner's discretion , the nonresident license application, fees, license terms, license application and renewal processing, license transfer, and all other conditions and requirements of licensure will be as provided for in ORS chapter 696 and its implementing rules.

(10) The commissioner may enter into reciprocity agreements with other states or countries where necessary to permit Oregon real estate licensees to obtain licenses in such other states or countries.

(11) The commissioner may include in such agreements the terms and conditions prescribed in this rule and additional terms and conditions at the commissioner's discretion.

(12) Nonresident licenses granted under reciprocity agreements remain in force, unless suspended or revoked by the commissioner or for failure to pay the biennial renewal fees, only so long as the reciprocity agreement remains in effect between Oregon and the other state or country. If the non-resident licensee subsequently becomes an Oregon resident, such person may obtain, upon filing the proper application and other requisite documents and the applicable fees, the equivalent resident license in Oregon. Application must be made within one year after becoming a resident.

Stat. Auth.: ORS 696.265, 696.385 & 183.335
Stats. Implemented: ORS 696.255 & 696.265
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 4-2003(Temp), f. 12-18-03, cert. ef. 1-1-04 thur 6-29-04; REA 3-2004, f. 4-28-04 cert. ef. 5-3-04; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; Renumbered from 863-015-0080, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0085
Authorization to Control Broker's Business

(1)(a) A sole practitioner may authorize another sole practitioner or principal real estate broker to control and supervise his or her professional real estate activity during the sole practitioner's absence for a period not to exceed 90 days. Both licensees have joint responsibility for all professional real estate activity conducted during the authorizing sole practitioner's absence.

(b) A principal real estate broker may authorize another principal broker to control and supervise his or her professional real estate activity during the principal broker's absence for a period not to exceed 90 days. Both licensees have joint responsibility for all professional real estate activity conducted during the authorizing principal broker's absence.

(2) A copy of the written authorization, signed by the authorizing sole practitioner or principal real estate broker and the licensee accepting control and supervision responsibility under section (1), must be filed with the commissioner before the effective date of such authorization. The commissioner may allow a later filing for good cause shown.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.026
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 3-2004, f. 4-28-04 cert. ef. 5-3-04; Renumbered from 863-015-0085, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0095
Business Name Registration

(1) Before conducting business in a name other than the real estate licensee's legal name, the principal real estate broker or sole practitioner must register the business name with the Agency. For the purposes of this rule, "business name" means an assumed name or the name of a business entity, such as a corporation, partnership, limited liability company, or other business entity recognized by law. A licensee must maintain the registered business name with the Oregon Secretary of State's Corporation Division.

(2) To use or register a business name, the real estate licensee must provide the commissioner with all of the following:

(a) The business name in which the licensee wishes to conduct business; or

(b) Written authority by which the licensee is authorized to use the business name; and

(c) A copy of the registration filed with the Oregon Secretary of State Business Registry.

(3) Business names registered with the Agency do not expire and need not be renewed by the licensee. Any change in the business name registered

with the Agency will be treated as the registration of a new business name, and the change in business name must be registered with the Agency together with the fee authorized by ORS 696.270.

(4) If a licensee wishes to transfer the right to use a business name that is registered with the Agency, the licensee acquiring the right to use the name must file a change of business name registration with the Agency together with the fee authorized by ORS 696.270. A licensee must notify the Agency in writing if the licensee terminates its use of a business name.

(5) A business name registration becomes void when the Agency receives notice of termination of the use of a business name. A business name registration becomes void when no licensees are affiliated with the registered business name. A business name registration may be reactivated within one year from the voiding of a registration, unless a new user has registered the business name, without paying the fee authorized by ORS 696.270.

(6) No real estate broker, principal broker, or sole practitioner may engage in professional real estate activities under more than one registered business name. An exception to this requirement is that a principal broker or sole practitioner may engage in professional real estate activities under more than one registered business name if the business entity is an affiliated or subsidiary organization as described in OAR 863-014-0061.

Stat. Auth.: ORS 696.026, 696.385 & 183.335
Stats. Implemented: ORS 696.026
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; Renumbered from 863-015-0095, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0100
Branch Office Registration

(1) Before engaging in professional real estate activity from a branch office, a principal real estate broker or sole practitioner must provide to the commissioner on an Agency-approved form the branch office street and mailing addresses and the fee authorized by ORS 696.270.

(2) For the purposes of ORS 696.270, a branch office registration does not require renewal.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.026 & 696.200
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; Renumbered from 863-015-0100, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

863-014-0160
Deceased or Incapacitated Broker

(1) If the Agency issues temporary license under ORS 696.205, the temporary licensee may only close or terminate the transactions that are in various stages of completion or termination at the broker's death or incapacity. The activities authorized under the temporary license include, but are not limited to:

(a) Terminating all listings and buyer's service agreements in which there were no outstanding offers or earnest money receipts when the broker died or became incapacitated;

(b) Completing all negotiations between buyers and sellers on open transactions;

(c) Depositing and withdrawing monies from the clients' trust account in connection with the completion of all transactions pending when the broker died or became incapacitated;

(d) Promptly paying all real estate commissions owing after closing all transactions, both to the decedent broker's estate and to participating real estate brokers entitled to commissions resulting from the transactions; and

(e) Disbursing earnest moneys or other funds according to any outstanding earnest money receipt or other agreement.

(2) The holder of a temporary license may not enter into any new listing or sale agreements or conduct professional real estate activity for others who are not principals in a current contract with the deceased or incapacitated broker.

(3) The holder of a temporary license is subject to ORS Chapter 696 and its implementing rules while engaging in professional real estate activity under the terms of the temporary license.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.205
Hist.: REC 46, f. & ef. 1-22-76; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1981, f. 10-30-81, ef. 11-1-81; REC 5-1984, f. 6-18-84, ef. 7-1-84; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0092; Renumbered from 863-015-0160, REA 5-2008, f. 12-15-08, cert. ef. 1-1-09

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Rule Caption: Amend regulations for real estate brokers.
Adm. Order No.: REA 6-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Adopted: 863-015-0000, 863-015-0188
Rules Amended: 863-015-0130, 863-015-0135, 863-015-0140, 863-015-0145, 863-015-0150, 863-015-0155, 863-015-0175, 863-015-0186, 863-015-0190, 863-015-0200, 863-015-0205, 863-015-0210, 863-015-0215, 863-015-0250, 863-015-0255, 863-015-0260, 863-015-0265, 863-015-0275
Rules Repealed: 863-015-0025, 863-015-0165, 863-015-0180, 863-015-0185, 863-015-0195, 863-015-0220
Rules Ren. & Amend: 863-015-0120 to 863-015-0003
Subject: The rules include significant amendments for clarity, to align rules with statutes, and to repeal rules that are a restatement of a statute. Licensing rules in this division were moved to new divisions: real estate broker licensing rules were moved to new division 14 and property manager licensing rules were moved to new division 24. Investigations and discipline were moved to new division 27.
Rules Coordinator: Laurie Skillman—(503) 378-4630

863-015-0000
Applicability and Purpose

(1) This division applies to real estate brokers, sole practitioners, and principal real estate brokers, as those terms are defined by ORS 696.010.

(2) The purposes of this division are:

(a) To specify the regulations for licensees engaged in professional real estate activities, as that term is defined in ORS 696.010;

(b) To protect the owners, buyers, and sellers of real estate; and

(c) To make the sole practitioner and principal real estate broker responsible for establishing a system of recordkeeping that:

(A) Provides the Agency with access to the licensees' records; and

(B) Complies with the requirements contained in OAR chapter 863 and ORS Chapter 696.

(3) The Agency's goal is to encourage real estate licensees to comply with the applicable statutes and implementing rules through education and, if necessary, through progressive discipline, as provided in OAR chapter 863, division 27.

(4) Section (3) of this rule does not limit the Agency's authority to reprimand, suspend, or revoke a license pursuant to ORS 696.301 or assess civil penalties as authorized by 696.990.

Stat. Auth.: ORS 696.385
Stat. Implemented: ORS 696.015
Hist.: REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0003
Definitions

As used in this division, unless the context requires otherwise, the following definitions apply:

(1) "Addendum" means additional material attached to and made part of a document. The addendum must refer to the document and be dated and signed or otherwise acknowledged by all the parties.

(2) "Agent" is defined in ORS 696.800.

(3) "Agency" is defined in ORS 696.010.

(4) "Bank" is defined in ORS 696.010.

(5) "Banking day" means each day a financial institution is required to be open for the normal conduct of its business but does not include Saturday, Sunday, or any legal holiday under ORS 187.010.

(6) "Board" means the Real Estate Board established pursuant to ORS 696.405.

(7) "Branch office" is defined in ORS 696.010.

(8) "Buyer" is defined in ORS 696.800.

(9) "Clients' Trust Account" means an account in a "bank," as defined in ORS 696.010, that is subject to the provisions of 696.241.

(10) "Closing" means the transfer of all property titles and the disbursement or distributions of all monies and documents for a real estate transaction.

(11) "Commissioner" is defined in ORS 696.010.

(12) "Compensation" is defined in ORS 696.010.

(13) "Competitive market analysis" is defined in ORS 696.010.

(14) "Confidential information" is defined in ORS 696.800.

(15) "Day" or "days" means each calendar day, including legal holidays under ORS 187.010.

(16) "Disclosed limited agency" is defined in ORS 696.800.

(17) "First contact with a represented party" means the initial contact by a licensee, whether in person, by telephone, over the Internet, or by elec-

tronic mail, electronic bulletin board, or similar electronic method, with an individual who is represented by a real estate licensee or can reasonably be assumed from the circumstances to be represented or seeking representation.

(18) "Letter opinion" is defined in ORS 696.010.

(19) "Licensed Name" means the name of a real estate licensee as it appears on the current, valid real estate license issued to the licensee pursuant to ORS 696.020.

(20) "Listing agreement" is defined in ORS 696.800.

(21) "Offer" is defined in ORS 696.800.

(22) "Offering price" is defined in ORS 696.800.

(23) "Principal" is defined in ORS 696.800.

(24) "Principal broker" means "principal real estate broker," as defined in ORS 696.010.

(25) "Real estate" is defined in ORS 696.010.

(26) "Real estate activity," "professional real estate activity," and "real estate business" mean "professional real estate activity" as defined in ORS 696.010.

(27) "Real estate broker" is defined in ORS 696.010 and includes a principal real estate broker and a sole practitioner, as those terms are defined in ORS 696.010, unless the context requires otherwise.

(28) "Real estate licensee" and "licensee" mean a "real estate licensee" as defined in ORS 696.010, unless the context requires otherwise.

(29) "Real property" is defined in ORS 696.800.

(30) "Real property transaction" is defined in ORS 696.800.

(31) "Registered business name" is defined in ORS 696.010.

(32) "Sale" and "sold" are defined in ORS 696.800.

(33) "Seller" is defined in ORS 696.800.

(34) "Sole Practitioner" is defined in ORS 696.010.

(35) "Timely" means as soon as is practicable under the circumstances.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.010
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; Renumbered from 863-015-0120, REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0130
Listing Agreements

(1) A real estate licensee who enters into a listing agreement, as defined by ORS 696.800, must give the seller signing the listing agreement a true, legible copy thereof at the time of securing such listing.

(2) Every listing agreement must meet the following requirements:

(a) It must state an expiration date;

(b) It may not contain a provision requiring the seller signing the listing to notify the licensee of the individual's intention to cancel the listing after the stated, definite expiration date;

(c) It may not contain a provision subjecting the seller of the listed property to the payment of two or more commissions for one sale if the seller lists the same property with a second or subsequent broker after the first or preceding listing agreement expires or is terminated by mutual agreement; and

(d) It must be signed by all parties to the agreement,

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.280
Hist.: REC 20, f. 5-5-65, ef. 7-1-65; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1981, f. 10-30-81, ef. 11-1-81; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0015; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0135
Offers to Purchase

(1) When a real estate licensee receives an offer to purchase real property or a counter-offer, the licensee must give the individual signing the offer or counter-offer a true, legible copy thereof.

(2) A real estate licensee must promptly deliver to the offeror or offeree every written offer or counter-offer the licensee receives.

(3) The licensee must maintain a written record of the date and time of each written offer or counter-offer delivered pursuant to section (2) of this rule and of the seller's or buyer's response. The licensee must maintain this record as required under OAR 863-015-0250, and if the seller rejects the offer or counter-offer, the licensee must provide a true copy to the offeror.

(4) When a licensee receives a written acceptance of an offer or counter-offer to purchase real property, the licensee must deliver within three banking days true, legible copies of the offer or counter-offer, signed by the seller and buyer, to both the buyer and seller.

(5) Real estate licensees must include all of the terms and conditions of the real estate transaction in the offer to purchase or, directly or by reference, in the counter-offer, including but not limited to whether the transaction will be accomplished by way of deed or land sales contract, and whether and at what time evidence of title will be furnished to the prospective buyer.

(6) The document serving as an earnest money receipt must specifically state the type of earnest money received, whether in the form of cash, check, or promissory note.

(7) In preparing a promissory note for use as earnest money, a licensee must make the note payable upon the seller's acceptance of the offer or payable within a stated time after the seller's acceptance. Absent a written agreement to the contrary, the note must be made payable to the seller.

(8) An offer signed by a prospective buyer is an offer to purchase, regardless of any pending inspections, conditions, or other contingencies.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.280
Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.280
Hist.: REC 10, f. 8-27-59; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 3-1980, f. 10-20-80, ef. 11-1-80; REC 1-1981, f. 10-30-81, ef. 11-1-81; REC 5-1984, f. 6-18-84, ef. 7-1-84; REA 1-1997, f. 4-28-97, cert. ef. 5-5-97; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0020; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0140
Principal Real Estate Broker Supervision Responsibilities

(1) No principal real estate broker may allow any individual to use the principal broker's license for the sole purpose of allowing other real estate licensees to engage in professional real estate activity when the principal broker's only interest is receiving a fee for the use of the principal broker's license by others or when the principal broker only nominally supervises the professional real estate activity conducted under the principal broker's license.

(2) A principal real estate broker may not state or imply to current or prospective licensees or the public that the real estate brokers associated with the principal real estate broker are not fully subject to the principal real estate broker's supervision or are not acting as the principal real estate broker's agents.

(3) A principal real estate broker must supervise and control the professional real estate activity at any main or branch office registered by the principal broker.

(4) The principal real estate broker must directly supervise the licensees associated with the broker in fulfilling their duties and obligations to their respective clients. The principal real estate broker must review each document of agreement generated in a real estate transaction within seven banking days after it has been accepted, rejected, or withdrawn. If the document or agreement originates in a branch office, the principal real estate broker who manages the branch office under ORS 696.200 may review such document. The document review may be done electronically or in hard copy. If the principal broker reviews a document electronically, the principal broker or the principal broker who is the branch office manager must make an electronic record of the review showing the name of the reviewer and the date of the review. If the principal broker reviews such document in hard copy, the principal broker or principal broker who manages the branch office must initial and date the document in writing at the time of review.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.301(29) & 696.200
Hist.: REC 17, f. 3-1-63; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1980, f. 2-1-80, ef. 3-1-80; REC 3-1980, f. 10-20-80, ef. 11-1-80; REC 1-1981, f. 10-30-81, ef. 11-1-81; REC 5-1984, f. 6-18-84, ef. 7-1-84; REA 1-1997, f. 4-28-97, cert. ef. 5-5-97; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0043; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0145
Real Estate Transactions Involving a Licensee as a Principal to the Transaction

(1) If a real estate licensee, whether active or inactive, either directly or indirectly offers or negotiates for the sale, exchange, lease option, or purchase of real estate and the licensee is a principal to the transaction, the licensee must disclose to the other party to the offer or transaction that the licensee is a real estate licensee. The licensee must make the disclosure in any advertising or display signs, and it must appear in writing on at least the first written document of agreement concerning the offer or transaction. The disclosure set forth on the agreement document also must state that the real estate licensee is representing himself or herself as either the buyer or the seller in the transaction.

(2) Transactions described in section (1) of this rule of a principal real estate broker must be processed in the same manner as the licensee's other

professional real estate activities and comply with the records requirements under OAR 863-015-0250.

(3) Each transaction described in section (1) of this rule of a real estate broker associated with a principal real estate broker must be conducted under the supervision of the licensee's principal real estate broker and all documents and funds must be transmitted through the licensee's principal real estate broker.

(4) If the licensee holds an inactive license while an offer or transaction described in section (1) of this rule is being effected:

(a) The licensee must place all funds received in or necessary to effect the offer or transaction into a neutral escrow depository within the state; and

(b) The licensee must maintain documents concerning the matter as required of a real estate broker under OAR 863-015-0250.

(5) This section applies to offers and transactions entered into by corporations, partnerships, limited partnerships, or other legal entities in which any real estate licensee, active or inactive, is an owner and where the licensee at any time participates in negotiations concerning the offer or transaction on behalf of the entity. As used in this rule, "owner" means an individual having an ownership interest equaling more than five percent of the total ownership interest in the legal entity.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.015, 696.020(2), 696.241, 696.280 & 696.301(1)(6) & (29)
Hist.: REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1981, f. 10-30-81, ef. 11-1-81; REA 1-1992, f. 1-13-92, cert. ef. 2-1-92; REA 1-1997, f. 4-28-97, cert. ef. 5-5-97; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0046; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0150
Closing Real Estate Transactions

(1) Unless all parties to the transaction agree in writing to delegate the closing function to an escrow agent licensed in Oregon, an attorney, or another real estate broker engaged in the transaction, a principal broker or sole practitioner must promptly close any real estate transaction in which the broker is the listing broker.

(2) A real estate broker associated with a principal real estate broker may handle a closing function only if authorized in writing by the principal real estate broker and only under the principal real estate broker's direct supervision. A copy of the written authorization bearing the principal real estate broker's signature must be filed with the commissioner.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.301(4) & (29)
Hist.: REC 19, f. 8-5-64; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1981, f. 10-30-81, ef. 11-1-81; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0060; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0155
Attorney's Advice

A real estate licensee must not discourage any party to a real estate transaction from seeking the advice of an attorney concerning any matter involving real estate activity in which such licensee is involved.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.015 & 696.301(31)
Hist.: REC 10, f. 8-27-59; REC 3-1978, f. 6-15-78, ef. 7-1-78; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered to 863-010-0090; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0175
Reporting Litigation Involving Licensees

(1) A real estate licensee must notify the commissioner of the following:

(a) Any criminal conviction (felony or misdemeanor), including a "no contest" plea or bail forfeiture;

(b) Any adverse decision or judgment resulting from any civil or criminal suit or action or arbitration proceeding or any administrative or Oregon State Bar proceeding related to the licensee in which the licensee was named as a party and against whom allegations concerning any business conduct or professional real estate activity is asserted; and

(c) Any adverse decision or judgment resulting from any other criminal or civil proceeding that reflects adversely on the "trustworthy and competent" requirements contained in ORS Chapter 696 and its implementing rules.

(2) The Agency's administrative proceeding determinations are not subject to this rule's notification requirements.

(3) The notification required by this rule must be in writing and must include a brief description of the circumstances involved, the names of the parties, and a copy of the adverse decision, judgment, or award and, in the case of a criminal conviction, a copy of the sentencing order. If any such judgment, award, or decision is appealed, each subsequent appellate court decision is subject to this rule's notification requirements.

(4) The notification required by this rule must be made within twenty 20 calendar days after receiving written notification of an adverse judgment, award, or decision described in this rule. Notification must be made under this rule whether or not the decision is appealed.

(5) Arbitration proceedings between licensees concerning only a commission payment dispute are not subject to this rule's notification requirements.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.301(26) & (31)
Hist.: REC 23, f. 7-3-69, ef. 9-1-69; REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1981, f. 10-30-81, ef. 11-1-81; REA 1-1997, f. 4-28-97, cert. ef. 5-5-97; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0120; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0186
Clients' Trust Accounts — Disbursal of Disputed Funds

(1) A sole practitioner or principal real estate broker may disburse disputed funds in a clients' trust account using the procedures in this rule or may disburse funds in a clients' trust account under the terms of a lawful contractual agreement, by law, or under the provisions of ORS Chapter 696, Chapter 105, or OAR 863-025-0025.

(2) For purposes of ORS 696.241(10) and this rule, "disputed funds" are funds in a clients' trust account delivered by a person to a sole practitioner or principal real estate broker pursuant to a written contract and the parties to such contract dispute the disbursal of the funds.

(3) As soon as practicable after receiving a demand by one of the parties for the disbursal of funds in a clients' trust account, the sole practitioner or principal real estate broker must deliver written notice to all parties that a demand has been made for disbursal of the funds, and that such funds may be disbursed to the party who delivered the funds within 20 calendar days of the date of the demand.

(4) The written notice must include substantially the following information:

(a) A party has made a demand for disbursal of funds, and the sole practitioner or principal real estate broker may disburse such funds from the clients' trust account to the party who delivered the funds, unless:

(A) The parties enter into a written agreement regarding disbursal of the funds and deliver such agreement to the sole practitioner or principal real estate broker within 20 calendar days of the date of the demand for disbursal; or

(B) A party provides proof to the sole practitioner or principal real estate broker that the party has filed a legal claim to such funds within 20 calendar days of the date of the demand for disbursal;

(b) The sole practitioner or principal real estate broker has no legal authority to resolve questions of law or fact regarding disputed funds in a clients' trust account;

(c) The disbursal of the funds from the clients' trust account to the party who delivered the funds will end the responsibility of the sole practitioner or principal real estate broker to account for the funds but will not affect any right or claim a person may have to such funds; and

(d) Both parties may wish to seek legal advice on the matter.

(5) Regardless of whether a party disputes the disbursal of funds as outlined in this rule, if the parties have not entered into a written agreement regarding such disbursal, or if a party has failed to provide proof of filing a legal claim, the sole practitioner or principal real estate broker may disburse the disputed funds to the person who delivered the funds within 20 calendar days of the date of the demand for disbursal.

(6) Nothing in this rule prevents a sole practitioner or principal real estate broker from disbursing such funds pursuant to:

(a) The terms of the original contract between the parties;

(b) Any subsequent agreement between the parties regarding the disbursal of funds; or

(c) The requirements of law.

(7) Nothing in this rule prevents the broker from filing an action to interplead the disputed funds.

(8) Real estate licensees with property management clients' trust accounts must review and follow the requirements for handling client funds under the Residential Landlord and Tenant statutes in ORS Chapter 90. For any other non-real estate sales transaction disputes, the sole practitioner or principal real estate broker must review the terms of the written contract for handling disputed funds.

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.241 & 696.396 696.810, 696.990 & 696.800 - 696.855
696.810, 696.990 & 696.800 - 696.855

Hist.: REA 4-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-29-06; REA 1-2006, f. 6-29-06, cert.ef. 6-30-06; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0188
Compensation Agreements

Pursuant to ORS 696.582, only a sole practitioner or principal real estate broker may enter into a compensation agreement with a principal to a real estate transaction.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.290 & 696.582
Hist: REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0190
Competitive Market Analyses; Letter Opinions; Lending Collateral Analysis; Default Collateral Analysis

(1) Real estate licensees may provide competitive market analyses and letter opinions in the normal course of their business when they are giving an opinion in pursuit of a listing, to assist a potential buyer in formulating an offer, or to provide a broker's price opinion, whether or not done for a fee.

(2) The term "value" as used in a competitive market analysis or letter opinion is the estimated worth of or price for a specific property and is not intended to mean or imply the "value" was arrived at by any method of appraisal.

(3) A competitive market analysis or letter opinion must be in writing and contain at least the following:

(a) A statement of purpose and intent;

(b) A brief property description;

(c) The basis for the value, including the applicable market data and/or capitalization computation;

(d) Any limiting conditions;

(e) A disclosure of any existing or contemplated interest of the licensee in the subject property;

(f) The licensee's signature and the date it was prepared;

(g) A disclaimer that, unless the licensee is also licensed by the Appraiser Certification and Licensure Board, the report is not intended to meet the requirements set out in the Uniform Standards of Appraisal Practice; and

(h) A disclaimer that the competitive market analysis or letter opinion is not intended as an appraisal and that if an appraisal is desired, the services of a competent professional licensed appraiser should be obtained.

(4) Real estate licensees can provide a "lending collateral analysis" or "default collateral analysis," if the analysis is used only for the internal purposes of a financial institution and, in the case of a "lending collateral analysis," that any loan transaction at issue is less than $250,000.

(a) "Lending collateral analysis" means a real property market analysis where the purpose of the analysis is for use by a lending institution in support of a loan application.

(b) "Default collateral analysis" means a real property market analysis where the purpose of the analysis is for use by a lending institution in considering its actions with respect to a loan in default

(5) If a real estate broker completes a lending collateral analysis or default collateral analysis on a property in which the real estate broker or principal real estate broker has either a current, active listing agreement or is representing the buyer or seller in a pending transaction, the real estate broker must disclose to the buyer and seller the real estate broker's relationships with the lending institution.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.010(8) & (10)
Hist.: REA 4-1997, f. 11-24-97, cert. ef. 12-1-97; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0270; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0200
Agency Relationships

(1) Unless the parties expressly agree to a different relationship not otherwise prohibited by law, the types of agency relationships a real estate licensee may establish in a real estate transaction are limited to the following:

(a) An agency relationship between a real estate licensee and the seller exclusively;

(b) An agency relationship between a real estate licensee and the buyer exclusively;

(c) A disclosed limited agency relationship where one or more real estate licensees associated with the same principal broker represents both the seller and the buyer in the same real estate transaction;

(d) A disclosed limited agency relationship where real estate licensees associated with the same principal broker are designated to represent, respectively, the buyer exclusively and the seller exclusively;

(e) A disclosed limited agency relationship where one or more real estate licensees associated with the same principal broker represent more than one buyer in the same real estate transaction.

(2) Unless the parties expressly agree to a different relationship not otherwise prohibited by law:

(a) A licensee representing a seller by written agreement or course of conduct establishes an agency relationship under sections (1)(a) or (d) above;

(b) A licensee representing a buyer by written agreement or course of conduct establishes an agency relationship under sections (1)(b) or (d) above;

(c) A licensee representing both a buyer and a seller or two or more buyers in the same real estate transaction is a disclosed limited agent of both the buyer and seller or all buyers under sections (1)(c) or (e) above,

(3) When an agency relationship is formed between a real estate licensee and a client under section (2) above, the following apply:

(a) The principal broker with whom the licensee is associated is the client's disclosed limited agent;

(b) In a real estate transaction in which different real estate licensees associated with the same principal broker establish agency relationships with different parties to the real estate transaction, the principal broker is the only disclosed limited agent of both parties; and

(c) In a real estate transaction in which one or more real estate licensees associated with the same principal broker establish agency relationships with more than one party to the real estate transaction, those licensees and the principal broker are the only disclosed limited agents of those parties.

(4) Except as provided in sections (2) and (3) above, licensees associated with the same real estate business are not agents of all clients of the real estate business.

(5) Payment, or promise of payment, of a real estate commission or other fee does not by itself create an agency relationship.

(6) A principal real estate broker acting as a disclosed limited agent under section (3) above must do each of the following:

(a) Supervise the licensees associated with the principal broker in fulfilling their duties and obligations to their respective clients;

(b) Avoid advocating on behalf of either the seller or the buyer; and

(c) Avoid disclosing or using, without permission, confidential information of any client with whom the principal broker has an agency relationship.

(7) Real estate licensees associated with a principal broker who is acting as a disclosed limited agent under section (3) above must do both of the following:

(a) Serve as the agent of only the party or parties in the transaction with whom the real estate licensee has established an agency relationship; and

(b) Fulfill the duties owed to the respective client as set forth in the ORS 696.815 and as agreed in a disclosed limited agency agreement entered into pursuant to OAR 863-015-0210.

(8) All real estate licensees associated with a principal broker who are acting as disclosed limited agents under section (2) above must refrain from disclosing or using any confidential information relating to the other party that has been acquired as a result of the licensee's association with the principal broker, unless authorized to do so by that party.

(9) Nothing in this rule prohibits licensees from disclosing or using factual, non-confidential information relating to all parties to a transaction in order to fulfill a licensee's duties to the client under ORS 696.815.

(10) If a principal real estate broker acting as a disclosed limited agent under section (3) above determines that confidential information of one principal to a transaction has become known to another client in the transaction as the result of a violation of this rule, the principal broker must promptly and fully disclose the violation to the affected client in writing.

(11) Affirmative duties under ORS 696.805 and 696.810, where appropriate, apply to the agents, principal, other principals, and the principals' agents. The duties do not, however, create fiduciary or other similar duties inconsistent with the actual legal relationship between an agent and other principals to a transaction or that principal's agents.

(12)(a) The Final Agency Acknowledgement of the agency relationships described in this rule and required by ORS 696.845 must be printed in substantially the following form:

FINAL AGENCY ACKNOWLEDGEMENT

Both Buyer and Seller acknowledge having received the Oregon Real Estate Agency Disclosure Pamphlet, and hereby acknowledge and consent to the following agency relationships in this transaction:

(1)_____(Name of Selling Licensee) of _____ (Name of Real Estate Firm) is the agent of (check one) __ The Buyer exclusively. __ The Seller exclusively (Seller Agency"). __ Both the Buyer and the Seller ("Disclosed Limited Agency").

(2) _____ (Name of Listing Licensee) of _____ (Name of Real Estate Firm) is the agent of (check one) __ The Seller exclusively. __ Both the Buyer and the Seller ("Disclosed Limited Agency").

(3) If both parties are each represented by one or more licensees in the same real estate firm, and the licensees are supervised by the same principal broker in that real estate firm, Buyer and Seller acknowledge that said principal broker shall become the disclosed limited agent for both Buyer and Seller as more fully explained in the disclosed Limited Agency Agreements that have been reviewed and signed by Buyer, Seller and Licensee(s).

Buyer shall sign this acknowledgment at the time of signing this Agreement before submission to Seller. Seller shall sign this acknowledgment at the time this Agreement is first submitted to Seller, even if this Agreement will be rejected or a counter offer will be made. Seller's signature to this Final Agency Acknowledgment shall not constitute acceptance of the Agreement or any terms therein.

ACKNOWLEDGED

Buyer: _____ Print _____Dated: _____

Buyer: _____ Print _____Dated: _____

Seller: _____ Print _____Dated: _____

Seller: _____ Print _____Dated: _____

(b) If incorporated as a part of a preprinted agreement, the Final Agency Acknowledgement required by subsection (a) shall appear at the top of the first page of the preprinted agreement, separate and apart from the sale agreement and shall be signed separately from the sale agreement. If the Final Agency Acknowledgement required by subsection (a) is not included within a preprinted agreement, the Final Agency Acknowledgement shall also include the property address or legal description of the subject property, a reference to the attached sale agreement, and shall include separate signature lines for buyers and sellers.

Stat. Auth.: ORS 696.385 & 183.335

Stats. Implemented: ORS 696.805, 696.810 & 696.815

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 4-2003(Temp), f. 12-18-03, cert. ef. 1-1-04 thur 6-29-04; REA 3-2004, f. 4-28-04 cert. cr. 5-3-04; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0205

Disclosed Limited Agency

(1) Licensees must establish the agency relationships described in OAR 863-015-0200(1) only by written agreement. Such agreements must meet all the requirements of 863-015-0210.

(2) A disclosed limited agency relationship exists when a single licensee undertakes by written agreement or conduct to represent more than one party to a real estate transaction. For the purpose of this rule, two or more buyers are involved in the same real estate transaction when all have submitted offers on the same real property.

(3) Except as provided for in section (5), a disclosed limited agency relationship exists when two or more licensees supervised by the same principal broker undertake by written agreement or conduct to represent more than one party to a real estate transaction. Notwithstanding the other provisions of this rule, individual agents may be designated to represent the buyer exclusively or the seller exclusively as described in OAR 863-015-0200(1).

(4) The following conditions apply to the disclosed limited agency relationship described in OAR 863-015-0200(1):

(a) The principal broker with whom the licensee is associated must ensure that a licensee who represents one client will not have access to and will not obtain confidential information concerning another client involved in the same transaction;

(b) In situations where a real estate business has two or more principal brokers, each principal broker must be the disclosed limited agent of all clients in the transaction, unless each of the following conditions is met:

(A) The principal brokers have entered into a written agreement dividing control and supervision responsibilities. Principal brokers may comply with subsection (a) above by holding open records of real estate activity in different offices or by otherwise initiating procedures that secure open records so as to prevent licensees representing different parties to the same transaction from accessing or obtaining confidential information concerning another party to the transaction;

(B) The licensees designated to represent the seller exclusively and the buyer exclusively are associated with the same principal broker. If the principal broker has an existing agency relationship with one party to the transaction (either as a seller's agent or buyer's agent), the principal broker, pursuant to the requirements of OAR 863-015-0210, must act as the disclosed limited agent of both parties, and another licensee must be designated to represent the other party exclusively; and

(C) Each client to the transaction has signed a disclosed limited agency agreement that indicates which principal broker will act as the disclosed limited agent in the transaction.

(5) If principal brokers have entered into a written agreement dividing control and supervision responsibilities and have individually complied with subsection (4)(a) above by holding open records of real estate activity in different offices or by otherwise initiating procedures that secure open records in such a way as to prevent licensees representing different parties to the same transaction from accessing or obtaining confidential information concerning another principal in the transaction, then a transaction involving agents associated with different principal brokers is not a disclosed limited agency transaction.

Stat. Auth.:ORS 696.385 & 183.335

Stats. Implemented:ORS 696.805, 696.810 & 696.815

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0210

Disclosed Limited Agency Agreement

(1) Disclosed limited agency agreements required by ORS 696.815 must be in writing, signed and dated by the parties to be bound or by their duly appointed real estate agents.

(2) Each disclosed limited agency agreement must contain the following:

(a) The name under which the representation will take place, which must be the registered business name or, if none, the licensed name of the principal broker or sole practitioner;

(b) Identification of any existing listing or service agreement between the parties to the disclosed limited agency agreement;

(c) The name(s) of the licensee(s), including the principal real estate broker, who will represent the client; and

(d) A plain language description of the requirements of ORS 696.815;

(e) Full disclosure of the duties and responsibilities of an agent who represents more than one party to a real estate transaction. This requirement can be met by providing the client with a copy of the initial agency disclosure pamphlet required by ORS 696.820, discussing the portion of the pamphlet entitled "Duties and Responsibilities of an Agent Who Represents More that One Party to a Transaction" with the client, and incorporating the pamphlet into the disclosed limited agency agreement by reference; and

(f) Consent and agreement between the parties to the disclosed limited agency agreement regarding representation of the client in future transactions.

(3) Use of a disclosed limited agency agreement for sellers in substantially the following form is prima facie evidence of compliance with sections (1) and (2) of this rule:

Property Address _____

Addendum to Listing Agreement Dated _____

Real Estate Firm _____

DISCLOSED LIMITED AGENCY AGREEMENT FOR SELLER

The Parties to this Disclosed Limited Agency Agreement are:

Listing Agent (print) _____

Listing Agent's Principal Broker (print) _____

Seller (print) _____

Seller (print) _____

The Parties to this Agreement understand that Oregon law allows a single real estate agent to act as a disclosed limited agent -- to represent both the seller and the buyer in the same real estate transaction, or multiple buyers who want to purchase the same property. It is also understood that when different agents associated with the same principal broker (the broker who directly supervises the other agents) establish agency relationships with the buyer and seller in a real estate transaction, the agents' principal broker shall be the only broker acting as a disclosed limited agent representing both seller and buyer. The other agents shall continue to represent only the party with whom they have an established agency relationship, unless all parties agree otherwise in writing.

In consideration of the above understanding, and the mutual promises and benefits exchanged here and in the Listing Agreement, the Parties now agree as follows:

1. Seller acknowledge they have received the initial agency disclosure pamphlet required by ORS 696.820 and have read and discussed with the Listing Agent that part of the pamphlet entitled "Duties and Responsibilities of an Agent Who Represents More than One Party to A Transaction." The initial agency disclosure pamphlet is hereby incorporated into this Disclosed Limited Agency Agreement by reference.

2. Seller, having discussed with the Listing Agent the duties and responsibilities of an agent who represents more than one party to a transaction, consent and agree as follows:

a. The Listing Agent and the Listing Agent's Principal Broker, in addition to representing Seller, may represent one or more buyers in a transaction involving the listed property;

b. In a transaction involving the listed property where the buyer is represented by an agent who works in the same real estate business as the Listing Agent and who is supervised by the Listing Agent's Principal Broker, the Principal Broker may represent both Seller and Buyer. In such a situation, the Listing Agent will continue to represent only the Seller and the other agent will represent only the Buyer, consistent with the applicable duties and responsibilities as set out in the initial agency disclosure pamphlet; and

c. In all other cases, the Listing Agent and the Listing Agent's Principal Broker shall represent Seller exclusively.

Seller signature _____

Date _____

Seller signature _____

Date _____

Listing Agent signature _____

Date _____

(On their own and on behalf of Principal Broker)

Broker initial and review date_____

(4) Use of a disclosed limited agency agreement for buyers in substantially the following form is prima facie evidence of compliance with sections (1) and (2) of this rule.

Property Address _____
Addendum to Buyer Service Agreement Dated _____
Real Estate Firm _____
DISCLOSED LIMITED AGENCY AGREEMENT FOR BUYER
The Parties to this Disclosed Limited Agency Agreement are:
Buyer's Agent (print) _____
Buyer's Agent's Principal Broker (print)_____
Buyer (print) _____
Buyer (print) _____
The Parties to this Agreement understand that Oregon law allows a single real estate agent to act as a disclosed limited agent — to represent both the seller and the buyer in the same real estate transaction, or multiple buyers who want to purchase the same property. It is also understood that when different agents associated with the same principal broker (the broker who directly supervises the other agents) establish agency relationships with the buyer and seller in a real estate transaction, the agents' principal broker shall be the only broker acting as a disclosed limited agent representing both seller and buyer. The other agents shall continue to represent only the party with whom they have an established agency relationship, unless all parties agree otherwise in writing.
In consideration of the above understanding, and the mutual promises and benefits exchanged here and, if applicable, in the Buyer Service Agreement, the Parties now agree as follows:
1. Buyer(s) acknowledge they have received the initial agency disclosure pamphlet required by ORS 696.820 and have read and discussed with the Buyer's Agent that part of the pamphlet entitled "Duties and Responsibilities of an Agent Who Represents More than One Party to A Transaction." The initial agency disclosure pamphlet is hereby incorporated into this Disclosed Limited Agency Agreement by reference.
2. Buyer(s), having discussed with Buyer's Agent the duties and responsibilities of an agent who represents more than one party to a transaction, consent and agree as follows:
a. Buyer's Agent and the Buyer's Agent's Principal Broker, in addition to representing Buyer, may represent the seller or another buyer in any transaction involving Buyer;
b. In a transaction where the seller is represented by an agent who works in the same real estate business as the Buyer's Agent and who is supervised by the Buyer's Agent's Principal Broker, the Principal Broker may represent both seller and Buyer. In such a situation, the Buyer's Agent will continue to represent only the Buyer and the other agent will represent only the Seller, consistent with the applicable duties and responsibilities set out in the initial agency disclosure pamphlet;
c. In all other cases, the Buyer's Agent and the Buyer's Agent's Principal Broker shall represent Buyer exclusively.
Buyer signature_____
Date _____
Buyer signature _____
Date _____
Buyer's Agent signature_____
Date _____
(On their own and on behalf of Principal Broker)
Broker initial and review date_____
Stat. Auth.: ORS 696.385 & 183.335
Stat. Implemented: ORS 696.805, 696.810 & 696.815
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0215
Initial Agency Disclosure Pamphlet

(1) An agent must provide a copy of the Initial Agency Disclosure Pamphlet provided for in section (3) of this rule at first contact with each represented party to a real property transaction.

(2) An agent need not provide a copy of the Initial Agency Disclosure Pamphlet to a party who has, or may be reasonably assumed to have, already received a copy of the pamphlet from another agent.

(3) The Initial Agency Disclosure Pamphlet must be printed in substantially the following form: [Form not included. See ED. NOTE.]

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 696.385, 696.820 & 183.335
Stats. Implemented: ORS 696.805, 696.810 & 696.815
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0250
Professional Real Estate Activity Records

(1) Complete and adequate records of professional real estate activity include complete, legible, and permanent copies of all documents required by law or voluntarily generated during a real estate transaction, including all offers received by or through brokers or principal brokers to the client, including, but not limited to, the following:

(a) A copy of any written agreement creating an agency relationship between a real estate broker or principal real estate broker and a client that must be signed by all parties to the agreement.

(b) A copy of any written acknowledgment of an agency relationship between a real estate broker or principal real estate broker and a client that must be signed by all parties to such acknowledgment.

(c) A copy of any written agreement for the listing, sale, purchase, rental, lease, lease option, or exchange of real property generated by a real estate broker or principal real estate broker while engaging in professional real estate activity that must be signed by all parties to such agreement.

(d) A copy of any receipt issued by a real estate broker or principal real estate broker to evidence acceptance of funds or documents.

(e) A copy of any vouchers or bills or obligations paid by the real estate broker or principal real estate broker for the account of a client or customer.

(f) A copy of any other document within the scope of the agency relationship provided to or received by a client through a real estate broker or principal real estate broker during the term of an agency relationship.

(g) All financial records as required in OAR 863-015-0255 and 863-015-0275.

(2) In any real estate transaction in which a principal real estate broker or a sole practitioner performed the closing, the principal real estate broker or sole practitioner must retain a copy of any closing statement showing a receipts, disbursements and adjustments, which must evidence the signature of the seller(s) and the buyer(s).

Stat. Auth.: ORS 696.385 & 183.335
Stats. Implemented: ORS 696.280
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0255
Clients' Trust Account Records Requirements and Document Transmittal Requirements

(1) This rule applies to clients' trust fund accounts that hold funds from transactions involving the sale, purchase, lease option, or exchange of real property. The purpose of clients' trust accounts is to preserve clients' monies and keep them segregated from the broker's general and personal funds.

(2) Principal brokers and sole practitioners must retain and store the records described in this rule as required by OAR 863-015-0250 and 863-015-0260. However, where separate general business or clients' trust accounts or both are maintained at branch offices, the financial records described in this rule may be maintained and located either at the principal broker's or sole practitioner's main office or, if the principal real estate principal broker, sole practitioner, or branch office manager conducts the real estate business from that branch office, at that branch office.

(3) A real estate broker must transmit to the real estate broker's principal real estate broker within three banking days of receipt any money, checks, drafts, warrants, promissory notes, or other consideration and any documents received by the licensee in any professional real estate activity in which the licensee is engaged. Absent the buyer's written instructions to the contrary, the real estate broker must transmit all earnest monies to the principal real estate broker within three banking days of receipt.

(4) If a real estate broker, principal broker, or sole practitioner receives a check as earnest money in a transaction, he or she may hold the check undeposited until the offer is accepted or rejected, provided that the written sale agreement states that the real estate broker, principal broker, or sole practitioner is holding the check undeposited and further states where and when the check will be deposited upon acceptance of the offer.

(5) The real estate broker, principal broker, or sole practitioner must deposit a check held pursuant to section (4) into a clients' trust account established under ORS 696.241 or transmit the check to a neutral escrow depository located within this state before the close of the third banking day following acceptance of the offer or a subsequent counter offer. The principal broker or sole practitioner must track the earnest money deposit from the buyer to the principal broker or sole practitioner and to the escrow depository.

(6) All other funds, whether in the form of money, checks, drafts, or warrants belonging to others and accepted by any real estate broker, principal broker, or sole practitioner while engaged in professional real estate activity, must be deposited before the close of business of the fifth banking day following the date the real estate broker, principal broker, or sole practitioner receives the funds into a neutral escrow depository located within this state or into a clients' trust account established under ORS 696.241. The principal broker or sole practitioner must retain a copy of each executed agreement required under 696.241 and OAR 863-015-0265 for interest-bearing clients' trust accounts.

(7) For all funds received under sections (3) and (4) of this rule, the principal broker, and sole practitioner must comply with the following requirements:

(a) Account for all funds received;

(b) Maintain a copy of any check received; and

(c) Maintain a dated, acknowledged receipt for any check returned to the offeror.

(8) Every deposit made under ORS 696.241, must be made with deposit slips identifying each offer or transaction by a written notation of the file reference assigned to the offer or transaction.

(9) Principal brokers and sole practitioners must maintain a complete ledger account and record all funds received in their professional real estate activity. This ledger account must show:

(a) From whom the funds were received;

(b) The date the funds were received;

(c) The date the funds were deposited;

(d) Where the funds were deposited; and

(e) When the transaction has been completed or the offer has failed, the final disposition of the funds.

(10) If a real estate licensee is a principal in an offer or transaction, all earnest money or other deposits must be handled as provided in OAR 863-015-0145.

(11) Checks used to disburse funds from a clients' trust account must be pre-numbered, issued from one numbering sequence, and bear the words "Clients' Trust Account" upon the face thereof. Principal brokers and sole practitioners must account for all checks, including voided checks, as a part of the records they maintain.

(12) Principal brokers and sole practitioners must record and track the transfer of promissory notes and other forms of consideration by a ledger account or by other means including, but not limited to, written proof of transmittal or receipt retained in their offer or transaction file.

(13) If a principal broker or sole practitioner accepts a credit card payment as funds in a real estate transaction:

(a) The face amount of the credit card payment, without reducing the face amount by any merchant's discount and processing fee charged to the principal broker or sole practitioner, is the amount he or she must maintain, use, and refund as necessary; or

(b) The face amount of the credit card payment, reduced by any merchant's discount and processing fee, may be maintained and used by the principal broker or sole practitioner when he or she has a separate written agreement signed by the credit card user authorizing this reduction. The face amount, including any merchant's discount and processing fees paid by the credit card user, must be refunded to the credit card user when a refund is necessary;

(c) The principal broker or sole practitioner may not benefit from any of the merchant's discounts or processing fees generated by the use of a credit card;

(d) A principal broker's or sole practitioner's clients' trust account may not be charged or debited for any merchant's discount or processing fees for use of the credit card in such transaction.

(14) All funds deposited into a clients' trust account established under ORS 696.241 and not disbursed or transferred to a neutral escrow depository pursuant to the sale agreement may only be disbursed:

(a) To individuals, as directed by order of court of competent jurisdiction;

(b) To individuals, as directed in writing by one or more principals; or

(c) To the court, upon filing by the principal broker or sole practitioner of an interpleader action for disputed earnest money funds.

(15) A principal broker or sole practitioner may not use any form of debit card on clients' trust accounts.

Stat. Auth.: ORS 696.385 & 183.335

Stats. Implemented: ORS 696.221, 696.241, 696.280 & 696.301(10)

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0260

Records Retention

(1) Principal real estate brokers and sole practitioners must maintain and store complete and accurate records of professional real estate activity, including any items generated through e-mail or other electronic means, pursuant to ORS 696.280 and as follows:

(a) Records of professional real estate activity may be stored at the principal broker's main office, and records of professional real estate activity originating at a branch office may be maintained and stored at either that branch office or at the principal broker's main office.

(b) A principal real estate broker or sole practitioner may store records of professional real estate activity in a single location other than his or her office, main office, or branch office, in which the records are readily available for inspection, if the principal real estate broker or sole practitioner first:

(A) Notifies the commissioner in writing of the intended removal of such records, includes the address of the new location for such records, and

(B) Authorizes the commissioner in writing to inspect such records at the new location. Such authorization must include the name of any necessary contact and the means of gaining access to the records for an inspection. The principal real estate broker or sole practitioner must notify the commissioner of any change in the contact or means of access within ten days after such change occurs.

(2) A principal real estate broker or sole practitioner must maintain at the broker's office a means of viewing copies of documents or records. A principal real estate broker or sole practitioner must provide, at his or her expense, a paper copy of any document or record the Agency requests.

(3) A principal real estate broker or sole practitioner may use electronic image storage media to retain and store copies of all listings, deposit receipts, canceled checks, clients' trust account records, and other documents executed by him or her or obtained by him or her in connection with any professional real estate activity transaction under the following conditions:

(a) The electronic image storage must be nonerasable "write once, read many" ("WORM") that does not allow changes to the stored document or record;

(b) The stored document or record is made or preserved as part of and in the regular course of business;

(c) The original record from which the stored document or record was copied was made or prepared by the principal broker, sole practitioner, or their employees at or near the time of the act, condition, or event reflected in the record;

(d) The custodian of the record is able to identify the stored document or record, the mode of its preparation, and the mode of storing it on the electronic image storage;

(e) The electronic image storage media contains a reliable indexing system that provides ready access to a desired document or record, appropriate quality control of the storage process to ensure the quality of imaged documents or records, and date-ordered arrangement of stored documents or records to ensure a consistent and logical flow of paperwork to preclude unnecessary search time; and

(f) At least once each month, the broker backs up any data that is stored in the computerized system necessary to produce the records. The back up data must be retained for no less than 60 days and must be made available to the commissioner or to the commissioner's authorized representatives on demand.

Stat. Auth.: ORS 696.385 & 183.335

Stats. Implemented: ORS 696.280

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0265

Interest-Bearing Accounts

(1) The written approval necessary to establish a federally insured interest-bearing clients' trust account must specify to whom and under what circumstances the interest earnings from the account will accrue and be paid.

(2) In a transaction subject to ORS 696.241(5), the broker's interest in or receipt of any of the trust funds or interest earnings in the account is not a violation of 696.241(9).

(3) In a transaction subject to ORS 696.241(5), money belonging to others may not be invested in any type of account or security or certificate of deposit that has a fixed term for maturity or imposes any fee or penalty for withdrawal before maturity unless the written consent of all parties to the transaction has been secured. An arrangement may be made with a depository to deposit a sufficient amount of the broker's funds to maintain such account, and such arrangement is not a violation of 696.241(9).

Stat. Auth.: ORS 183.335 & 696.385

Stats. Implemented: ORS 696.241(5) & 696.301(10)

Hist.: REC 3-1978, f. 6-15-78, ef. 7-1-78; REC 1-1981, f. 10-30-81, ef. 11-1-81; REC 5-1984, f. 6-18-84, ef. 7-1-84; REA 3-1987, f. 12-3-87, ef. 1-1-88; REA 3-1989, f. 12-13-89, cert. ef. 2-1-90; REA 2-1991, f. 11-5-91, cert. ef. 1-1-92; REA 4-1997, f. 11-24-97, cert. ef. 12-1-97; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0026; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

863-015-0275

Clients' Trust Account Reconciliation and Records

A principal real estate broker or sole practitioner must reconcile each clients' trust account at least once each month. The reconciliation must comply with all of the following conditions:

(1) The reconciliation must have three components:

(a) The bank statement balance, adjusted for outstanding checks and other reconciling bank items;

(b) The balance of the receipts and disbursements journal or check book register as of the bank statement closing date; and

(c) The sum of all the balances of the individual trust account ledgers as of the bank statement closing date.

(2) The balances of each component of the reconciliation must be equal to and reconciled with each other. If any adjustment is needed, the adjustment must be clearly identified and explained.

(3) The principal broker or sole practitioner must verify, sign, and date the reconciliation when completed.

(4) Outstanding checks must be listed by check number, issue date, payee, and amount.

(5) The principal broker or sole practitioner must preserve and file in logical sequence the reconciliation worksheet, bank statements, and all supporting documentation, including but not limited to, copies of the receipts and disbursements journal or check book register and a listing of each individual clients' trust fund account with a balance as of the reconciliation date. If these records are computerized, they must be printed out for filing with the reconciliation.

(6) All reconciling items must be identified and cleared promptly.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.280
Hist.: REA 3-1989, f. 12-13-89, cert. ef. 2-1-90; REA 1-1992, f. 1-13-92, cert. ef. 2-1-92; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0245; REA 6-2008, f. 12-15-08, cert. ef. 1-1-09

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Rule Caption: Create a new division and update existing licensing rules for property managers.
Adm. Order No.: REA 7-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Adopted: 863-024-0000, 863-024-0003, 863-024-0005, 863-024-0010, 863-024-0015, 863-024-0020, 863-024-0030, 863-024-0050, 863-024-0055, 863-024-0060, 863-024-0061, 863-024-0062, 863-024-0063, 863-024-0065, 863-024-0070, 863-024-0075, 863-024-0076, 863-024-0085, 863-024-0095, 863-024-0100
Rules Ren. & Amend: 863-015-0045 to 863-024-0045
Subject: This division and the rules under this notice are all new rules except or one renumbered rule. Real estate property manager licensing rules were moved ("renumbered") from division 15 to this new division to help applicants, licensees and the Agency more easily find and use licensing rules. These rules only cover licensing requirements for real estate property managers. Renumbered rules were amended to provide clarity. New rules were added for application and purpose of the division and for definitions.
Rules Coordinator: Laurie Skillman—(503) 378-4630

863-024-0000
Application and Purpose

(1) This division sets forth the requirements and process for licensing real estate property managers, as that term is defined in ORS 696.010.

(2) The purpose of this division is to specify the requirements for obtaining a real estate property manager license.

Stat. Auth.: ORS 696.385
Stat. Implemented:
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0003
Definitions

As used in this division, unless the context requires otherwise, the following definitions apply to this division:

(1) "Agency" is defined in ORS 696.010.

(2) "Board" means the Real Estate Board established pursuant to ORS 696.405.

(3) "Branch office" is defined in ORS 696.010.

(4) "Commissioner" is defined in ORS 696.010.

(5) "Licensed Name" means the name of a real estate licensee as it appears on the current, valid real estate license issued to the licensee pursuant to ORS 696.020.

(6) "Management of rental real estate" is defined in ORS 696.010.

(7) "Principal broker" means "principal real estate broker," as defined in ORS 696.010.

(8) "Property manager" means "real estate property manager," as defined in ORS 696.010.

(9) "Real estate activity," "professional real estate activity," and "real estate business" mean "professional real estate activity" as defined in ORS 696.010, which includes managing rental real estate.

(10) "Real estate broker" is defined in ORS 696.010.

(11) "Real estate licensee" and "licensee" mean a "real estate licensee" as defined in ORS 696.010.

(12) "Registered business name" is defined in ORS 696.010.

(13) "Sole Practitioner" is defined in ORS 696.010. A sole practitioner engages in professional real estate activity under the individual's licensed name or under a registered business name.

Stat. Auth.: ORS 696.385
Stat. Implemented: ORS 696.010 & 696.020
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0005
Education

(1) The required courses of study for a property manager's license must be designed pursuant to the Guidelines for Oregon Private Real Estate Schools and Instructional Guidelines and approved by the commissioner.

(2) The commissioner may at any time reevaluate an approved course or instructor. If the commissioner finds there is basis for consideration of revocation of the approved course or the instructor, the commissioner shall give notice by ordinary mail to the coordinator of that provider or instructor of a hearing on the possible revocation of an approved course at least 20 days prior to the hearing.

(3) The commissioner may deny or revoke approval of a program, course, activity, or instructor, but that decision may be appealed to the commissioner within 20 days of the date of mailing the notice of denial or revocation and is subject to the contested case hearing provisions of the Oregon Administrative Procedures Act, ORS Chapter 183.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0010
License Application Form and Content

(1) Applicants for a property manager's license must submit a license application in writing on an Agency-approved form with all information provided by the applicant and verified by the applicant.

(2) The license application must contain:

(a) The applicant's legal name, mailing address, and phone number;

(b) If the applicant is to be associated with a principal real estate broker, the name of the principal real estate broker who will supervise the applicant's professional real estate activity;

(c) The place or places, including the street and number, city, and county where the business will be conducted; and

(d) If the applicant will be associated with a principal real estate broker, the principal broker's authorization for the applicant to use the principal broker's registered business name.

(3) Every license application must be accompanied by the license fee authorized by ORS 696.270. At all periods of the year, the fee for all licenses issued is as authorized by 696.270. That is, the Agency does not pro-rate license fees.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0015
Background Check Application and Fingerprint Card

(1) Applicants for a property manager license must submit to a background check, except applicants who are currently licensed as a real estate broker, sole practitioner, or principal real estate broker or who are eligible for renewal of such licenses. The background check includes a criminal background check as provided in OAR chapter 863, division 005. The applicant must apply for the background check in writing on an Agency-approved form with all information provided by the applicant and verified by the applicant.

(2) The background check application must include, but is not limited to, the following information:

(a) The applicant's legal name, residence address, and telephone number;

(b) The applicant's date and place of birth;

(c) The applicant's Social Security Number;

(d) Whether the applicant:

(A) Has ever been convicted of or is under arrest, investigation, or indictment for a felony or misdemeanor;

(B) Has ever been refused a real estate license or any other occupational or professional license in any other state or country;

(C) Has ever had a real estate or any other occupational or professional license revoked or suspended; or

(D) Has ever been fined or reprimanded as such a licensee; and

(e) Any other information the commissioner considers necessary to evaluate the applicant's trustworthiness and competency to engage in the management of rental real estate in a manner that protects the public interest.

(3) As part of any application submitted under section (2) of this rule, the applicant must submit one completed fingerprint card on the form prescribed by the Oregon State Police and FBI and an additional fee sufficient to recover the costs of processing the applicant's fingerprint information and securing any criminal offender information pertaining to the applicant.

(4) The Agency must receive the background check application, fingerprint card, and processing fee before it will issue a license.

(5) As provided in ORS 181.540, all fingerprint cards, photographs, records, reports, and criminal offender information obtained or compiled by the Agency are confidential and exempt from public inspection. The commissioner will keep such information segregated from other information on the applicant or licensee and maintain such information in a secure place.

(6) If the Agency determines that additional information is necessary in order to process the application, the Agency may request such information in writing, and the applicant must provide the requested information in order to complete the application. If the applicant fails to provide the requested information, the Agency may determine that the application is incomplete, which will result in termination of the application.

(7) An applicant who has otherwise qualified for licensing may not be considered for any real estate license until the background check process and review has been completed, including but not limited to the Agency's receipt of criminal offender information from the Oregon State Police, other regulatory or law enforcement agencies, and the FBI. If an individual who has had a successfully completed background check process and review does not successfully complete the remaining portions of the entire licensing application process within twelve months from the date of the successfully completed background check process and review, the successfully completed background check process and review is no longer valid.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0020
Examinations

(1) In addition to any other licensing eligibility requirements, a property manager license applicant must apply for and pass a property manager examination that includes subject matter determined by the Board.

(2) An applicant may apply for an examination whether or not the Agency has finished processing the applicant's fingerprint card and background check or has received documentation on the applicant's licensing educational courses. However, the Agency will not consider an applicant for a license until the Agency has completed such processing and review.

(3) An applicant must apply for an examination by submitting to the Agency:

(a) An Agency-approved license examination application form; and

(b) An examination application fee authorized by ORS 696.270.

(4) If an applicant for a property manager license examination passes the examination but is not issued a license within one year from the date of the examination:

(a) The applicant is no longer qualified for the license on the basis of the examination; and

(b) The applicant must reapply for the examination as required by this rule.

(5) If a property manager's license has not been active for two or more consecutive years, before applying to reactivate such license under OAR 863-024-0065, the licensee must apply for and pass a reactivation examination To apply for the reactivation examination, the licensee must submit to the Agency:

(a) An Agency-approved license reactivation examination application form; and

(b) The examination application fee authorized by ORS 696.270.

(6) Examination fees are not refundable if an applicant:

(a) Fails to appear for a scheduled examination;

(b) Fails to cancel or reschedule an examination appointment at least two business days before the appointment; or

(c) Fails to pass an examination.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020, 696.022 & 696.425
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0030
License Issue, Term, Form, and Inspection

(1) The Agency will issue a property manager's license to an applicant after determining that the applicant meets the license requirements contained in ORS 696.022 and 696.790 and receiving:

(a) The license application form required by OAR 863-024-0010; and

(b) The fees authorized by ORS 696.270.

(2) A licensee may engage in property management from the date the license is issued until the license expires, becomes inactive, or is revoked, surrendered, or suspended.

(3) A licensee may hold only one of the following Oregon real estate licenses at any time:

(a) Real estate broker;

(b) Principal real estate broker;

(c) Sole practitioner; or

(d) Property manager.

(4) The license expiration date is the last day of the month of a licensee's birth month.

(5) The license term is not more than 24 months plus the number of days between the date the license is issued or renewed and the last day of the month of the licensee's birth month.

(6) The license will include the following information:

(a) The licensee's legal name;

(b) The license number, effective date, and expiration date;

(c) The name under which the licensee conducts real estate business or the registered business name;

(d) The licensee's business address;

(e) The seal of the Real Estate Agency; and

(f) Any other information the Agency deems appropriate.

(7) Each license must be available for inspection in the licensee's principal place of business. If a licensee is associated with a principal real estate broker, the principal broker must make the license available for inspection in the licensee's principal place of business, which is:

(a) The principal broker's principal place of business; or

(b) A branch office.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020, 696.022 & 696.270
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0045
Property Manager Licensing Requirements

(1) To be eligible for a real estate property manager's license, an individual must:

(a) Submit a complete license application and background check application as required by OAR 863-024-0010 and 863-024-0015;

(b) Pass the licensing examination prescribed by the Agency under OAR 863-024-0020;

(c) Pay the licensing fees authorized by ORS 696.270; and

(d) Submit a certificate of completion for the course of study for real estate property manager licensing as prescribed by the Agency.

(2) A real estate property manager may only engage in the management of rental real estate. The licensee may not offer to, negotiate, attempt to, or engage in the sale, purchase, lease-option, appraisal, or exchange of real estate for another individual for compensation. The licensee may not charge, pay, receive, or accept a referral fee, finder's fee, or compensation from or share in a commission paid to a real estate broker for any activity involving the sale, purchase, lease-option, appraisal, or exchange of real estate. However, the licensee may charge, pay, receive, or accept a referral fee or finder's fee from or to a real estate broker or another real estate property manager for finding or referring an owner, renter, or lessee in real estate property management activity.

(3) A real estate property manager is responsible for all property management activity conducted under the property manager's license and for the actions of the property manager's nonlicensed property management employees. A licensed property manager may not authorize an unlicensed individual to supervise that property manager's licensed activity in the manager's absence. Except as provided for in OAR 863-024-0085, a property manager may not authorize another real estate licensee to supervise that property manager's licensed activity in the property manager's absence.

(4) A real estate property manager may be associated with a principal real estate broker to engage in property management activity on behalf of the principal real estate broker and under the supervision of that principal real estate broker. However, a property manager may not act in the broker's absence under OAR 863-024-0085.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2005(Temp), f. 6-9-05, cert. ef. 7-1-05 thru 12-26-05; Administrative correction 1-20-06; Renumbered from 863-015-0045, REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0050
License Renewal

(1) A property manager's license expires if a licensee fails to renew the license on or before the license expiration date. A licensee may not engage in any professional real estate activity after a license expires.

(2) The Agency will renew an active or inactive property manager license to an active property manager license status for the term prescribed in OAR 863-024-0030 when the Agency has received the following:

(a) The renewal fee authorized by ORS 696.270; and

(b) An Agency-approved renewal application form requesting active license status that includes certification that the licensee has met the real estate continuing education renewal requirements for active license status under OAR 863-024-0055.

(3) The Agency will renew an active or inactive real estate license to an inactive real estate license status for the term prescribed in OAR 863-024-0030, and the license will remain on inactive status, when the Agency has received the following:

(a) The renewal fee authorized by ORS 696.270; and

(b) An Agency-approved renewal application form requesting inactive status.

(4) The Agency will renew an expired property manager license to an active or inactive license status under the following conditions:

(a) The licensee applies for a license renewal on a agency-approved renewal application form requesting active or inactive license status within one year of the date the license expired;

(b) The Agency has received both the renewal fee and a late fee authorized by ORS 696.270; and

(c) If the licensee renews to an active status, the Agency has received an Agency-approved renewal application form that includes certification that the licensee met the real estate continuing education renewal requirements under OAR 863-024-0055.

(5) When the Agency renews an expired license, the renewed license is effective as of the renewal date. The renewal is not retroactive, and the expired license retains the status of expired until the renewal date.

(6) A license that is renewed under this rule expires two years from the date of the original expiration date.

(7) A real estate license that has expired for more than one year is lapsed, as defined in ORS 696.010.

(8) A license may not be renewed if it is lapsed, surrendered, suspended, or revoked. Except as provided in OAR 863-024-0075, the former licensee must reapply and meet all the licensing qualifications required of new license applicants.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020, 696.022 & 696.270
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0055
Continuing Education

(1) To renew an active license, a licensee must certify that the licensee has completed at least 30 clock-hours of real estate oriented continuing education during the preceding two license years.

(a) A licensee must complete 15 clock-hours of continuing education in one or more of the following required topics:

(A) Trust Accounts;
(B) Misrepresentation;
(C) Anti-Trust;
(D) Rule and Law Update;
(E) Property Management;
(F) Commercial Brokerage and Leasing;
(G) Real Estate Taxation: Federal, State, and Local;
(H) Agency;
(I) Fair Housing;
(J) Contracts;
(K) Property Evaluation;
(L) Brokerage Management;
(M) Land;
(N) Business Ethics; or
(O) Compliance Review.

(b) A licensee must complete the remaining 15 clock-hours in any combination of the above course topics or in other elective real estate oriented continuing education courses.

(c) Courses related to personal skills, such as time management, and routine meetings and luncheons are not considered real estate oriented continuing education courses and do not qualify as such.

(d) Courses must be a minimum of one clock-hour in length. A clock-hour is measured in sixty-minute increments, excluding meal or rest breaks.

(e) Credit will not be given for repeating a continuing education course with the same content during a two-year renewal period.

(2) Licensees must complete a standard Certificate of Attendance developed by the Agency for each course completed by a licensee. "Certifying licensee" means a property manager or, if property manager is associated with a principal real estate broker, the principal real estate broker, who certifies on an Agency-approved form that a licensee completed the continuing education requirements.

(3) In completing the standard Certificate of Attendance, the certifying licensee must decide:

(a) Whether a continuing education course meets the continuing education requirements; and

(b) Whether to classify the course as a required topic or an elective topic.

(4) A certifying licensee may approve continuing education courses completed outside of Oregon. However, for courses completed outside of Oregon, the number of approved credit hours must reflect the clock-hours of course content related to the practice of real estate in Oregon. Credit hours will not be approved for courses with content specific to another state or jurisdiction.

(5) The certifying licensee must retain the Certificate of Attendance in its records as prescribed in ORS 696.280. The certifying licensee must produce a copy of the Certificate of Attendance if the associated licensee or the Agency so requests.

(6) Property managers must:

(a) Self-certify that they have completed their continuing education requirements;

(b) Retain their Certificate of Attendance as prescribed in ORS 696.280; and

(c) Produce a copy of the Certificate of Attendance if the Agency so requests.

(7) Providing false information on an Agency license renewal form or Certificate of Attendance or falsely certifying such information is a violation of ORS 696.301.

(8) In certifying a continuing education course, the certifying licensee must consider the totality of the information provided and the class content and may consider additional criteria including, but not limited to:

(a) Evidence of the instructor's qualifications to teach the course;

(b) Whether the course content is current and accurate, the learning objectives for the course, and whether the course content fulfills the learning objectives;

(c) Whether the course includes ways of measuring learning outcome, such as a final examination; and

(d) Whether students get to evaluate the course and instructor.

(9) Certifying licensees may approve continuing education courses completed through alternative delivery methods. "Alternative delivery" means presentation of continuing education material in a method other than classroom lecture, including but not limited to correspondence, and electronic means such as satellite broadcast, videotape, computer disc, and Internet.

(a) In addition to the certification criteria in section (8) of this rule, in determining whether to certify an alternative delivery method course, the certifying licensee may consider:

(A) Whether the course offers operational or electronic security measures;

(B) The students' ability to interact with an instructor or access other resources to support their learning;

(C) Whether the learning environment and technical requirements are explained to students in advance of the course; and

(D) Whether the course includes a proctored final examination.

(b) In determining the number of credit hours to approve for an alternative delivery course, the certifying licensee may consider:

(A) The number of questions in the examination, with a minimum standard of 10 questions per hour of credit;

(B) The number of pages for Internet, Computer-Based Training, CD-ROM, and book courses, with a minimum standard of 10 pages per hour of credit; and

(C) The clock hours elapsed for videocassette, audiotape, or teleconference courses.

(10) Continuing education course sponsors may:

(a) State in their advertising that the licensee's principal broker must approve the continuing education requirements, e.g., course content, topics, and hours; and

(b) Complete the following information on a Certificate of Attendance:

(A) Real estate licensee's name;

(B) Continuing education course title and date of completion;

(C) Instructor's name and location of course; and

(D) Method of course delivery and whether a final examination was administered.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.174, 696.301 & 696.280
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0060
Limited Licenses

If the commissioner issues a limited license to an individual under ORS 696.130, the licensee must apply in writing for an unrestricted license after the period of limitation.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020, 696.022 & 696.130
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0061
Affiliated and Subsidiary Organizations

(1) Affiliated organizations are two or more organizations whose controlling ownership interests are owned by the same licensee, licensees, entity, or entities.

(2) A subsidiary organization is one in which the majority of the voting stock or controlling ownership interest is owned by another organization.

(3) Affiliated or subsidiary business organizations engaging in the management of rental real estate may use the same property manager or principal broker, provided that the individual registering the business name submits proof satisfactory to the commissioner that the property manager or principal real estate broker actually manages and controls each affiliated and subsidiary organization.

(4) As used in this rule, controlling ownership interest means owning 51 percent or more.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0062
Mailing Address, Address Change, Service of Notice

(1) Each property manager licensee must maintain on file with the Agency a current mailing address and notify the Agency within 10 calendar days of a change of address.

(2) A forwarding address is effective as a "current mailing address" when the Agency receives notice of the forwarding address by the United States Postal Service.

(3) Agency notice by mail, whether registered, certified, or regular, to the real estate licensee's current mailing address on file with the Agency constitutes service.

(4) This rule applies regardless of license status.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0063
Property Manager License Transfers, Principal Brokers' Responsibilities, Authority to Use Registered Business Name

(1) As used in this rule:

(a) "Authorized licensee" means a licensee who has authority over the use of a registered business name;

(b) "License transfer form" means a completed and signed Agency-approved form that does one of the following:

(A) Transfers a property manager license to a receiving principal broker in order to become associated with the receiving principal broker, or

(B) Authorizes a property manager to use a registered business name to conduct management of rental real estate.

(c) "Sending principal broker" means the principal real estate broker with whom an active property manager license is associated before the license transfer;

(d) "Receiving principal broker" means the principal real estate broker with whom an active property manager license will be associated after the license transfer.

(2) The property manager licensee must provide the following information on a license transfer form:

(a) The name, mailing address, and license number of the property manager licensee who is transferring the license or documenting the authorized use of a registered business name;

(b) The current status of the license, whether active or inactive;

(c) If the property manager is associated with a sending principal broker, certification that the property manager provided written notice of the transfer to the sending principal broker, and that such notice was provided before the date the transfer form is submitted to the Agency, including:

(A) The date of personal service of such notice; or

(B) The date a certified letter was delivered by the post office to the sending principal broker's address;

(d) If the form is used to authorize the use of a different registered business name, certification that the property manager licensee provided written notice of such change to the authorized licensee for the current registered business name, and that such notice was provided before the date the license transfer form is submitted to the Agency, including:

(A) The date of personal service of such notice; or

(B) The date a certified letter was delivered to the authorized licensee's address;

(e) If applicable, the receiving principal broker's registered business name, street address, and registered business name identification number;

(f) If applicable, the street address, registered business name identification number, and the registered business name under which the property manager licensee will be authorized to conduct management of rental real estate; and

(g) The receiving broker's or authorized licensee's name, license number, telephone number, date, and signature.

(3) The Agency will transfer the license of an active property manager associated with a sending principal broker to a receiving principal broker when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

(4) The Agency will transfer the license of a property manager to a receiving principal broker when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

(5) The Agency will transfer the license of an inactive property manager licensee, who has been inactive for a period of 30 days or less, to a receiving principal broker when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

(6) A principal real estate broker with whom a property manager licensee is associated remains responsible for the licensee's management of rental real estate until the Agency receives one of the following:

(a) The licensee's property manager license;

(b) An Agency-approved form submitted by the principal real estate broker terminating the relationship with the licensee under OAR 863-024-0065; or

(c) A license transfer form and fee.

(7) If a principal real estate broker with whom a property manager is associated voluntarily gives the license to the property manager named in the license, the principal real estate broker remains responsible for the licensee's subsequent management of rental real estate until the Agency receives one of the following:

(a) The licensee's property manager license;

(b) An Agency-approved form submitted by the principal real estate broker terminating the relationship with the licensee under OAR 863-024-0065;

(c) An Agency-approved form submitted by the licensee terminating the relationship with the principal real estate broker under OAR 863-024-0065; or

(d) A license transfer form and fee.

(8) The Agency will document the registered business name under which a property manager licensee is authorized to conduct management of rental real estate when the Agency receives a license transfer form and the transfer fee authorized by ORS 696.270.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0065
Inactive License, Change License Status to Active, License Reactivation

(1) A property manager licensee whose license is on inactive status may not engage in management of rental real estate.

(2) The commissioner may reprimand, suspend, revoke, or impose a civil penalty against an inactive licensee under ORS 696.301.

(3) The Agency will change an active property manager license to inactive license status when the Agency actually receives the following:

(a) The license; or

(b) A request by the licensee submitted on an Agency-approved form to change the license status to inactive.

(4) An inactive property manager licensee may renew such license under OAR 863-024-0050.

(5) For a period of 30 days after a property manager license becomes inactive, a property manager may change such license status from inactive to active under OAR 863-024-0063.

(6) If a property manager license has not been on active status for two or more consecutive years, before applying for reactivation of such license:

(a) The licensee must submit to the Agency:

(A) An application for licensing reactivation examination and

(B) The examination fee authorized by ORS 696.270; and

(b) The licensee must pass the reactivation examination.

(7) After the 30-day period in section (5) of this rule, and subject to the examination requirements in section (6) of this rule, a property manager may change the license statuts from inactive to active only by submitting to the Agency:

(a) An application for license reactivation; and

(b) Payment of the reactivation fee authorized by ORS 696.270.

(8) Subject to the examination requirements in section (6) of this rule, if an inactive licensee renews a license and maintains inactive status, the licensee may, within 60 days of the date of renewal, change the license status to active by submitting to the Agency:

(a) An Agency-approved application for license reactivation that includes certification that the licensee met the real estate continuing education renewal requirements under OAR 863-024-0055; and

(b) Payment of the active renewal fee authorized by ORS 696.270, less the amount of the inactive renewal fee already paid by the licensee.

(9) The change of license status, transfer of license, or the reactivation of a license under of this rule, are effective when the Agency actually receives all required forms and fees.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0070
License Surrender

(1) A property manager may surrender the licensee's license to the commissioner on an Agency-approved form. Upon surrender, the license is terminated, and the licensee's rights under the surrendered license are terminated. The Commissioner retains continuing jurisdiction to investigate the management of rental real estate conducted under the license and to take disciplinary action against the former licensee under ORS Chapter 696 and its implementing rules.

(2) A surrendered license may not be renewed. The former licensee must reapply and meet all the licensing qualifications required of new license applicants.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & ORS 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0075
Reissuing Suspended License

(1) The Agency may reissue an unexpired property management license that has been suspended by order of the Commissioner if the licensee asks that it be reissued and pays the required fee within 30 days after the close of the suspension period.

(2) If the licensee fails to act within 30 days, the license becomes inactive and may be reactivated only pursuant to OAR 863-024-0065.

(3) If the license expires before the request for reissuance, the Agency will renew the license within the 30-day period only pursuant to OAR 863-024-0050.

(4) A license reissued under this rule is effective for licensing purposes when the Agency receives all required forms and fees.

(5) If the license has had a status other than active for two or more consecutive years, the licensee must comply with the reactivation requirements of OAR 863-024-0065.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0076
Signature Requirements

(1) Subject to ORS 84.001 to 84.061, the Agency may, but is not required to, accept any electronic or facsimile signature created, generated, sent, communicated, received, or stored regarding licensing documents including, but not limited to, background check applications, examination applications, license applications, license change forms, and license surrender forms.

(2) The Agency may require an individual to submit an original signature on any document.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.020 & 696.022
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0085
Authorization to Control Property Manager's Business

(1) A property manager may authorize another property manager to control and supervise his or her property management activity during the property manager's absence for a period not to exceed 90 days. Both licensees have joint responsibility for all property management activity conducted during the authorizing property manager's absence.

(2) A copy of the written authorization, signed by the authorizing property manager and the licensee accepting control and supervision responsibility under section (1), must be filed with the Agency before the effective date of such authorization. The Agency may allow a later filing for good cause shown.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.026
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0095
Business Name Registration

(1) Before conducting business in a name other than the licensee's legal name, the property manager must register the business name with the Agency. For the purposes of this rule, "business name" means an assumed name or the name of a business entity, such as a corporation, partnership, limited liability company, or other business entity recognized by law. A licensee must maintain the registered business name with the Oregon Secretary of State's Corporation Division.

(2) To use or register a business name, the licensee must provide the Commissioner with all of the following:

(a) The business name in which the licensee wishes to conduct business; or

(b) Written authority by which the licensee is authorized to use the business name; and

(c) A copy of the registration filed with the Oregon Secretary of State Business Registry.

(3) Business names registered with the Agency do not expire and need not be renewed by the licensee. Any change in the business name registered with the Agency will be treated as the registration of a new business name, and the change in business name must be registered with the Agency together with the fee authorized by ORS 696.270.

(4) If a licensee wishes to transfer the right to use a business name that is registered with the Agency, the licensee acquiring the right to use the name must file a change of business name registration with the Agency together with the fee authorized by ORS 696.270. A licensee must notify the Agency in writing if the licensee terminates its use of a business name.

(5) A business name registration becomes void when the Agency receives notice of termination of the use of a business name. A business name registration becomes void when no licensees are affiliated with the registered business name. A business name registration may be reactivated within one year from the voiding of a registration, unless a new user has registered the business name, without paying the fee set forth in ORS 696.270.

(6) No real estate property manager may engage in professional real estate activities under more than one registered business name. An exception to this requirement is that a real estate property manager may engage in the management of rental real estate under more than one registered business name if the business entity is an affiliated or subsidiary organization as described in OAR 863-024-0061.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.026
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

863-024-0100
Branch Office Registration

(1) Before engaging in the management of rental real estate from a branch office, a property manager must provide to the commissioner on an Agency-approved form the branch office street and mailing addresses and the fee authorized by ORS 696.270.

(2) For the purposes of ORS 696.270, a branch office registration does not require renewal.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.026 & 696.200
Hist.: REA 7-2008, f. 12-15-08, cert. ef. 1-1-09

Rule Caption: Amend regulations for property managers.
Adm. Order No.: REA 8-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Amended: 863-025-0005, 863-025-0010, 863-025-0015, 863-025-0020, 863-025-0025, 863-025-0030, 863-025-0035, 863-025-0040, 863-025-0045, 863-025-0050, 863-025-0055, 863-025-0060, 863-025-0065, 863-025-0070, 863-025-0080
Subject: The rules amend existing rules for the regulation of property managers, including amendments for clarity and to align rules with statutes. Reconciliations of clients' trust account were streamlined and clarified. New rules on maintaining records outside the state are proposed. Production of records by licensees and cash receipts for collection from vending rules are clarified, Significant changes to termination or property management agreement and transfers, and to compliance review and mail-in audit rules are proposed.
Rules Coordinator: Laurie Skillman—(503) 378-4630

863-025-0005
Application and Purpose

(1) OAR 863-025-0010 to 863-025-0080 apply to the activities of a real estate property manager in the management of rental real estate.

(2) The purposes of OAR 863-025-0010 to 863-025-0080 are:

(a) To specify requirements for the management of rental real estate as defined in ORS 696.010(9);

(b) To protect owners and tenants of rental real estate; and

(c) To make the real estate property manager responsible for establishing a system of recordkeeping that:

(A) Provides the Agency with access to the records of the real estate property manager; and

(B) Complies with OAR 863-025-0010 to 863-025-0080 and ORS Chapter 696.

(3) The goal of the Agency is to encourage real estate property managers to comply with the applicable statutes and rules through education and, if necessary, through the use of progressive discipline as defined in ORS 696.396.

(4) Section (3) of this rule does not limit the Agency's authority to reprimand, suspend or revoke a real estate property manager license under ORS 696.301 or assess civil penalties under ORS 696.990.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.361
Hist.: REA 3-1987, f. 12-3-87, ef. 1-1-88; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0207; REA 2-2006(Temp), f. 9-11-06, cert. ef. 9-15-06 thru 3-12-07; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0010
Definitions

In addition to the definitions used in ORS 696.010 and 863-015-0120, as used in OAR 863-025-0015 to 863-025-0080, unless the context requires otherwise:

(1) "Audit trail" means a documented history of a financial transaction by which the transaction can be traced to its source.

(2) "Bank account" means an account in this state established by a property manager for receiving, holding and disbursing trust funds in a bank as defined in ORS 696.010(3).

(3) "Banking day" means each day a bank is required to be open for the normal conduct of its business but does not include Saturday, Sunday, or any legal holiday under ORS 187.010.

(4) "Compliance review" means an Agency review of a property manager's records and procedures for the purpose of educating the property manager on statutes and rules.

(5) "Clients' Trust Account" means a federally insured bank account labeled as "Clients' Trust Account" on all bank records and checks that is established and maintained by a property manager, acting on behalf of an owner under a property management agreement, for depositing, holding and disbursing funds received by the property manager on behalf of an owner, including application fees and application screening fees.

(6) "Cure noncompliance" means a property manager's acts that resolve the property manager's failure to comply with statutory and rule requirements.

(7) "Employee" means a non-licensed individual employed by a property manager for wages or a salary.

(8) "Identifying code" means a unique series of letters and/or numbers assigned by a property manager to a property management agreement at the time the agreement is signed by the parties and used on all transactions and records to reference the agreement. A property manager may use a supplemental unique series of letters and/or numbers on transactions and records if the property manager establishes a clear audit trail to a specific property management agreement and to the original identifying code.

(9) "Investigation" means an Agency-initiated investigation of a property manager that may result in administrative actions against the licensee.

(10) "Mail-in audit" means an Agency audit of a clients' trust account based on information and documents prepared by a property manager and mailed to the Agency.

(11) "Owner" means a person or persons who own rental real estate that is managed by a property manager.

(12) "Property manager" means a real estate licensee authorized to engage in management of rental real estate as defined in ORS 696.010(12).

(13) "Records" and "property management records" mean a complete and adequate documentation of the management of rental real estate.

(14) "Security Deposit" means a conditionally refundable payment or deposit of money, however designated, the primary function of which is to secure the performance of a rental or lease agreement or any part of a rental or lease agreement.

(15) "Security Deposits Account" means a federally insured clients' trust account labeled as "Clients' Trust Account — Security Deposits" on all bank records and checks that is established and maintained by a property manager, acting in a fiduciary capacity on behalf of an owner under a property management agreement, for depositing, holding and disbursing security deposit funds.

(16) "Sufficient funds" or "sufficient credit balance" means an amount of funds on an owner's ledger or a tenant's ledger that is equal to or greater than the amount of a planned disbursement from a clients' trust account or a security deposits account but which must not include any security deposits in a security deposits trust account that are required to be held pending the termination of a rental agreement. Only funds belonging to the owner or tenant on whose behalf the disbursement is planned may be considered in determining if there are sufficient funds or a sufficient credit balance.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0015
Written Policies and Delegation of Authority

(1) Each property manager must develop, maintain and follow written policies for persons and activities under this rule.

(2) Each policy must state the effective date of the policy.

(3) Policies must specify the duties, responsibilities, supervision and authority, including any authority to handle funds in a clients' trust account or security deposits account, for the following persons:

(a) A licensed property manager employed by the property manager, including any authority to negotiate tenant rental and lease agreements;

(b) An active real estate licensee engaged in the management of rental real estate under the supervision and control of a principal broker, including any authority to sign property management agreements under OAR 863-025-0020(6) and tenant rental and lease agreements under 863-025-0045(2); and

(c) An employee of the property manager, including any authority to:

(A) Negotiate tenant rental or lease agreements under OAR 863-025-0045(2);

(B) Check applicant or tenant references, including credit references;

(C) Physically maintain the real estate of an owner;

(D) Conduct tenant relations;

(E) Collect rent and other payments;

(F) Supervise premise managers; or

(G) Discuss financial matters relating to management of the real estate with the owner; and

(d) Contractors.

(5) Policies must include provisions that specify the production and maintenance of all reports, records and documents required under this division.

(6) The following delegations of the property manager's authority must be in writing, dated and signed by the property manager, and kept with written policies:

(a) Negotiate and sign property management agreements under OAR 863-025-0020(6);

(b) Review and approve reconciliations and receive and disburse funds under OAR 863-025-0025(23); and

(c) Review, approve and accept tenant rental and lease agreements under OAR 863-025-0045(2).

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0020
Property Management Agreements

(1) A property manager must not engage in the management of rental real estate without a written, unexpired property management agreement between the owner and the property manager.

(2) A property management agreement must include, but is not limited to:

(a) The address or legal description of the owner's rental real estate;

(b) The duties and responsibilities of the property manager and the owner;

(c) The authority and powers given by the owner to the property manager;

(d) The term of the agreement and the method for termination;

(e) The terms and conditions of the agreement;

(f) The management fees, application fees, screening fees, rebates, discounts, overrides and any other form of compensation to be received by the property manager for management of rental real estate including when such compensation is earned and when it will be paid;

(g) A description of the monthly statements of accounting the property manager will provide to the owner;

(h) The disposition of the property manager's records of the management of the owner's rental real estate after termination of the agreement;

(i) Disclosure of the use of employees or a business in which the property manager has a pecuniary interest at the time of the execution of the property management agreement, that will provide services for the owner's property;

(j) A statement that the property manager will disclose to the owner, in writing, the property manager's planned use of any employees or a business in which the property manager has a pecuniary interest to provide services for the owner's property, if such employees or business were not disclosed in the property management agreement pursuant to section (2)(i) of this rule;

(k) An identifying code;

(l) Signatures of the property manager, or a person authorized in section (6) of this rule, and the owner; and

(m) The date of the agreement.

(3) If the property manager and owner agree to any of the following terms, the terms must be included in the property management agreement:

(a) Payment of a referral fee, rent credit or other compensation to a tenant as allowed under ORS 696.290(2);

(b) Placement of trust funds received by a property manager in a federally insured interest-bearing clients' trust account or security deposits account as allowed under ORS 696.241(5) or (6), including provisions specifying to whom the interest earnings inure as follows:

(A) If the interest earnings inure to the benefit of the owner, when such interest earnings will be disbursed;

(B) If the interest earnings inure to the benefit of the property manager, that such interest will be disbursed to the property manager within ten calendar days from the date of the bank statement on which such interest is first shown as required in OAR 863-0025-0025(8) and

(c) Specific pass-through charges that will be paid by the owner.

(4) Any amendment or addendum to the property management agreement must be in writing and include the identifying code, the date of the amendment, the signature of the property manager and the signatures of all owners who signed the initial property management agreement.

(5) Only a principal real estate broker or real estate broker may enter into an agreement, which must be separate from the property management agreement, authorizing the real estate broker to represent an owner in the purchase, sale, lease-option or exchange of the rental real estate that must include:

(a) The scope of the professional real estate activity;

(b) The term of the agreement;

(c) The compensation to be paid by the owner to the broker;

(d) Signatures of the real estate broker and the owner; and

(e) The date of the separate agreement.

(6) Only a property manager may negotiate and sign a property management agreement, except that a principal real estate broker engaging in the management of rental real estate may delegate such authority under OAR 863-025-0015(6) to a real estate licensee who is under the supervision and control of the principal real estate broker.

(7) The property manager must promptly deliver a legible copy of the fully executed property management agreement, and any addenda or amendments, to the owner.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.361 & 696.280
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0025
Clients' Trust Account and Security Deposits Account Requirements

(1) All clients' trust accounts and security deposits trust accounts must be federally insured bank accounts.

(2) A property manager must open and maintain at least one clients' trust account as defined in OAR 863-025-0010.

(3) Only the following funds may be held in a clients' trust account:

(a) Funds received by the property manager on behalf of an owner; and

(b) Interest earned, but only if the account is a federally insured interest-bearing account and the property management agreement complies with OAR 863-025-0020(3).

(4) Except as provided in section (7) of this rule, a property manager who receives security deposits on behalf of an owner must open and maintain a security deposits account, as defined in OAR 863-025-0010, that is separate from the property manager's clients' trust account.

(5) Except as provided in section (7) of this rule and OAR 863-025-0030, a property manager who receives a security deposit on behalf of an owner must deposit the security deposit into the property manager's security deposits account within five banking days after receipt.

(6) Only the following funds may be held in a security deposits account:

(a) Security deposits as defined in OAR 863-0025-0010; and

(b) Interest earned, but only if the account is a federally insured interest-bearing account and the property management agreement complies with OAR 863-025-0020(3) and the tenant has provided the property manager with written approval required in 863-0035-0025(24).

(7) When a property management agreement and a corresponding lease or rental agreement provide that the security deposit will be transferred to and held by the owner, the security deposit funds must be deposited in the clients' trust account and disbursed to the owner in the month in which they are received.

(8) If interest earned in a clients' trust account under section (3)(b) of this rule or in a security deposits account under section (6)(b) of this rule inures to the benefit of the property manager, such interest must be disbursed to the property manager within ten calendar days from the date of the bank statement on which such interest first appears.

(9) A property manager may not allow an owner to be an authorized signer on a clients' trust account or security deposit account and may not allow an owner to deposit, hold or disburse funds in a clients' trust account or security deposit account.

(10) A property manager must be an authorized signer on each client's trust account and each security deposits account and is solely responsible for the receipts and disbursements on each bank account.

(11) A property manager must maintain and account for all checks used for a clients' trust account or security deposits account including, but not limited to, voided checks. All such checks must:

(a) Include the account number;

(b) Be pre-numbered or, if checks are computer-generated, must be numbered consecutively;

(c) If the account is a clients' trust account, include the words "clients' trust account," but may include additional identifying language; and

(d) If the account is a security deposits account, include the words "clients' trust account — security deposits," but may include additional identifying language.

(12) A property manager must not disburse funds from a clients' trust account or security deposits account unless there are sufficient funds, as defined in OAR 863-025-0010, in the ledger account against which the disbursement is made.

(13) A property manager may only transfer funds from an owners' ledger account to one or more different owners' ledger accounts if:

(a) Each of the affected owners authorizing the transfer have signed and dated an agreement authorizing such transfer that is separate from any property management agreements;

(b) At the time of the transfer, the property manager enters the transfer information on each affected owners' ledger account, including but not

limited to the amount of the transfer, date of the transfer and the source or destination of the transferred funds, as appropriate; and

(c) The property manager gives each owner a separate monthly accounting on the transfer or includes the accounting of the transfer activity in the regular monthly report to the owner.

(14) A property manager may only transfer funds between two or more owner's ledger accounts maintained for the same owner if:

(a) The owner has given the property manager prior written approval in the property management agreement or in an addendum to the agreement; and

(b) At the time of the transfer, the property manager enters the transfer information in each of the owner's affected ledger accounts including, but not limited to, the amount of the transfer, date of the transfer and the source or destination of the transferred funds, as appropriate.

(15) A property manager must disburse earned management fees from the client's trust account at least once each month unless a different schedule of disbursement is specified in the property management agreement, and may only disburse such fees if sufficient funds are available.

(16) The monthly cycle for a clients' trust account or security deposits account may begin and end on a stipulated date every month, if the date is consistent from month to month.

(17) A property manager may not disburse funds from a clients' trust account or security deposits account based upon a wire or electronic funds transfer deposited into the account, until the deposit has been verified by the property manager. The property manager must arrange with the account depository and other entities for written verification of when funds are received or disbursed by wire or electronic transfer.

(18) Upon request by the commissioner or an authorized representative of the commissioner, a property manager must demonstrate that a sufficient credit balance, as defined in OAR 863-025-0010, existed in a ledger account at the time of a disbursement is made from a clients' trust account or security deposits account by producing financial records showing that such disbursement did not involve the use of any other owner's or tenant's trust funds.

(19) A property manager may not utilize any form of debit card issued by financial institutions on a client trust account or security deposits account.

(20) A property manager must reconcile each clients' trust account within 30 calendar days of the date of the bank statement pursuant to the requirements contained in this section.

(a) The reconciliation must have three components that are contained in a single reconciliation document:

(A) The bank statement balance, adjusted for outstanding checks and other reconciling bank items;

(B) The balance of the record of receipts and disbursements or the check register as of the date of the bank statement; and

(C) The sum of all positive owners' ledgers as of the date of the bank statement.

(b) The balances of each component in section (20)(a) of this rule must be equal to and reconciled with each other. If any adjustment is needed, the adjustment must be clearly identified and explained on the reconciliation document.

(c) Outstanding checks must be listed by check number, issue date, payee and amount;

(d) Within 30 calendar days from the date of the bank statement, the property manager must:

(A) Complete the reconciliation document; and

(B) Sign and date the reconciliation document, attesting to the accuracy and completeness of the reconciliation; and

(e)The property manager must preserve and file in logical sequence the reconciliation document, bank statement, and all supporting documentation including, but not limited to, copies of the record of receipts and disbursements or check register and a listing of each owner's ledger balance as of the date of the bank statement.

(21) A property manager must reconcile each security deposits account within 30 calendar days of the bank statement date pursuant to the requirements contained in this section.

(a) The reconciliation must have three components that are contained in a single reconciliation document:

(A) The bank statement balance, adjusted for outstanding checks and other reconciling bank items;

(B) The balance in the records of receipts and disbursements or the check register as of the date of the bank statement;

(C) The sum of all positive balances of individual security deposits and fees held in the security deposits account.

(b) The balances of each component in section (21)(a) of this rule must be equal to and reconciled with each other. If any adjustment is needed, the adjustment must be clearly identified and explained on the reconciliation document;

(c) Outstanding checks must be listed by check number, issue date, payee and amount;

(d) Within 30 calendar days of the date of the bank statement, the property manager must:

(A) Complete the reconciliation document; and

(B) Sign and date the reconciliation document, attesting to the accuracy and completeness of the reconciliation; and

(e)The property manager must preserve and file in logical sequence the reconciliation document, bank statement, and all supporting documentation including, but not limited to, copies of the record of receipts and disbursements or check register and a listing of all balances of individual security deposits and fees as of the date of the bank statement.

(22) A property manager must take corrective action to resolve all adjustments made in a reconciliation prior to the next reconciliation or document the good faith efforts the property manager has taken to resolve the adjustment.

(23) A property manager may delegate the property manager's authority to review and approve reconciliations and to receive and disburse funds for a clients' trust account or security deposits account to another person if the property manager complies with the provisions of OAR 863-025-0015; however, the property manager remains solely responsible for all funds and transactions.

(24) A property manager may place security deposits received by the property manager in a federally insured interest-bearing security deposits account if:

(a) The property management agreement includes a provision for such an account under OAR 863-025-0020(3);

(b) The tenant or tenants whose security deposits are deposited into such account have provided written approval for such an account; and

(c) The provisions in the property management agreement and the written approval of the tenant specify to whom and under what circumstances the interest earnings will accrue and be disbursed.

(25) The property manager's interest in or disbursement to the property manager of interest earnings from a clients' trust account or security deposits account is not a commingling of trust funds with a licensee's personal funds.

(26) A property manager must record the transfer of any funds from a clients' trust account or security deposits account by a check, by written proof of transmittal or receipt retained in the property manager's records. The property manager must record the transfer of other documents by written proof of transmittal or receipt retained in the property manager's records. A property manager may transfer funds electronically via the Internet or Automated Clearing House (ACH) software from a client's trust account to a bank account maintained by the owner and a property manager may make payments electronically to a vendor's account for expenses relating to the owner's property. If the software program used for the transfer does not automatically update the owner's ledger, the property manager must manually record the transfer in the owner's ledger. At the time the transfer is made, the property manager must print and preserve a hard copy of the electronic record of the transfer.

(27) A property manager may use a bank lockbox process in which the bank collects payments from tenants, creates an electronic record of the transaction, and deposits the payments into the appropriate clients' trust account by following the written instructions of the property manager only if the lockbox process is authorized in a property management agreement and:

(a) The property manager is responsible for determining that the lockbox process and lockbox software program provide controls adequate to ensure the security of the funds and to provide an accurate accounting for them;

(b) For the purposes of this rule, the bank is considered an agent of the property manager; and

(c) The software program for the lockbox process must permit monthly reconciliations of the accounts into which the deposits are made and printing of daily deposit records for the period of time required for retention of other records.

Stat. Auth.: ORS 183.335 & 696.385

Stats. Implemented: ORS 696.241, 696.280 & 696.361

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2006(Temp), f. 9-11-06, cert. ef. 9-15-06 thru 3-12-07; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0030
Tenant Security Deposits

(1) Except as provided in section (3) of this rule, all tenants' security deposits received by a property manager must be deposited and maintained in a security deposits account until:

(a) The property manager forwards the tenant's security deposit to the owner of the property according to the terms of the tenant's rental or lease agreement and the property management agreement;

(b) The property manager disburses the tenant's security deposit for purposes authorized by the tenant's rental or lease agreement and the property management agreement;

(c) The property manager refunds a deposit to the tenant according to the terms of the tenant's rental or lease agreement and the property management agreement; or

(d) The property management agreement is terminated and the property manager transfers the tenant's security deposit to the owner unless the owner directs the property manager, in writing, to transfer the security deposits and fees to another property manager, escrow agent or person.

(2) If a property manager receives a security deposit as part of a larger check containing funds other than security deposits, the property manager may deposit the check into a clients' trust account of the property manager; however, the portion of the funds constituting security deposits must be deposited into the security deposits account within three banking days after deposit of the check into the clients' trust account.

(3) When a property manager establishes a clients' trust account for a single property and the property management agreement and the corresponding lease or rental agreement provide that the security deposit will be transferred to and held by the owner, the security deposit must be deposited in the clients' trust account and disbursed to the owner in the month in which they are received.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.241, 696.280 & 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0035
Records; Required Records; Maintenance; Production

(1) The property manager's records of the management of rental real estate are "complete and adequate" as required under ORS 696.280 if the records contain, at least, the following:

(a) A legible copy of each executed property management agreement and any executed addenda or amendments to that agreement;

(b) Client trust account and security deposit account records required by OAR 863-025-0000 to 863-025-0080 and ORS Chapter 696;

(c) An owner's ledger for each property management agreement;

(d) A record of receipts and disbursements or check register maintained for each clients' trust account or security deposits account;

(e) A legible copy of each tenant agreement;

(f) A tenant's ledger for each tenant;

(g) A record of all cash receipts;

(h) All paid bills and receipts required under OAR 863-025-0040(8);

(i) A record of electronic bank transactions required under OAR 863-025-0040(9);

(j) Records of the reconciliation of each clients' trust account and security deposits account, including the reconciliation document;

(k) All cancelled checks or bank-supplied images of cancelled checks as provided under ORS 696.243(1) with the bank statements to which the checks pertain; and

(l) A record of all deposits for each clients' trust account and security deposits account.

(2) A property manager must produce records required under section (1) of this rule for inspection by the Agency as follows:

(a) When the Agency makes a request for production of property management records, the property manager must provide such records within no less than five banking days; and

(b) If the Agency has reasonable grounds to believe that funds of an owner or tenant may be missing or misappropriated or that the property manager is engaging in fraudulent activity, any records demanded or requested by the Agency must be produced immediately; and

(c) Failure to produce such records within the timelines stated in subsection (a) or (b) of this section is a violation of ORS 696.301.

(3) If a property manager uses a computerized system for creating, maintaining and producing required records and reports:

(a) The property manager must back up any data that is stored in the computerized system at least once every month; and

(b) Posting of owner ledgers, record of receipts and disbursements, tenant ledgers and manipulation of information and documents must be maintained in a format that will readily enable tracing and reconciliation.

(4) A property manager must maintain all records required under section (1) of this rule for a period of six years following the date on which such agreement or document is superseded, terminated, has expired or otherwise ceased to be used in the management of rental real estate.

(5) Subject to section (6) of this rule, a property manager may maintain records required under section (1) of this rule within this state at a location other than the property manager's licensed business location, or outside this state, but within the United States, if the property manager notifies the Commissioner in writing of each new location of records at least five banking days prior to establishing a new location. Notice to the Commissioner must include at least:

(a) The name, business address and telephone number of the property manager;

(b) A statement that the property manager intends to establish a new location for records;

(c) The complete address of the new location;

(d) The means of gaining access to the records at the new location and the name, address and telephone number of all contact persons who will provide access to the records during regular business hours;

(e) If the property manager has sole custody, control and access to the records, written, signed and dated authorization by the property manager for the Commissioner to freely access and inspect all records at the new location;

(f) If the property manager authorized a third party authority over custody, control or access to records, joint authorization from the property manager and such third party for the Commissioner to freely access and inspect all records at the new location; and

(g) The signature of the property manager attesting to the accuracy of the information and the date the notice is signed.

(6) If a property manager stores records at a location other than the property manager's licensed business location, the property manager must maintain an inventory of such records and information necessary to retrieve specific records.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.280 & 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2006(Temp), f. 9-11-06, cert. ef. 9-15-06 thru 3-12-07; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0040
Record of Receipts and Disbursements

(1) Except as provided in section (4) of this rule, a property manager must prepare and maintain a chronological record of receipts and disbursements or a check register for each client's trust account and each security deposits account in which the manager must record each receipt of funds and each disbursement of funds.

(2) A record of receipts and disbursements or a check register must contain at least the following information:

(a) For each receipt of funds:

(A) The date the funds were received, unless the date is recorded in a separate document as provided in section (3) of this rule;

(B) The amount of the funds received;

(C) The purpose of the funds and identity of the person who tendered the funds; and

(D) The date the funds were deposited.

(b) For each disbursement of funds:

(A) The date the funds were disbursed;

(B) The amount of funds disbursed;

(C) The check number and payee of the disbursement; and

(D) The purpose of the disbursement.

(c) If there is more than one property in a clients' trust account, each entry for a receipt, deposit or disbursement must be identified with the applicable identifying code;

(d) If the trust account is an interest-bearing account, the amount of interest earned and the date the interest was credited to the account; and

(e) The account balance after each entry.

(3) The property manager may record the date funds were received as required in section (2)(a)(A) of this rule in a record that is separate from the record of receipts and disbursement or check register if the property manager establishes an audit trail that shows when the funds were received and deposited.

(4) If a property manager maintains a separate client's trust account for a single owner pursuant to property management agreement, the property manager must maintain at least one of the following:

(a) A record of receipts and disbursements;

(b) A check register; or

(c) An owner's ledger as defined under OAR 863-025-0055.

(5) Upon any activity, the property manager must record each receipt, deposit or disbursement as required in this rule and record each deposit or disbursement on the corresponding owner's ledger as required in OAR 853-025-0055 and/or tenant's ledger as required in 863-025-0050.

(6) A property manager may aggregate individual deposits or individual disbursements and record the aggregated total in the record of receipts and disbursements or check register only if the property manager:

(a) Aggregates the deposits or disbursements on a daily basis;

(b) Maintains a separate report that details the individual deposits or disbursements, which states the information for each deposit and disbursement as required in section (2) of this rule; and

(c) Preserves and maintains the detailed report as a required record.

(7) A record of receipts and disbursements or check register for a clients' trust account may show a negative balance during the course of a day only if the record of receipts and disbursements or check register shows a positive balance at the close of the day.

(8) A property manager must retain all paid bills and receipts explaining the amount of and purpose for the receipt or disbursement entered in the record of receipts and disbursements.

(9) A property manager may engage in electronic banking transactions, including the use of the Internet or by telephone, if a record of the transaction, sufficient to establish an audit trail, is created and maintained by:

(a) Printing a copy of the Internet transaction that includes the date, time, and nature of the transaction;

(b) Making a written notation of the telephone transaction including the date, time, and nature of the transaction; or

(c) Creating an electronic document that readily relates to the transaction containing the information in (a) or (b) of this section.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.280 & 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2006(Temp), f. 9-11-06, cert. ef. 9-15-06 thru 3-12-07; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0045
Tenant Agreements

(1) Residential Property. The property manager must file and maintain legible copies of all tenant rental or lease agreements for the time period required under OAR 863-025-0035. Each tenant rental or lease agreement prepared by a property manager for residential real estate must contain, in addition to and not in lieu of any applicable requirements of the Residential Landlord and Tenant Act, the following:

(a) The licensed name and business address of the property manager and the name and address of the tenant. If a real estate licensee executes the rental or lease agreement on behalf of the licensee's principal real estate broker, the name of the real estate licensee acting for the principal real estate broker in executing the agreement;

(b) The mailing address or unit number of property being rented or leased, the amount and payment conditions of the rental or lease, and the rental or lease term; and

(c) The amount of and the reason for all funds paid by the tenant to the property manager including, but not limited to, funds for rent, conditionally refundable security deposits, and any fees or other charges.

(2) Residential and Non-Residential Property. The property manager must file and maintain legible copies of all tenant's rental or lease agreements for the time period required under OAR 863-025-0035. A property manager must review each tenant rental or lease agreement generated by the property manager; however, a property manager may authorize in writing another individual who is licensed to or employed by the property manager to review and approve and accept tenant rental and lease agreements on behalf of the property manager. In case of such authorization, the property manager remains responsible for each tenant rental and lease agreement approved or accepted by such real estate licensee or employee. The property manager must produce the written authorization at the request of the Commissioner or the Commissioner's authorized representative.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.280 & 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 2-2006(Temp), f. 9-11-06, cert. ef. 9-15-06 thru 3-12-07; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0050
Tenant's Ledger

(1) Except as provided in section (3) of this rule, a property manager must prepare and maintain at least one tenant's ledger for each tenant or individual from whom the property manager has received any funds under a property management agreement, whether or not the tenant has executed a written rental or lease agreement at the time of the payment of funds to the property manager.

(2) A property manager must use the balances of tenant security deposits in individual tenant's ledgers in the monthly reconciliation of the security deposits account as required in OAR 863-025-0025.

(3) A property manager must prepare and maintain a separate record of the receipt of funds from prospective tenants who are not tenants at the time of paying the funds to the property manager, who do not pay the funds for a particular rental unit and who do not become tenants after such payment

(4) A tenant's ledger must contain at least the following information:

(a) The name of the tenant;

(b) The legal description of the property, the mailing address of the property and the unit number, or a unique series of letters and/or numbers that establishes an audit trail to the tenant agreement;

(c) The identifying code;

(d) For each deposit of funds:

(A) The amount of funds received;

(B) The purpose of the funds and identity of the person who tendered the funds; and

(C) The check number, cash receipt number or a unique series of letters and/or numbers that established an audit trail to the receipt of funds; and

(D) The date the funds were deposited;

(e) For each disbursement of funds:

(A) The date the funds were disbursed;

(B) The amount of funds disbursed;

(C) The check number or bank-generated electronic tracking number;

(D) The payee of the disbursement;

(E) The purpose of the disbursement; and

(f) The balance after each recorded entry.

(5) If a property manager receives a check from a tenant or prospective tenant for rent, tenant's security deposits or fees and the tenancy fails for any reason within three banking days following receipt of the check, the property manager may return the check to the tenant or prospective tenant without first depositing and processing the check through the property manager's client trust account. The property manager must retain a photocopy of the check and a dated receipt for the check in the required records of property management activity. The property manager must record the amount of the check, the dates of receipt and return of the check on the ledger required under section (3) of this rule.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.280 & 696.361
Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0055
Owner Ledger

(1) A property manager must prepare and maintain at least one separate owner's ledger for each property management agreement, for all monies received and disbursed.

(2) If a property manager maintains a separate client's trust account for a single owner pursuant to property management agreement, the property manager may maintain either a record of receipts and disbursements or check register in lieu of an owner's ledger.

(3) All owner ledgers must contain at least the following information:

(a) The owner's name and identifying code;

(b) For each deposit of funds:

(A) The amount of funds received;

(B) The purpose of the funds and identity of the person who tendered the funds;

(C) The check number, cash receipt number or a unique series of letters and/or numbers that established an audit trail to the receipt of funds; and

(D) The date the funds were deposited;

(c) For each disbursement of funds:

(A) The date the funds were disbursed;

(B) The amount of funds disbursed;

(C) The check number or bank-generated electronic tracking number;

(D) The payee of the disbursement;

(E) The purpose of the disbursement; and

(d) The balance after each recorded entry.

(4) A property manager must report in writing to each owner any change in the owner's ledger. A monthly report, showing all receipts and disbursements for the account of the owner during the prior monthly period, is sufficient under this section. A copy of each such report must be preserved and filed in the property manager's records. If an annual report contains information not required to be provided by the property manager under these rules, the property manager must set forth such information separately.

(5) A property manager must retain all paid bills and receipts explaining the amount of and purpose for the receipt or disbursement entered in the owner's ledger.

Stat. Auth.: ORS 183.335 & 696.385

Stats. Implemented: ORS 696.280 & 696.361

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0060

Cash Receipts

(1) A property manager must prepare a legible written receipt for any cash funds received under a property management agreement.

(2) If a property management agreement states that the property manager is responsible for collecting cash from machines located on the owner's property including, but not limited to, vending and laundry machine, the property manager must prepare and maintain cash receipts as provided in this rule.

(3) Cash receipts must be consecutively pre-numbered, be printed in at least duplicate form and must contain:

(a) The date of receipt of the cash funds;

(b) The amount of the funds;

(c) The reason for payment or collection of the funds received;

(d) The identifying code of the owner on whose behalf the cash funds were received;

(e) The tenant's name or, in the case of collection of cash as provided in section (2) of this rule, the machine(s) the cash was collected from;

(f) The payee of the funds; and

(g) The name and signature of the individual who actually received the cash and prepared the receipt.

(4) A copy of the receipt must be maintained in the property manager's records.

Stat. Auth.: ORS 696.385

Stats. Implemented: ORS 696.280 & 696.361

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0065

Deposits and Funds Received

(1) All funds, whether in the form of money, checks, or money orders belonging to others and accepted by any property manager while engaged in property management activity, must be deposited prior to the close of business of the fifth banking day following the date of the receipt of the funds into a clients' trust account or security deposits account as defined in OAR 863-025-0010 and established by the property manager under ORS 696.241. The property manager must account for all funds received.

(2) Any person employed by the property manager must promptly transmit to the property manager any money, checks, money orders, or other consideration and any documents received while engaged in property management activity.

(3) A property manager may not deposit any funds received on behalf of an owner in the property manager's personal account or commingle any such funds received with personal funds of the property manager.

(4) Except for funds received pursuant to OAR 863-025-0050(3) and 863-025-0025(16), every deposit made under ORS 696.241, must be made with deposit slips identifying each entry by a written notation of the owner's identifying code assigned to the property management agreement.

(5) A property manager must maintain a complete record of all funds or other consideration received in the property manager's property management activity. This record must show from whom the funds or other consideration was received, the date of the receipt, the place and date of deposit, and, the final disposition of the funds or other consideration.

Stat. Auth.: ORS 183.335 & 696.385

Stats. Implemented: ORS 696.280 & 696.361

Hist.: REA 1-2002, f. 5-31-02, cert. ef. 7-1-02; REA 1-2003(Temp), f. 2-27-03, cert. ef. 2-28-03 thru 8-27-03; REA 3-2003, f. 7-28-03, cert. ef. 8-1-03; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0070

Termination, Transfer of Property Management

(1) If a property management agreement is terminated, the property manager must terminate property management activity pursuant to the terms of the property management agreement and this rule.

(2) Not later than 60 days after the effective date of the termination, the property manager must:

(a) Disburse all obligated funds to the party or parties entitled to the funds; and

(b) Provide the owner with the following:

(A) A final accounting of the owner's ledger account;

(B) All funds belonging to the owner as shown on the owner's ledger, unless the owner directs the property manager, in writing, to transfer the funds to another property manager, escrow agent or person;

(C) An accounting of all security deposits and fees held for tenants;

(D) All tenant security deposits and fees held for tenants, unless the owner directs the property manager, in writing, to transfer the security deposits and fees to another property manager, escrow agent or person;

(E) Copies of all current tenant rental or lease agreements, unless the owner waives such requirement in writing or directs the property manager, in writing, to provide such documents to another property manager, escrow agent or person; and

(F) A notice the property manager may destroy the required records of the property management activity performed after six years.

(3) No later than the next calendar day after the effective date of the termination, a property manager must notify each tenant for whom the property manager holds a security deposit that:

(a) The security deposit and all fees held for the tenant will be transferred to the owner or, if applicable, to another property manager, escrow agent or person; and

(b) The name and address of the owner, other property manager, escrow agent or person to whom these deposits will be transferred;

(4) A property manager may not expend any tenant security deposits for payment of any expenses or fees not otherwise allowed by the tenant's rental or lease agreement.

(5) If a tenant's termination of tenancy occurs simultaneously with or prior to the effective date of termination of the property management agreement, a property manager must complete any final accounting, inspection or other procedures within the time required by:

(a) The tenant rental or lease agreement;

(b) The Residential Landlord Tenant Act; and

(c) The property management agreement, unless the owner otherwise directs in writing.

(6) A property manager must transfer and assign by written agreement any interest of the property manager in a rental or lease agreement to the owner or to a new property manager.

Stat. Auth.: ORS 183.335 & 696.385

Stats. Implemented: ORS 696.280 & 696.361

Hist.: REA 3-1987, f. 12-3-87, ef. 1-1-88; REA 3-1989, f. 12-13-89, cert. ef. 2-1-90; REA 2-1991, f. 11-5-91, cert. ef. 1-1-92; REA 1-2002, f. 5-31-02, cert. ef. 7-1-02, Renumbered from 863-010-0225; REA 1-2005, f. 5-5-05, cert. ef. 5-6-05; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

863-025-0080

Compliance Reviews and Mail-in Audits

(1) The Agency will provide a property manager with written notice at least five business days before conducting a compliance review.

(2) A compliance review is completed when the Agency delivers a written notice of completion to the property manager.

(3) Except as provided in section (4) of this rule, if the Agency determines that a property manager is not in compliance with ORS 696.010 to 696.495, 696.600 to 696.785, 696.800 to 696.870, or OAR chapter 863 after the Agency completes a compliance review, the Agency will allow the property manager at least 30 days from the date the compliance review is completed to cure the noncompliance without sanction.

(4) Upon completion of a compliance review, if the Agency has reasonable grounds to believe that the funds of an owner or tenant may be missing, funds may have been misappropriated, or that the property manager's records are in such a condition that the property manager is placing owners' and/or tenants' money at risk the Agency may immediately initiate an investigation without providing a property manager with an opportunity to cure noncompliance.

(5) The Agency will provide a property manager with written notice of a mail-in audit at least 30 days before required information and documentation must be provided to the Agency.

(6) After the Agency reviews the information and documents provided in a mail-in audit, the Agency will take one of the following actions:

(a) If the information and documents are in compliance with statutes and rules, the Agency will provide written notice to the property manager confirming compliance only as to the information and documents provided;

(b) If the information and documents indicate that the property manager may be subject to additional documentation and procedural requirements that were not part of the mail-in audit, the Agency will provide written notice to the property manager detailing the Agency's expectations for compliance on those matters;

(c) If the information and documents demonstrate that the property manager is not in compliance with ORS 696.010 to 696.495, 696.600 to 696.785, 696.800 to 696.870, or OAR chapter 863, the Agency will provide written notice to the property manager that includes:

(A) The property manager must cure all noncompliance issues and provide information and documentation to the Agency that the noncompliance has been cured within 30 days of the date of the notice; and

(B) If all noncompliance issues are not cured within 30 days, the Agency may impose sanctions on the property manager or may initiate an investigation and not allow additional time for the property manager to cure the noncompliance.

(d) If the Agency has reasonable grounds to believe that the funds of an owner or tenant may be missing, funds may have been misappropriated, or that the property manager's records are in such a condition that the property manager is placing owners' and/or tenants' money at risk, the Agency may immediately initiate an investigation without providing a property manager with an opportunity to cure noncompliance.

(7) If a property manager does not respond to a mail-in audit within the time period required in the notice, the Agency may initiate an investigation.

(8) The Agency may conduct a mail-in audit of a property manager:

(a) As part of a regular, routine and random selection of property manager clients' trust accounts for mail-in audits;

(b) When the Agency has determine, after a compliance review, that the property manager was not in compliance and provided the property manager with an opportunity to cure the non-compliance; and

(c) After an investigation has been initiated.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.280 & 696.361
Hist.: REA 2-2006(Temp), f. 9-11-06, cert. ef. 9-15-06 thru 3-12-07; REA 1-2007, f. & cert. ef. 3-12-07; REA 8-2008, f. 12-15-08, cert. ef. 1-1-09

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Rule Caption: New division for existing rules on investigations and progressive discipline for real estate licensees.
Adm. Order No.: REA 9-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Adopted: 863-027-0000, 863-027-0005
Rules Ren. & Amend: 863-015-0225 to 863-027-0010, 863-015-0230 to 863-027-0020
Subject: This division is new and includes renumbered rules and two new rules. Rules on investigations and progressive discipline of real estate licensees were moved)"renumbered") from division 15 to this new division. The amendments for renumbered rules for investigations and progressive discipline were housekeeping amendments. Two new rules were added: one on applications and purpose and the other for definitions.
Rules Coordinator: Laurie Skillman—(503) 378-4630

863-027-0000
Applicability and Purpose

This division applies to licensed real estate brokers and property managers. It describes the methods and procedures the Agency will use to investigate complaints and the process the Agency will follow when taking disciplinary action.

Stat. Auth.: ORS 696.385
Stat. Implemented: ORS 696.396
Hist.: REA 9-2008, f. 12-15-08, cert. ef. 1-1-09

863-027-0005
Definitions

As used in this division, unless the context requires otherwise, the following definitions apply:

(1) "Agency" is defined in ORS 696.010.

(2) "Commissioner" is defined in ORS 696.010.

Stat. Auth.: ORS 696.385
Stat. Implemented: ORS 696.010
Hist.: REA 9-2008, f. 12-15-08, cert. ef. 1-1-09

863-027-0010
Investigation of Licensees: Procedures and Reporting

(1) The agency shall use the methods and procedures in this rule to investigate complaints that allege grounds for discipline under ORS 696.301.

(a) The commissioner or an agency manager shall review the complaint to determine whether there are reasonable grounds to believe that a violation of ORS 696.007 to 696.995, or any rule promulgated thereunder, may have occurred that constitutes grounds for discipline under 696.301. Reasonable grounds means a reasonable belief in facts or circumstances which, if true, would in law constitute a violation of 696.007 to 696.995 or its implementing rules.

(b) If the commissioner or an agency manager determines there are reasonable grounds to believe a violation may have occurred, the agency will initiate an investigation. The individual assigned to investigate the complaint shall gather all relevant facts in an objective, impartial and unbiased manner. The investigative report must contain all facts discovered during the investigation, including facts which may be exculpatory or mitigating.

(c) The individual assigned to investigate the complaint will promptly notify the commissioner or an agency manager if a licensee fails or refuses to cooperate in an investigation.

(d) An investigative interview may be electronically recorded if the person to be interviewed consents to the recording and states such consent on the recording.

(e) The individual assigned to investigate the complaint may not communicate with a licensee or a member of the public about the findings of the investigation, whether a violation may have occurred based on the facts, or whether the agency will initiate administrative action against a licensee.

(f) Individuals assigned to investigate complaints shall not solicit complaints against any licensee.

(g) The scope of an investigation shall be limited to the conduct or transaction(s) that formed the basis initiating the investigation. However, if there are reasonable grounds to believe that additional violations may have occurred that would result in reprimand, suspension, revocation or license denial, the commissioner or an agency manager may expand the scope of the investigation or authorize additional investigations.

(2) The investigation report shall be written in an objective manner and may not contain any conclusions about whether a violation has occurred or any recommendation regarding discipline.

(3) An agency manager will review the investigation report and file and determine whether the evidence supports charging a person under investigation with a violation of ORS 696.007 to 696.995, or any rule promulgated thereunder. The agency shall not assert, propose to stipulate to, or issue a contested case notice alleging a violation of said statutes and rules without reasonable grounds as defined in section (1)(a) of this rule.

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.396
Hist.: REA 4-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-29-06: REA 1-2006, f. 6-29-06, cert. ef. 6-30-06; Renumbered from 863-015-0225, REA 9-2008, f. 12-15-08, cert. ef. 1-1-09

863-027-0020
Progressive Discipline of Licensees

(1) The goal of progressive discipline is to correct a licensee's inappropriate behavior, deter the licensee from repeating the conduct, and educate the licensee to improve compliance with applicable statutes and rules. Progressive discipline means the process the agency follows, which may include using increasingly severe steps or measures against a licensee when a licensee fails to correct inappropriate behavior or exhibits subsequent instances of inappropriate behavior.

(2) The commissioner will evaluate all relevant factors to determine whether to issue a non-disciplinary educational letter of advice or to discipline a licensee through reprimand, suspension or revocation under ORS 696.301, including but not limited to:

(a) The nature of the violation;

(b) The harm caused, if any;

(c) Whether the conduct was inadvertent or intentional;

(d) The licensee's experience and education;

(e) Whether the licensee's conduct is substantially similar to conduct or an act for which the licensee was disciplined previously;

(f) Any mitigating or aggravating circumstances;

(g) The licensee's cooperation with the investigation;

(h) Any agency hearing orders addressing similar circumstances; and

(i) The licensee's volume of transactions.

(3) An agency manager may issue a non-disciplinary educational letter of advice to a licensee which includes, but is not limited to, the following statements:

(a) The commissioner has determined not to pursue disciplinary action against the licensee; and

(b) The letter is the result of an investigation and closes the investigation; and

(c) The letter is not disciplinary in nature and will not appear in the agency's disciplinary records; and

(d) The purpose of the letter is to educate the licensee; and

(e) The letter will be expunged from the agency's records six years from the date of issuance.

(4) A reprimand is the maximum disciplinary action the commissioner may issue against a licensee if the licensee has committed an act or conduct that constitutes grounds for discipline under ORS 696.301 and such act or conduct does not:

(a) Result in significant damage or injury;

(b) Exhibit incompetence in the performance of professional real estate activity;

(c) Exhibit dishonesty or fraudulent conduct; or

(d) Repeat conduct or an act that is substantially similar to conduct or an act for which the real estate licensee was disciplined previously.

(5) The commissioner may impose suspension or revocation only if the licensee has committed an act that constitutes grounds for discipline under ORS 696.301 and such act also meets the requirements of 696.396(2)(c).

Stat. Auth.: ORS 696.385
Stats. Implemented: ORS 696.301 & 696.396
Hist.: REA 4-2005(Temp), f. 12-30-05, cert. ef. 1-1-06 thru 6-29-06; REA 1-2006, f. 6-29-06, cert. ef. 6-30-06; Renumbered from 863-015-0230, REA 9-2008, f. 12-15-08, cert. ef. 1-1-09

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Rule Caption: Amend and update regulations for escrow and escrow agents.
Adm. Order No.: REA 10-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 1-1-09
Notice Publication Date: 10-1-2008
Rules Adopted: 863-050-0052
Rules Amended: 863-050-0000, 863-050-0015, 863-050-0020, 863-050-0025, 863-050-0030, 863-050-0033, 863-050-0035, 863-050-0050, 863-050-0055, 863-050-0060, 863-050-0065, 863-050-0066, 863-050-0100, 863-050-0105, 863-050-0115, 863-050-0150, 863-050-0240
Rules Repealed: 863-050-0040, 863-050-0151, 863-050-0205, 863-050-0210, 863-050-0215, 863-050-0220, 863-050-0225, 863-050-0230, 863-050-0235
Subject: The rules include significant amendments for clarity, to align rules with statutes, and to repeal rules that are a restatement of statute. All rules relating to processing of claims were deleted because provisions are found in statutes.
Rules Coordinator: Laurie Skillman—(503) 378-4630

863-050-0000
Definitions

As used in OAR chapter 863, division 50, unless the context requires otherwise, the following definitions apply:

(1) "Agency" means the Oregon Real Estate Agency.

(2) "Bank" has the meaning given that term in ORS 706.008. As used in ORS 696.578, "a bank authorized to do business within this state" means a banking business, as that term is defined in 706.005, that has either a bank charter or a certificate of authority issued by the Oregon Department of Consumer and Business Services pursuant to Chapters 706 to 716.

(3) "Banking Day" means each day a bank is required to be open for the normal conduct of its business but does not include Saturday, Sunday, or any legal holiday under ORS 187.010.

(4) "Bank services" are any monetary benefits received directly or indirectly from an escrow agent's bank as services to the escrow agent in consideration for the escrow agent's depositing and maintaining its clients' trust funds in such bank.

(5) "Closed Escrow" means that all property titles have been transferred and all monies and documents have been disbursed or distributed in accordance with the instructions of the principals to the escrow transaction.

(6) "Escrow" is defined in ORS 696.505.

(7) "Escrow Activity" means any activity subject to regulation under ORS 696.505 to 696.590.

(8) "Escrow Agent" is defined in ORS 696.505.

(9) "Escrow Number" means a unique identifying number assigned to each escrow in logical sequence.

(10) "Escrow Trust Account" means a bank account established pursuant to ORS 696.578.

(11) "Holdback escrow" means a separate escrow, derived from a closing escrow, wherein funds are held after closing for the purpose of paying obligations related to the closing or to the financing of real or personal property therein after the closing has occurred.

(12) "Net worth," as used in ORS 696.535, means is the remaining balance after subtracting total liabilities from total assets.

(13) "One-sided escrow" as used in ORS 696.581 means an escrow that is opened by, or on behalf of, one party to a written, proposed agreement between two or more parties, for the purpose of depositing any written instrument, money, evidence of title to real or personal property, or other thing of value into the escrow account before execution of the agreement by the other party(s).

(14) "Owner" means an individual who has more than five percent ownership interest in the escrow agent.

(15) "Principal" is defined in ORS 696.505 and

(a) In a collection escrow, means the seller or buyer, lender or borrower, vendor or vendee.

(b) In a holdback escrow, means those parties directing the holdback.

(c) In a one sided escrow, means the depositing party.

(16) "Required Records" means all records required by OAR 863-050-0000 to 863-050-0150 and the Oregon Escrow Law, ORS 696.505 to 696.590.

(17) "Subservicer" is defined in ORS 696.505.

Stat. Auth.: ORS 183.335, 696.385, 696.541(1), 696.578(3)&(4) & 696.581(6)
Stats. Implemented: ORS 105.475 & 696.581
Hist.: REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0015
Documents or Property Held in Escrow

Except as otherwise provided in ORS 696.581, an escrow agent must use documents or other property deposited in escrow only in accordance with the dated written instructions of the principals to the escrow transactions or pursuant to court order.

Stat. Auth.: ORS 183.335, 696.385, 696.541(1), 696.578(3)&(4) & 696.581(6)
Stats. Implemented: ORS 105.475 & 696.581
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 2-1981, f. 10-30-81, ef. 11-1-81; REA 5-1992, f. 8-4-92, cert. ef. 9-1-92; REA 1-1993, f. 12-1-93, cert. ef. 1-1-94; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0020
Disclosure of Interest

(1) An escrow agent must act as a disinterested, neutral third party with regard to any of the principals to an escrow transaction.

(2) An escrow agent must provide the disclosure required by this rule if the escrow agent, its owners, officers, management staff in the office of the escrow agent handling the escrow transaction, or the escrow officer handling the escrow transaction knows of any interest or relationship described in section (5) of this rule.

(3) An escrow agent must disclose to the principals in an escrow transaction, in a separate written notice:

(a) The specific interest the agent or the agent's employees have in the transaction described in section (5) of this rule; and

(b) The statement described in section (6) of this rule.

(4) An escrow agent must deliver the notice required by this rule to the principals:

(a) When the escrow agent accepts the escrow and before any of the principals becomes liable for any costs or signs any written escrow instruction; or

(b) If the interest is discovered after any of the principals becomes liable for costs or signs written escrow instructions, upon discovery of the interest.

(5) An escrow agent must disclose any interest that the agent or the agent's employees have in the escrow transaction, other than as escrow agent, title insurer, or title insurance agent. Such interests include but are not limited to the following:

(a) A family relationship by blood, domestic partnership, or marriage with the escrow officer or such other staff member who may be assigned responsibility for the administration of the escrow agent's transaction file, with respect to any principal in the transaction, real estate licensee, lender,

mortgage or loan broker, builder, or subdivider with an interest in the transaction;

(b) Any pecuniary business interest in the transaction other than as escrow agent, title insurer, or title insurance agent; and

(c) Any financial interest of the escrow agent, escrow officer or such other staff member assigned responsibility for the administration of the escrow agent's file when that interest is more than five percent ownership interest in:

(A) A principal in the transaction; or

(B) A real estate licensee, lender, mortgage or loan broker, developer, builder or subdivider interest in the transaction.

(6) An escrow agent must include the following statement in a disclosure made under this rule:

"We call this interest to your attention in order to be open and fair with you. In our opinion this interest will not prevent us from being a fair and impartial escrow agent in this transaction. Nevertheless, you may request that this transaction be closed by some other licensed escrow agent if you so desire."

(7) An escrow agent making any disclosure required by this rule must take a written receipt for the disclosure statement or document the disclosure and its delivery to a principal. The escrow agent must maintain such receipts or documentation as a required record.

(8) For the purposes of this rule, if an escrow agent gives any services, property, or anything of value as a marketing tool to induce the recipient to bring or refer escrow business to the escrow agent, such giving is not a pecuniary business interest or financial interest for which disclosure must be made under this rule.

(9) The receipt by an escrow agent of bank services and interest earned on clients' trust funds under ORS 696.578(2) are not subject to the disclosure requirements of this rule.

Stat. Auth.: ORS 183.335, 696.385, 696.541(1), 696.578(3)&(4) & 696.581(6)
Stats. Implemented: ORS 696.535(1)(e) & 696.581
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 2-1990, f. 4-18-90, cert. ef. 7-1-90; REA 5-1992, f. 8-4-92, cert. ef. 9-1-92; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 4-2004, f. 4-28-04 cert. ef. 5-3-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0025
Closing Statement

(1) When an escrow closes, an escrow agent must prepare, sign, and date a closing statement of each principal's escrow account that includes the following:

(a) The funds received and disbursed on the principal's behalf for the principal's benefit; and

(b) Third party expenses paid by the escrow agent in connection with the escrow transaction, which must be clearly designated and separate from the escrow agent's otwn fees.

(2) If payments or credits are made outside of escrow, the escrow agent may show such payments or credits on the closing statement if they are designated as payments or credits outside of escrow and are set forth separately from payments or credits made by or to the escrow agent.

(3) The escrow agent must deliver a copy of the signed and dated closing statement of the applicable escrow account to:

(a) Each principal to the escrow or the principal's designee;

(b) A real estate broker who represents a principal to the transaction, upon the broker's request, but only the closing statement for the principal that the broker represents; and

(c) A seller who has financed some or the entire sales price, a copy of the buyer/borrower statement, at the seller's request.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.535(1)(g) & 696.535(3)
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 2-1981, f. 10-30-81, ef. 11-1-81; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0030
Bank Charges

An escrow agent may not authorize or allow a bank to remove funds from its account established under ORS 696.578 for payment of bank service charges, overdraft charges, printed check charges, collection charges, or bank fees or bank service charges of any kind. Such charges must be paid from the escrow agent's own funds.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.541 & 696.578
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0033
Notice of Judgments

(1) Except as otherwise provided by section (4) of this rule, an escrow agent must notify the Commissioner in writing of any of the following:

(a) A judgment entered against the escrow agent in any civil action involving the alleged misconduct of the escrow agent in an escrow transaction or of any owner, officer, employee, or director of the escrow agent in an escrow transaction handled through the escrow agent;

(b) A conviction in any criminal proceeding involving the misconduct of the escrow agent in an escrow transaction or of any owner, officer, employee, or director of the escrow agent in an escrow transaction handled through the escrow agent; or

(c) A decision adverse to the escrow agent resulting from court-ordered binding arbitration involving the alleged misconduct of the escrow agent in an escrow transaction or of any owner, officer, employee, or director of the escrow agent in an escrow transaction handled through the escrow agent.

(2) The notice required by section (1) of this rule must contain a brief description of the escrow transaction involved and the names of the principals. If a civil action or court-ordered binding arbitration, the notice must include a copy of the judgment entered or arbitrator's decision. If a criminal proceeding, the notice must include the criminal charge for which the escrow agent, officer, employee, or director was convicted and the sentence imposed.

(3) The notice required by sections (1) and (2) of this rule must be made within ten banking days after the judgment is entered, the arbitrator's decision is issued, or the sentencing date. The escrow agent must provide notice under this section even if the judgment or conviction is appealed. If the judgment or conviction is appealed, the escrow agent must report each subsequent decision of an appellate court within ten banking days after the date the appellate order is entered.

(4) A judgment of the Small Claims Department of any Circuit Court or Justice's Court is exempt from the notice requirements. However, if the judgment is appealed, each subsequent decision of any appellate court must be reported under this rule.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.511 & 696.535(1)(b)
Hist.: REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0035
Letters of Credit

(1) For a certified, annually renewable letter of credit to be satisfactory to the Commissioner under ORS 696.527 in lieu of a surety bond or deposit, the letter of credit must:

(a) Be executed by a bank;

(b) Name the State of Oregon Real Estate Agency as beneficiary;

(c) Make no reference to any other conditional agreement, document, or entity;

(d) Be annually renewable, without amendment, for successive one-year periods from the stated expiration or any future expiration date until such time as notice is given in accordance with this section;

(e) Provide for no less than sixty (60) calendar days notice to the Agency as beneficiary of any election not to renew the letter of credit; and

(f) Be payable by sight draft or upon presentation at an office of the bank by an authorized representative of the beneficiary accompanied by a signed statement certifying that "The attached order from the Commissioner of the Oregon Real Estate Agency represents that the escrow agent is in violation of ORS 696.505–696.590."

(3) The Commissioner may require that a Letter of Credit include additional terms and conditions.

Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.527
Stat. Auth.: ORS 183.335 & 696.385
Stats. Implemented: ORS 696.527
Hist.: REA 2-2004(Temp), f. & cert. ef. 1-15-04 thru 6-25-04; REA 4-2004, f. 4-28-04 cert. ef. 5-3-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0050
Accounting Controls; Record Inspection

(1) An escrow agent must establish and maintain the escrow business records described in this rule as required records.

(a) Individual ledgers must be established to record the accounting for each escrow.

(A)The ledgers must be identified by the escrow number and the names of the principals.

(B) Entries must record each receipt and disbursement of escrow funds and must be posted in date order on, or as of, the date they occur.

(C) Entries must show the amount of the entry, the date of the entry, the receipt number, and the check number or wire identification number and must identify from or to whom funds were received or disbursed.

(D) Each ledger must show and record a running balance of funds held in the individual escrow, on a daily basis, as entries occur.

(E) If an escrow agent uses more than one escrow trust bank account, each ledger must identify the account in which its escrow funds are deposited.

(b) A journal or register must be established for each escrow trust bank account and must record all receipts and disbursements of escrow funds.

(A) Entries must be posted in date order and record a running book balance for total escrow liability of the agent in each escrow trust account, on a daily basis.

(B) If entries are posted in batch totals, backup documentation adequate to identify the individual items in the batch and verify the total must be maintained.

(2) An escrow agent must reconcile each escrow trust account within 30 days of the bank statement date pursuant to the requirements contained in this section.

(a) The reconciliation must have three components, which must be contained in a single reconciliation document:

(A) The bank statement balance, adjusted for outstanding checks and other reconciling bank items;

(B) The balance of the receipts and disbursements journal or check book register as of the bank statement closing date; and

(C) The sum of all the balances of the individual escrow ledgers as of the bank statement closing date.

(b) The balances of each component of the reconciliation must be equal to and reconciled with each other. If any adjustment is needed, the adjustment must be clearly identified and explained on the reconciliation document;

(c) The escrow agent or an authorized officer in direct control of the agent's escrow operations must date and sign the reconciliation document upon completion, attesting to the accuracy and completeness of the reconciliation;

(d) Outstanding checks must be listed by check number, issue date, payee, and amount; and

(e) The escrow agent must preserve and file in logical sequence the reconciliation document, bank statement, and all supporting documentation including, but not limited to, copies of the receipts and disbursements journal or check book register and a listing of each individual escrow ledger with a balance as of the bank statement closing date.

(3) An escrow agent must take corrective action to resolve all adjustments in a reconciliation before the next reconciliation or document the good faith efforts the escrow agent has taken to resolve the adjustment.

(4) In addition to the maintenance and production requirements contained in ORS 696.534, an escrow agent must comply with the following requirements:

(a) An escrow agent using the computer services of another firm must file a continuing authorization with the Commissioner and the other firm authorizing the Commissioner to examine or audit the escrow agent's records maintained at the other firm's place of business.

(b) If an escrow agent uses a computerized system for producing and maintaining the records and accounts required in the escrow agent's licensed activity, the computerized system must have the following capabilities:

(A) Be capable of printing out any document used in the required accounting and record keeping process that would otherwise be generated or maintained by hand, such as receipt and check registers, receipt, and disbursement journals;

(B) Be capable of backing up its stored data. At least once each month, the escrow agent must back up any data that is stored in the computerized system that was not printed out and preserved under subsection (a) of this section within the last month. The back up data must be made available to the Commissioner or to the Commissioner's authorized representatives upon demand;

(C) The reconciliations and all required supporting data must be capable of being printed out at the time of reconciliation and preserved as required records of the licensed escrow activity.

Stat. Auth.: ORS 181, 183, 293 & 696
Stats. Implemented: ORS 696.535(2), 696.541(2) & 696.578
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 2-1981, f. 10-30-81, ef. 11-1-81; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 3-1989, f. 12-13-89, cert. ef. 2-1-90; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0052
Disbursal of Disputed Real Estate Broker Compensation

If there is a dispute among or between real estate brokers who are sole practitioners or principal real estate brokers regarding who is entitled to the moneys or other property agreed to as compensation in a written compensation agreement, and the escrow agent is holding such moneys or other property pursuant to ORS 696.582(1)(a), the escrow agent must hold the moneys or other property until the escrow agent receives a written agreement between the brokers or a final order from a court directing the escrow agent to disburse the moneys or other property.

Stat. Auth.: ORS 696.385, ORS 696.541
Stats. Implemented: ORS 696.582
Hist.: REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0055
Accounting Practices

(1) An escrow agent may not draw, execute, or date a check on an individual escrow account ledger or escrow trust account before the account has sufficient monies to pay the check. An escrow agent may not withdraw or transfer money from any individual escrow account or escrow trust unless such account has sufficient monies for such payment or transfer.

(2) An escrow agent may not withdraw escrow fees from a closing escrow account until:

(a) The escrow is cancelled; or

(b) The escrow is closed with the exception of customary post-closing procedures as contained in the escrow instructions of the principals to the escrow transaction.

(3) An escrow agent may deposit only the funds received as part of an escrow transaction or as trustee of a trust deed under ORS 86.705 to 86.795 in an account established under 696.578.

(4) All funds deposited in an escrow trust account established under ORS 696.578 may be withdrawn, paid out, or transferred to other accounts as specified in the written escrow instructions of the principals to the escrow transaction directed to the escrow agent or pursuant to order of a court of competent jurisdiction.

(5) An escrow agent must provide the Commissioner upon the Commissioner's request with a continuing authorization to certify the actual balance in any escrow trust account the escrow agent has established under ORS 696.578. The escrow agent must file the authorization in the depository in which the escrow trust account is maintained and file a copy of the authorization with the Commissioner.

(6) Upon request by the Commissioner or an authorized representative, an escrow agent must demonstrate that an individual escrow account contained sufficient funds before any disbursement by producing documentation and financial records showing that:

(a) The trust funds deposited into an escrow trust account on behalf of a principal and credited to the individual account were collected and available for disbursement; and

(b) The disbursement of these funds did not involve the use of any other principal's trust funds.

Stat. Auth.: ORS 696.385 & 696.541
Stats. Implemented: ORS 696.535(2) & 696.578
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 1-1988, f. 5-31-88, cert. ef. 7-1-88; REA 2-1990, f. 4-18-90, cert. ef. 7-1-90; REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0060
Interest-Bearing Accounts

(1) If an escrow agent deposits and maintains the trust funds in an interest-bearing escrow trust account pursuant to ORS 696.578(2) and (3), the written escrow instructions from all principals having an interest in the funds must include:

(a) The names of all principals;

(b) Written approval of all principals to the escrow transaction;

(c) The escrow number;

(d) To whose account the interest earnings will accrue;

(e) How and when the interest will be disbursed; and

(f) Any limitations that may be imposed on withdrawing trust funds deposited in the interest-bearing escrow trust account.

(2) The escrow agent may deposit funds to the interest-bearing escrow trust account before receiving the written instructions required by this rule, but the escrow agent may not disburse any funds from the escrow account until the escrow agent has received the written instructions.

(3) An escrow agent must account separately for the funds deposited and the disposition of interest earned, if any, in each escrow transaction and treat disposition of interest earned as a disbursement in the closing of the escrow transaction.

(4) An escrow agent may maintain one or more separate federally insured interest-bearing accounts for each escrow transaction subject to this rule.

Stat. Auth.: ORS 183.335, 696.385, 696.541(1), 696.578(3) & (4) & 696.581(6)

Stats. Implemented: ORS 696.578
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 2-1981, f. 10-30-81, ef. 11-1-81; REC 7-1984, f. 9-4-84, ef. 10-1-84; REA 5-1992, f. 8-4-92, cert. ef. 9-1-92; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0065
Disclosure of Bank Services and Refunds

(1) An escrow agent may retain bank services, but only with approval in the written closing instructions of the principals. If an escrow agent retains bank services, the agent must disclose to the principals in a transaction the nature of the benefit the agent receives and retains. The disclosure must contain a good faith estimate of the amount of the benefit received as it applies to the individual escrow.

(2) If an escrow agent disburses funds and those funds are returned or refunded to escrow, the escrow agent must:

(a) Account for and handle such moneys as any other funds deposited in escrow;

(b) Adjust the ledger for the escrow transaction to reflect the refund or return;

(c) Disburse the refunded or returned funds in accordance with the appropriate principals' dated written escrow instructions, and

(d) Provide an explanation of the refund or return to the appropriate principals.

(3) The requirements contained in section (2) of this rule do not apply to de minimus amounts of fund if those amounts and the disposition of such funds are defined in the escrow instructions.

Stat. Auth.: ORS 183.335, 696.385, 696.541(1), 696.578(3) & (4) & 696.581(6)
Stats. Implemented: ORS 696.578(3)
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 2-1990, f. 4-18-90, cert. ef. 7-1-90; REA 5-1992, f. 8-4-92, cert. ef. 9-1-92; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0066
Deposits

An escrow agent must deposit all checks or cash received in escrow into the agent's escrow trust account established under ORS 696.578 no later than the close of business of the banking day the day after the agent receives the checks or cash. This requirement does not apply to checks received from a lender who requires that the checks not be deposited until an escrow is ready to close.

Stat. Auth.: ORS 696
Stats. Implemented: ORS 696.505 & 696.578
Hist.: REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0100
Records

(1) An escrow agent must keep at least the following records:

(a) Copies of all receipt records, including voided receipts;

(b) All cancelled checks or bank-supplied images provided pursuant to ORS 696.243, which must be filed with all numbered check forms accounted for, including voided checks;

(c) All vouchers and check stubs, including voided vouchers and check stubs;

(d) Copies of all transfer forms used in making transfers of funds between escrow accounts;

(e) An escrow log, with entries entered in logical sequence based on the escrow number assigned, containing an entry for each escrow that includes the escrow number, the date of opening, and the names of the principals;

(f) Copies of the escrow closing statements required by OAR 863-050-0025;

(g) The books and other records required by OAR 863-050-0050; and

(h) Any other required records, as that term is defined in OAR 863-050-0000.

(2) An escrow agent may use electronic image storage media to retain and store copies of deposit receipts, canceled checks, and other documents executed or obtained by the agent in connection with any escrow activity and transaction, provided the agent satisfies the following requirements:

(a) The electronic image storage must be non-erasable "write once, read many" ("WORM") that does not allow changes to the stored document or record;

(b) The stored document or record was made or preserved as part of and in the regular course of business;

(c) The original record from which the stored document or record was copied was made or prepared by the escrow agent or escrow agent employees at or near the time of the act, condition, or event reflected in the record;

(d) The custodian of the record is able to identify the stored document or record, the mode of its preparation, and the mode of storing it on the electronic image storage; and

(e) The electronic image storage media contains a reliable indexing system that provides ready access to a desired document or record, appropriate quality control of the storage process to ensure the quality of imaged documents or records, and date-ordered arrangement of stored documents or records to assure a consistent and logical flow of paperwork to preclude unnecessary search time.

(3) For any lost or missing checks, an escrow agent must maintain a signed, dated statement explaining why the check is missing.

(4) Except as provided in this rule, an escrow agent may not receive trust funds without issuing a receipt and my not disburse trust funds without issuing a check. An escrow agent must issue an appropriate receipt as soon as practicable after receiving cash in a collection escrow or receiving cash or checks in a closing escrow.

(5) An escrow agent must send an annual written statement to a principal in a collection escrow to show all receipts and disbursements in the collection escrow during the year covered in the report.

(6) For wire and electronic transfers, the following requirements apply:

(a) An escrow agent may not disburse funds from an individual escrow account based upon a wire or electronic transfer deposited into the escrow trust account until the escrow agent has verified the deposit;

(b) An escrow agent must arrange with the escrow depository and other entities for an immediate follow-up hard copy credit memo or a hard copy debit memo when funds are received or disbursed by wire or electronic transfer;

(c) An escrow agent must post the receipt of funds by wire or electronic in the same manner as other receipts and include a traceable identifying name or number supplied by the escrow depository receiving the funds or by the transferring entity; and

(d) The escrow agent disbursing funds by wire or electronic transfer must retain in the individual escrow transaction file a copy of the written authorization from the principals to use wire or electronic transfer for disbursement or funds.

(7) Check forms used by an escrow agent must be pre-numbered with consecutive numbers. If a computer fills in or generates checks and any check copies, all check stock and check copies must be consecutively pre-numbered. If a computer generates checks using unnumbered check stock, the computer must continually and consecutively number the checks as generated. The account number must appear in the magnetic coding on the bank check face to identify the account number for reading by the bank's computerized accounting system.

(8) An escrow agent must produce the records required under this rule for inspection by the Agency as follows:

(a) When the Agency makes a request for production of escrow records, the escrow agent must provide such records within no less than five banking days; and

(b) If the Agency informs an escrow agent that the Agency has reasonable grounds to believe that escrow funds may be missing or misappropriated or that the escrow agent has engaged in fraudulent activity, the escrow agent must produce any records demanded or requested by the Agency immediately.

Stat. Auth.: ORS 183.335, 696.385 & 696.541
Stats. Implemented: ORS 696.534, 696.578 & 696.581
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 2-1990, f. 4-18-90, cert. ef. 7-1-90; REA 5-1992, f. 8-4-92, cert. ef. 9-1-92; REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0105
Record Location

An escrow agent must notify the Commissioner of any relocation of the records at least 15 days before the relocation. The notice must include the street address of the new location of the agent's required records. If the new location is not the licensed main office or a licensed branch office of the escrow agent, the escrow agent must provide the Commissioner, in writing, with the information and contact persons necessary to have access to the records during regular business hours.

Stat. Auth.: ORS 183.335, 696.385 & 696.541
Stats. Implemented: ORS 696.534
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 3-1989, f. 12-13-89, cert. ef. 2-1-90; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0115
Records Retention

(1) In addition to and not in lieu of the requirements of ORS 192.825 to 192.855 (The Electronic Signature Act), the requirements of OAR 863-050-0005 through 863-050-0150 and the Oregon Escrow Law apply to all records, including any electronically generated items.

(2) An escrow agent must maintain at the escrow agent's office a means of viewing copies of documents or records stored pursuant to this section. An escrow agent must provide, at the escrow agent's expense, a paper copy of any document or record requested by the Agency.

Stat. Auth.: ORS 696.541
Stats. Implemented: 2003 OL Ch. 427, Sec. 3
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 4-2004, f. 4-28-04 cert. ef. 5-3-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0150
Annual Report; Financial Statements; Audit or Examination Expenses

(1) The escrow agent must pay to the Agency the reasonable expenses of an audit or examination as authorized by ORS 696.541.

(2) An escrow agent must submit to the Commissioner by March 31 of each year an Annual Report for the previous calendar year consisting of the following:

(a) A schedule of the amount of trust funds received and disbursed each month on collection escrows and the amount of trust funds received and disbursed each month on closing escrows. The schedule must include the beginning balance and the ending balance of each such account and be prepared based upon the individual escrow ledgers for such accounts;

(b) A list of closing escrows that have been open for more than twelve months as of December 31 of the previous year, showing the escrow number, date opened, names of principals, the escrow ledger balance, and a statement of the reason the escrow has remained open for more than one year;

(c) The amount of clients' trust funds received and disbursed each month by the escrow agent while acting as a trustee under a trust deed pursuant to ORS 86.705 to 86.795. The schedule must include the beginning balance and the ending balance for each account. The schedule must be prepared from the outstanding individual escrow ledgers for such accounts;

(d) An executed general authorization to inspect all clients' trust accounts set up as required by ORS 696.578(1) on a form approved by the Commissioner;

(e) A list of outstanding checks as of December 31 of the previous year, listed by check number, issue date, payee, and amount, for all escrow trust accounts; and

(f) Any other information the Commissioner may request from the escrow agent as necessary in administering the provisions of ORS 696.505 and 696.585.

(3) An escrow agent must submit to the Commissioner, not later than 150 days after the end of the agent's tax or accounting year, a set of the agent's financial statements as follows:

(a) The financial statements must be prepared in accordance with generally accepted accounting principals by a certified public accountant or other qualified person approved by the Commissioner.

(b) The person preparing the financial statements must provide a statement of the type of the presentation made and include all appropriate notes to the financial statement.

(c) The financial statements must include the following:

(A) A balance sheet as of the agent's year end,

(B) Statement of profit and loss,

(C) Statement of cash flows,

(D) Statement of retained earnings, and

(E) Any other changes in capital accounts for the year then ended.

(d) As part of the report submitted under this rule, the escrow agent must authorize the Commissioner or the Commissioner's authorized representative to examine and verify any asset or liability shown on the balance sheet. The authorization must be in writing and submitted to the Commissioner with the report.

(4) The Commissioner may require an escrow agent to submit to the Commissioner an independent audit by a certified public accountant or a public accountant, conducted at the escrow agent's expense. The Commissioner may specify the nature and scope of the independent audit. If an escrow agent submits a required independent audit to the Commissioner or the Commissioner's authorized representative, this does not preclude any subsequent audit within the same year.

(5) The Commissioner may grant an extension of time, to be determined by the Commissioner, for filing reports submitted under sections (2) or (3) of this rule if the agent so requests in writing and provides sufficient reason why the agent cannot file the reports by the specified date.

(6) The reports required by this rule must be signed by the owner or appropriate corporate officer of the escrow agent attesting to the accuracy of the information contained in the report.

Stat. Auth.: ORS 183.335, 696.385, 696.541(1), 696.578(3)&(4) & 696.581(6)
Stats. Implemented: ORS 696.534
Hist.: REC 29, f. 12-9-70, ef. 1-10-71; REC 34, f. 2-8-73, ef. 3-1-73; REC 5-1978, f. 11-15-78, ef. 1-1-79; REC 2-1981, f. 10-30-81, ef. 11-1-81; REC 6-1984, f. 6-18-84, ef. 7-1-84; REA 2-1990, f. 4-18-90, cert. ef. 7-1-90; REA 5-1992, f. 8-4-92, cert. ef. 9-1-92; REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 5-2003, f. 12-24-03, cert. ef. 1-1-04; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

863-050-0240
Fingerprint Requirements for Escrow Licensing

As part of any application submitted under ORS 696.511, the applicant must submit two completed fingerprint cards on a form prescribed by the Commissioner and an additional fee sufficient to recover the costs of processing the applicant's fingerprint information and securing any criminal offender information pertaining to the applicant.

Stat. Auth.: ORS 183.335, 696.385 & 696.541
Stats. Implemented: ORS 696.511
Hist.: REA 2-1997, f. 6-18-97, cert. ef. 7-1-97; REA 4-1997, f. 11-24-97, cert. ef. 12-1-97; REA 10-2008, f. 12-15-08, cert. ef. 1-1-09

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Secretary of State, Archives Division
Chapter 166

Rule Caption: Updates general records retention schedule for cities.
Adm. Order No.: OSA 3-2008
Filed with Sec. of State: 12-10-2008
Certified to be Effective: 12-10-08
Notice Publication Date: 10-1-2008
Rules Amended: 166-200-0005, 166-200-0010, 166-200-0015, 166-200-0020, 166-200-0025, 166-200-0030, 166-200-0035, 166-200-0040, 166-200-0045, 166-200-0050, 166-200-0055, 166-200-0060, 166-200-0065, 166-200-0070, 166-200-0075, 166-200-0080, 166-200-0085, 166-200-0090, 166-200-0095, 166-200-0100, 166-200-0105, 166-200-0110, 166-200-0115, 166-200-0120, 166-200-0125, 166-200-0130, 166-200-0135, 166-200-0140, 166-200-0145
Subject: Rule change updates general records retention schedule for cities.
Rules Coordinator: Julie Yamaka—(503) 378-5199

166-200-0005
City Records

This General Schedule prescribes minimum retention periods for public records created and maintained by the cities of Oregon. Retention periods apply to the record copy of all public records, regardless of medium or physical format, created or stored by the above specified agencies. Please note the exceptions to this General Schedule listed in OAR 166-030-0027 before disposing of records.

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0010
Administrative Records

(1) **Activity and Room Scheduling and Reservation Records** Records document scheduling and reservations related to public participation in and use of various city activities, events, classes, and meeting rooms. Includes schedules, logs, lists, requests, and similar records. SEE ALSO Participant Registration and Attendance Records and Park and Facility Use Permits in the Parks and Recreation section for records documenting public use of services or facilities for which formal registrations or permits are required. (Minimum retention: 1 year).

(2) **Activity Reports**, General Daily, weekly, monthly, or similar reports other than annual reports documenting the activities of city employees. Useful for compiling annual reports, planning and budgeting, monitoring work progress and other purposes. Usually tracks type of activity, employees and/or volunteers involved, time spent on activity, work completed, and related information in narrative or statistical form. SEE ALSO Grant Records in the Financial-General section for reports documenting activities directly related to projects funded by grants. (Minimum retention: 2 years).

(3) Annual Reports Reports document the program or primary functional activities and accomplishments of the office for the previous year. These are often compiled from monthly, quarterly, or other subsidiary activity reports. Usually includes statistics, narratives, graphs, diagrams, and similar information. SEE ALSO Activity Reports, General in this section for reports documenting shorter periods of time. (Minimum retention: Permanent).

(4) **Cemetery Records*** Records document the administration and management of city-owned cemeteries. Records may include lists of names and maps of grave locations, deeds, information on purchasing lots and burials, death certificates, State Mortuary and Cemetery Board licensing and reporting documentation, and related correspondence. Some records may have historic value. (Minimum retention: Permanent).

(5) Correspondence Records that: 1. document communications created or received by an agency AND 2. directly relate to an agency program or agency administration AND 3. are not otherwise specified in the City General Records Retention Schedule (OAR 166-200) or in ORS 192.170. Records may include but are not limited to letters, memoranda, notes and electronic messages that communicate formal approvals, directions for action, and information about contracts, purchases, grants, personnel and particular projects or programs. (Disposition: File with the associated program or administrative records. Retentions for city records are found in City General Records Retention Schedule. Communications not meeting the above criteria do not need to be filed and may be retained as needed).

(6) **Desk Calendars and Notes Records** documenting and facilitating routine planning, scheduling, and similar actions related to meetings, appointments, trips, visits, and other activities. Includes calendars, appointment books, notes, telephone messages, diaries, and similar records. Depending on content, some telephone messages and similar records may merit inclusion in related program or project files. This applies to records that contain significant information, which is not summarized or otherwise included in reports or similar documents. (Minimum retention: 1 year).

(7) **Emergency and Disaster Incident Records*** Records document the extent of impact and actions taken by the city in response to disasters, emergencies, and civil disorder. Incidents may be natural or manmade such as earthquakes, wild land fires, severe storms, floods, drought, airplane crashes, utility failures, hazardous materials incidents, riots, and similar events affecting the people, property, or government of the city. Records may include logs, diaries, damage assessment reports, response reports, situation and resource status reports, incident action plans, resource ordering and tracking records, financial documentation, messages, photographs, sign-in sheets, and any other incident related documentation. SEE ALSO the Emergency Management section, the Fire and Emergency Medical Services section, the Police section, the Public Works section, and the Risk Management section for related records. (Minimum retention: Permanent).

(8) **Fax Reports Reports** document the facsimile transactions of the city. Reports may also be used for billing purposes. Information includes date and time fax transmitted or received and recipient/sender fax number. (Minimum retention: (a) If used for billing, retain 3 years (b) If not used for billing, destroy).

(9) **Index/Finding Aid Records** Records created to facilitate the location and retrieval of information, files and physical objects. (Minimum retention: Until superseded or obsolete).

(10) **Internal Audit Records** Records document the examination of the city's fiscal condition, internal control, and compliance policies and procedures. Records may also document performance or other financially related audits by city or contracted auditors. Records may include audit reports, supporting documentation, comments, and correspondence. Minimum retention: 10 years).

(11) **Key and Keycard Records*** Records document the issuance of keys and keycards to agency staff to enable access to agency buildings and sites. Records may include but are not limited to key inventories, key issue forms, key replacement records, and key disposal records. (Minimum retention: 2 years after key is turned in).

(12) **Mailing Lists** Lists compiled to facilitate billing, community outreach, and other functions in the city. Information usually includes name of individual or group, address, name and title of contact person, phone number, comments, and similar data. (Minimum retention: Until superseded or obsolete).

(13) **Meeting Records**, Board, Commission, and Committee* Records document the proceedings of city boards, commissions, task forces, committees, advisory councils, and other similar groups, as described in Oregon's Public Meetings Law (ORS 192.610 to 192.710). Records may include minutes, agendas, exhibits, resolutions, staff reports, indexes, petitions, audio or visual recordings, correspondence, and related documentation. (Minimum retention: (a) Minutes* (except executive session minutes), agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records) permanently (b) Executive session minutes, retain 10 years (c) Audio or visual recordings 1 year after minutes prepared and approved (d) Other records and exhibits not pertinent to minutes, retain 5 years).

(14) **Meeting Records**, Governing Body* Records document the proceedings of any regularly scheduled, special, executive session, or emergency meeting of any governing body, as described in Oregon's Public Meetings Law (ORS 192.610 to 192.710) that is under city jurisdiction. These typically consist of boards, commissions, advisory councils, task forces, and similar groups. Records may include minutes, agendas, exhibits, resolutions, staff reports, indexes, petitions, tape recordings, and related documentation and correspondence. For further description of several specific examples of meeting records, refer to the subject index. SEE ALSO Meeting Records, Staff and Meeting Records, Board, Commission, and Committee; in this section. (Minimum retention: (a) Minutes* (except executive session minutes), agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records) permanently (b) Executive session minutes 10 years (c) Audio or visual recordings, retain 1 year after minutes prepared and approved (d) Other records and exhibits not pertinent to minutes, retain 5 years).

(15) **Meeting Records**, Staff Records document meetings within city government, which are not subject to Oregon's Public Meetings Law (ORS 192.610 to 192.710). These routine staff meetings deal with tasks and actions within existing policies and procedures. Records may include minutes, notes, reports, and related items. Some records may merit inclusion in other record series with longer minimum retention periods if the subject matter of the meeting adds significant information to that series. (Minimum retention: 2 years).

(16) **Mitigation Program Records*** Records document the establishment and maintenance of the city mitigation program, plans, and procedures. Records may include mitigation plans and strategies, policies, procedures, seismic surveys and structural upgrade records of city facilities, project reports, hazard mitigation grant records, and related documentation which may include capital improvement records, new and revised building codes, and zoning ordinances. SEE ALSO the Risk Management section. (Minimum retention: (a) Adopted plans,* retain permanently (b) Other records, retain for the life of the structure).

(17) News Releases Records document the release of prepared statements, announcements, news conference transcripts, and similar records issued to the news media by the city. Subjects include the adoption of new city programs, termination of old programs, policy shifts, changes in the status of elected officials or senior administrative personnel, and others. Also may include news releases announcing routine events or actions carried out within the scope of existing city policies. Some releases may merit inclusion in applicable related record series (e.g., Incident Case Files, Fire Investigation Records, etc.). (Minimum retention: (a) Policy and historic news releases, retain permanently (b) Routine news releases, retain 2 years).

(18) **Notary Public Log Book Records** document the notarial transactions completed by a notary public employed by the city. Cities may retain log books by agreement with the notary public after their separation from city employment. Cities retaining notary public log books without notary agreements should consult their city attorney and/or the Secretary of State, Corporation Division for retention instruction. (Minimum retention: 7 years after date of commission expiration).

(19) **Organizational Records** Records document the arrangement and administrative structure of the city government. May include charts, statements, studies, and similar records. Includes studies to determine the merit and feasibility of reorganization plans as well as other major studies related to the city's administrative hierarchy. (Minimum retention: Permanent).

(20) **Permit and License Records, City Issued* Records** document city review, background investigations, recommendations and other actions related to permits and licenses issued for various activities within the city. Subjects may include but are not limited to business, tree removal, temporary signs, taxi cab drivers, dances, parades, rocket launching, second hand dealers, alarm system dealers, keeping livestock in the city, and solicitors. Usually includes applications, background investigation reports, permits, licenses, and related records. This record series does not apply to several types of permit records related to construction, certain public works functions, and others. SEE ALSO the Financial sections, Building Permits in the Building section; Explosives Storage and Use Permits in the Fire and Emergency Medical Services section; Right-of-Way Permit Records in the

Public Works-Engineering section; and Industrial Pretreatment Permits in the Public Works-Wastewater Treatment section. (Minimum retention: (a) Fee permits or license records, retain 3 years after expiration, revocation, or denial (b) Free permits or license records, retain 2 years after expiration, revocation, or denial).

(21) **Postal Records** Records document transactions with the U.S. Postal Service and private carriers. Includes postage meter records, receipts for registered and certified mail, insured mail, special delivery receipts and forms, loss reports, and related items. (Minimum retention: 3 years).

(22) **Professional Membership Records** Records document institutional or agency-paid individual memberships and activities in professional organizations. Minimum retention: 3 years).

(23) **Public Notice Records*** Records document compliance with laws requiring public notice of city government activities. Subjects include assessments, elections, land use changes, public meetings and hearings, sale of property, and others. Records include public or legal notices, certificates, affidavits of publication, and similar documents. SEE ALSO Competitive Bid Records in the Financial-General section for public notices related to bid openings and awards. (Minimum retention: 3 years).

(24) **Publications Records** document the published records produced by or for the city or any of its departments or programs and made available to the public. Includes newsletters, pamphlets, brochures, leaflets, reports, studies, proposals, and similar published records. Does not include publications received from federal, state, private or other sources — these publications and extra copies of city-produced publications should be retained as needed. (Minimum retention: (a) Brochures, pamphlets, and leaflets, retain until superseded or obsolete (b) One copy of all others, retain permanently).

(25) Requests and Complaints Records document complaints or requests concerning a variety of city responsibilities. Information often includes name, phone number, and address of person making request or complaint, narration of request or complaint, name of person responding to request or complaint, dates of related activities, and other data. SEE ALSO Equal Employment Opportunity Complaint Records, and Grievance and Complaint Records in the Personnel Records section; Water Quality Complaint Records in the Public Works-Water Treatment Records section; and Incident Case Files, which contain law enforcement complaints in the Police Records section. SEE ALSO Correspondence, General in this section for routine requests for information or publications and Liability Claims Records in the Risk Management section. (Minimum retention: 2 years after last action).

(26) **Routing and Job Control Records** Records used to control the routine flow of documents and other items and actions in and between offices in the city. Includes routing slips, job control records, status cards, receipts for records charged-out, batch slips, and similar records. (Minimum retention: 1 year).

(27) **Scrapbooks Books** document a chronological, historical event or similar record of the city. May contain photographs, newspaper or magazine clippings, commentaries, and other items pertaining to the activities, actions, and reactions of the city officials, personnel, and citizens. Scrapbooks vary greatly in their content and value. Some may have historic value. For appraisal assistance, contact the Oregon State Archives. (Minimum retention: Retain as needed).

(28) **Seminar and Conference Records**, City-Sponsored Records document the design and implementation of city-sponsored seminars, conferences, workshops, conventions, and similar gatherings. Often includes class descriptions, instructional materials, course outlines, enrollment and attendance records, reports, speeches, planning documentation, and related records. For records documenting registration billings and related fiscal actions, see the Financial-General section. (Minimum retention: (a) Significant program and fee records, retain 3 years (b) Class enrollment and attendance records, retain 2 years (c) Other records, retain 1 year).

(29) **Seminar and Conference Records**, Non-City Sponsored Records document activities, seminars, conferences, workshops, conventions, and similar gatherings not sponsored by the city but attended by city officials or personnel. May include staff reports, instructional materials, recommendations, related correspondence and memoranda, and similar records. (Minimum retention: 2 years).

(30) **Special Event and Celebration Records** Records document city-sponsored celebrations of special and historic occasions such as pioneer days, centennials, and similar events. Provides a record of planning and promotional efforts, public attendance and response, major speeches and dedications, and other aspects of the celebration. These records may include studies, publications, photographs, attendance summaries, final reports, and other documents. Records may also include routine documentation related to implementing the promotion and organization of the event. These often include lists, rosters, correspondence, volunteer information, and related records. SEE ALSO Special Event Records, Traffic in the Public Works-Traffic Engineering section for related records. (Minimum retention: (a) Records documenting significant aspects of the event, retain permanently (b) Other records, retain 2 years after event).

(31) **Surveys, Polls, and Questionnaires Records** document the measurement of public opinion by or for the city related to various issues, actions, and concerns. May include surveys, polls, questionnaires, summaries, abstracts and related records. Examples of summaries include studies which incorporate the significant results of public opinion surveys, abstracts of questionnaires designed to determine the skills and interests of citizens volunteering for city service, and other records which distill survey data into summary form. (Minimum retention: (a) Summary reports and abstracts, retain 3 years (b) All other records, retain until summary report is completed or 3 years, whichever is sooner).

(32) **Technical Manuals, Specifications, and Warranties*** Owners manuals and warranties for city-owned vehicles and equipment. Manuals often include specifications, operating instructions, and safety information. Warranties include terms of coverage for repair or replacement of equipment. (Minimum retention: (a) Manuals, retain until disposition of vehicle or equipment (b) Warranties, retain until expiration).

(33) **Work Orders Records** document requests and authorizations for needed services and repairs to city property and equipment. May include copy center work orders, printing orders, telephone service and installation requests, repair authorizations, and similar records. (Minimum retention: (a) Work completed by city personnel, retain 1 year (b) Work completed by outside vendors, retain 3 years).

(34) **Work Schedules and Assignments Records** document the scheduling and assigning of shifts, tasks, projects, or other work to city employees. Useful for budget and personnel planning, review and other purposes. May include calendars, schedules, lists, charts, rosters, employee time surveys, and related records. Also includes rosters and similar records documenting vacation schedules. SEE ALSO the Personnel section for related records. (Minimum retention: 2 years).

(35) **Vehicle Maintenance and Repair Records** Records document the maintenance and repair history of all city-owned vehicles. Records may include reports, summaries, and similar records usually compiled from daily work records on a monthly or quarterly basis. Information often includes a description of work completed, parts and supplies used, date of service, date purchased, price, vehicle number, make and model, and other data. SEE ALSO Contracts and Agreements in Recorder-General section for contract records related to private companies maintaining and repairing city-owned vehicles. SEE ALSO Daily Work Records in the Public Works-Operations and Maintenance section and Work Orders in this section. (Minimum retention: 2 years after disposition of vehicle).

(36) **Visitor Logs Records** used to track visitors to city buildings. Records may include visitors' names, visitor badges issued, and entrance and exit times. (Minimum retention: 1 year).

(37) **Year 2000 (Y2K) Planning Records** Records document the planning and development of city Y2K Contingency Plans. Records may include but are not limited to meeting minutes, correspondence, draft plans, work notes, plan test results, and final plan. Information includes type of systems vulnerable to Y2K, level of priority, and party responsible for system solution or troubleshooting. (Minimum retention: Destroy).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 2-2005, f. & cert. ef. 5-10-05; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0015
Airport Records

(1) **Activity Reports**, Airport Records document various indicators of activity associated with the city airport. Subjects may include arrivals and departures, type of aircraft served, number of passengers, amount of cargo, amount of fuel use, activities of related operations such as restaurants, gift shops, and car rental outlets, and others. (Minimum retention: (a) Retain annual reports permanently; (b) All other reports, retain 2 years).

(2) **Airport Certification Records** Records document certifications, licenses, or permits from the Federal Aviation Administration (FAA) or other federal or state agencies. Includes any documentation bearing directly on the application for issuance or renewal. Federal Aviation Administration related records include city-prepared airport certification manuals for airports servicing aircraft with seating capacities of more than 30 passengers, as well as airport certification specifications for "limited" airports. Manuals include procedures for the maintenance of paved and

unpaved areas, lighting systems, and traffic and wind direction indicators. They also include procedures for self-inspection, rescue and fire fighting, and the control of hazardous substances and ground vehicles, as well as plans for snow and ice control, emergencies, wildlife hazard management, and others. (Minimum retention: (a) Certification manuals or specifications, retain permanently; (b) All other records, retain 2 years after expiration).

(3) **Airport Commission Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(4) **Airport Security Program Records** Records document the city airport's objectives, methods, and procedures designed to prevent or reduce illegal activities or interference with civil aviation. Program contents include a description of the airport, master security plan, planned improvements, procedures in case of hijackings or bomb threats, security gate information, airport statistics, and related subjects. (Minimum retention: (a) Program records described in 49 CFR 1542, retain permanently; (b) All other records, retain 2 years after superseded or obsolete).

(5) **Airport Self-Inspection Reports** Reports and related records document the Federal Aviation Administration (FAA) mandated inspections by airport staff to assure safe conditions. These generally are performed daily or more frequently if unusual conditions caused by construction, weather, or any accident or incident are present. Inspections include runway, ramp, and taxiway conditions, fire and reserve facilities, bird hazards, wind indicating devices, standby power system, and lighting. SEE ALSO Inspection and Occupancy Records and Fire and Emergency Medical Services Maps in the Fire and Emergency Medical Services section. (Minimum retention: (a) Reports documenting incidents, retain 2 years; (b) Self-inspection reports, retain 1 year; (c) Federal Aviation reports, retain 5 years; (d) All other reports, retain 6 months).

(6) **Complaint Records**, Airport Records document complaints or requests related to noise or other aspects of airport operations. Information often includes name, phone number, and address of person making complaint, name of person receiving and/or responding to complaint, description of complaint, resolution (if any), and other data. (Minimum retention: 2 years after resolved or last action).

(7) **Law Enforcement Action Records** Records document various types of security actions taken by the airport as described in 14 CFR 107.221. Examples include documents showing the number and type of firearms, explosives, and incendiaries discovered during any passenger screening process, and the method of detection of each; the number of acts and attempted acts of piracy; the number of bomb threats received, real and simulated bombs found, and actual bombings on the airport; as well as the number of detentions and arrests, and the immediate disposition of each person detained or arrested. SEE ALSO Incident Case Files in the Police section for records related to actual police reports filed. (Minimum retention: 2 years).

(8) **Navigational Facilities Maintenance and Operation Reports** Records document the maintenance and operation of various types of airport navigational equipment. Examples include non-directional radio beacon facilities, instrument landing system facilities, simplified directional facilities, distance measuring equipment, VHF marker beacons, interim standard microwave landing system, microwave landing system, and others. Includes meter readings and adjustment records, facility maintenance logs, radio equipment operation records, technical performance records, and other documents. SEE ALSO applicable record series in the Public Works-Operations and Maintenance section for records not related to navigational facilities. (Minimum retention: 2 years after equipment permanently removed from service).

(9) **Noise Compatibility Program Records** Records document the city's development of a noise compatibility program to moderate the impact of noise in areas surrounding the airport. Includes studies, reports, noise exposure and other maps, hearing records, public statements, and related documents. Program information includes a description and analysis of alternate measures, program measures to reduce or eliminate non-compatible land uses, a description of public participation, actual and anticipated effect of the program, and other summaries and descriptions. SEE ALSO Easements in Recorder — General Records section. (Minimum retention: (a) Program records described in 14 CFR 150.23 (e), retain permanently; (b) All other records, retain 5 years after program approved).

(10) **Notice to Airmen (NOTAM) Reports** Reports document the notification of air carriers as to changes in airport conditions. Subjects include construction, maintenance, surface irregularities, snow, ice, water, light malfunctions, unresolved wildlife hazards, and others. Includes Notice to Airmen (NOTAM) forms. Information includes date and time of issue, message from airport manager, and distribution data. SEE ALSO Building Records and Public Works – Operations and Maintenance sections. (Minimum retention: 1 year after notice removed).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0020
Attorney Records

(1) **Civil Case Files Records** document pending and closed cases filed by the city and against the city. Case Files contains complaints, summons, investigations, reports, attorney's notes, photographs, orders and judgments, dispositions, pleadings, medical reports, planning, engineering, and financial records, and related records. May include Court of Appeals, Circuit Court, and Supreme Court cases. SEE ALSO Liability Claims Records in the Risk Management section. (Minimum retention: 10 years after case closed, dismissed, or date of last action).

(2) **Criminal Case Files, Attorney Records** related to the prosecution of criminal cases by the attorney's office. May include copies of citations, police reports, driving records, DUII documents and tape recordings, complaints, subpoenas, motions, judgments, copies of records from other courts, and related records. May include Court of Appeals, Circuit Court, and Supreme Court cases. (Minimum retention: 10 years after case closed, dismissed, or date of last action).

(3) **Dispute Resolution Records** Records document personnel disputes resolved through mediation or arbitration instead of pursuing action through the court system. May include pleadings, investigation reports, dispositions, and related records. SEE ALSO the Personnel section. (Minimum retention: 3 years).

(4) **Land Use Board of Appeals (LUBA) Case Files Records** document land use decisions made by the city that have been appealed to and reviewed by the Land Use Board of Appeals. May include staff reports, land use orders, pleadings, briefs, and related records. SEE ALSO Land Use Hearings Records in the Planning and Development section. (Minimum retention: 10 years after final decision).

(5) **Legal Opinions Records** document formal opinions rendered by the attorney's office for various city departments or the city council and the rationale for policy maintaining consistency in related issues. Information usually includes date, department requesting opinion, and the text of the opinion. (Minimum retention: Permanent).

(6) **Public Records Disclosure Request Records** Records document requests for disclosure of public records and provides a record of city responses. Records may include but are not limited to requests for disclosure, types of records requested, request logs, notation of transfer to another district, approvals, denials, copies of petitions to the District Attorney for review of denials of disclosure, District Attorney Orders to grant or deny disclosure, correspondence, and related documentation. (Minimum retention: (a) Approved requests, retain 2 years; (b) Denied requests, retain 2 years after last action.)

(7) **Tort Claim Notices Records** document the notification given to the city of potential suits against it. ORS 30.275 requires these to be filed with the city before a potential claimant can bring certain actions against the city. Information includes notification stating the intent to sue, parties involved, date, the reason the suit is being filed, list of parties notified, and related information. SEE ALSO Liability Claim Records in the Risk Management section. (Minimum retention: 3 years after claim closed).

(8) **Victim/Witness Assistance Program Records** Records document the administration of victim/witness assistance programs. Generally includes reports, activity logs, expense statements, records documenting state action, and related memoranda and correspondence. (Minimum retention: 5 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0025
Building Records

(1) **Building Activity Records** Reports or statistical compilations tracking building activity on a monthly and annual basis. Used to plan budgets and staffing, as well as to monitor growth and chart building trends. Usually tracks number of permits issued, type of activity, value of projects, fees collected, and related information. May consist of reports compiled for the U.S. Bureau of the Census. (Minimum retention: (a) Reports summarizing activities on an annual basis, retain permanently; (b) All other reports, retain 2 years).

(2) **Building Board of Appeals Records** Records of appeals to decisions made by the city staff regarding alternate building materials or methods of construction. The board interprets city code and requirements. Often includes staff reports, applications to appeal, minutes, exhibits, and related documentation and correspondence. (Minimum retention: (a) Minutes, agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records), retain permanently; (b) Audio or visual recordings, retain 1 year after minutes prepared and approved; (c) All other records and exhibits not pertinent to minutes, retain 5 years).

(3) **Building Code Violation Records** Building department documentation related to violations of building, electrical, sign, heating, plumbing, and related city codes. May include notices of infractions, summons, complaints, compliance agreements, log books, compliance information, and related documentation and correspondence. SEE ALSO Ordinance Violation Case Files in the Municipal Court section. (Minimum retention: 10 years after last action.)

(4) **Building Inspection Records** Records document on-site visits by inspectors. May include daily inspection logs and comments noted as construction progresses. (Minimum retention: (a) Final inspections, retain for the life of the structure; (b) All other inspections, retain 2 years).

(5) **Building Permit Applications** Applications from property owners to erect new structures, including signs, or make structural modifications to existing ones. Information usually includes name, address, phone number, and signature of applicant, permit number, type and location of building, name of builder or contractor, legal description, description of work, and value of construction. (Minimum retention: (a) If permit issued, retain 2 years; (b) If no permit issued, retain 180 days).

(6) **Building Permits** Permits granted to property owners to erect new structures or demolish present structures, including signs, or make structural modifications to existing ones. Serves as official authorization for construction including installation of plumbing, electrical and mechanical equipment and other related work. (Minimum retention: (a) Permits for completed structures, retain for the life of the structure; (b) Demolition permits, retain 10 years after demolition; (c) All other permits, retain 2 years after revoked or expired).

(7) **Building Plans, Nonresidential** Blueprints and specifications submitted by building contractors or owners applying for a permit to build commercial, industrial, or apartment structures. Used for enforcement of building codes and reference for later modifications. Includes specifications of type, grade, and brand of materials used, as well as details related to temporary facilities, security, job cleanup, deadlines, and other conditions. Often includes change orders or plan modifications submitted after permit approved. (Minimum retention: (a) If permit issued and structure completed, retain 10 years after substantial completion [as defined by ORS 12.135(3)]; (b) If no permit issued, retain 180 days; (c) If permit issued, but structure not started, completed, or permit expired, retain 180 days after expiration date).

(8) **Building Plans, Publicly Owned Structures** Blueprints and specifications submitted by building contractors or government agencies applying for a permit to construct government buildings. Used for enforcement of building codes and reference for later modifications. Includes specifications of type, grade, and brand of materials used as well as details related to temporary facilities, job cleanup, deadlines, and other conditions. May also include change orders or plan modifications submitted after permit approved. (Minimum retention: (a) If permit issued and structure completed, retain for the life of the structure; (b) If no permit issued, retain 180 days; (c) if permit issued, but structure not started, completed, or permit expired, retain 180 days after expiration date).

(9) **Building Plans, Residential Blueprints, drawings, and specifications** submitted by building contractors or owners applying for a permit to build residential structures. Used for enforcement of building codes and reference for later modifications. Often includes specifications of type, grade, and brand of materials, as well as details related to temporary facilities, security, job cleanup, deadlines, and other conditions. May include change orders or plan modifications submitted after permit approved. (Minimum retention: (a) If permit issued and structure completed, retain 2 years after substantial completion; (b) If no permit issued, retain 180 days; (c) If permit issued, but structure not started or permit has expired, retain 180 days after expiration date).

(10) **Certificates of Occupancy Certificates** recognizing compliance with the minimum standards set by state and local laws for structures. Usually includes building name and location, city, occupancy, classification, load limit, date issued, and fee. (Minimum retention: Life of the structure).

(11) **Registered Contractor Lists** Lists issued quarterly by the State Construction Contractors Board verifying registration by contractors with the Board. Used to ensure compliance with state requirements regarding insurance, bonding, etc. before the issuance of building permits. Includes registration number, name of contractor, county code, type of building trade, and related information. (Minimum retention: Until superseded or obsolete).

(12) **Unsafe Building Records** Records document the demolition, boarding, or other actions related to structures determined by the city or owner to be unsafe. Includes structures determined to be unsafe due to the manufacture of illegal drugs. Also documents related repairs or actions to remedy deficiencies. Used for reference and litigation. Usually includes complaints, building inspection reports, letters to property owners, and demolition documents. May also include photographs, copies of contracts and payment records, and related records. (Minimum retention: 5 years after final action).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 8-1998, f. & cert. ef. 11-23-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0030
Emergency Management Records

(1) **Alert and Notification Records** Records document any written emergency warnings/notifications issued to the city from the county, the Oregon Emergency Management Division, National Oceanic and Atmospheric Agency (NOAA), or the Federal Emergency Management Agency (FEMA). Subjects may include landslides, earthquakes, windstorms, floods, fires, and other hazards. (Minimum retention: 30 days).

(2) **Civil Preparedness Guidance (CPG) and State and Local Guide (SLG) Records** Records issued by the Federal Emergency Management Agency (FEMA) to provide guidance to state and local agencies on appropriate elements of emergency management programs. These guidelines (known as CPGs or SLGs) provide mandatory policies and procedures for federally funded emergency management programs. (Minimum retention: Until superseded or obsolete).

(3) **Disaster Preparedness Planning and Recovery Records** Records document plans and procedures for the continuity of city government in the event that a major disaster destroys or compromises the operations of the city. Components of the recovery plan include but are not limited to physical plant repair and restoration; equipment restoration; electronic data restoration including steps to reload data, recover data, reconnect networks, and reestablish telephone connections; essential records protection; and related procedures and needs dealing with risk management, public relations, and financial issues. SEE ALSO Emergency Operations and Management Plans in this section, and Emergency and Disaster Incident Records in the Administrative section. (Minimum retention: Until superseded or obsolete).

(4) **Emergency Exercise Records** Records document emergency training exercises performed on a regular basis by the city emergency management department, as required by the State and Local Assistance and Emergency Management Assistance Programs. Documentation usually includes statements of purpose, scenario narratives, major and detailed sequences of events, messages and inputs (simulation material), evaluation points, critique and follow-up actions reports, lists of players, and names of controllers and evaluators. (Minimum retention: 3 years after annual or final expenditure report submitted).

(5) **Emergency Management Assistance Activity Reports** Reports document the city's emergency management work plan. These are created on a quarterly basis as required by the Federal Emergency Management Agency (FEMA). The reports provide a narrative of emergency management program elements that were accomplished annually, along with supporting documentation (samples of completed work). Subjects include personnel, equipment, current projects, progress reports, training, and others. (Minimum retention: 3 years after annual or final expenditure report submitted).

(6) **Emergency Management Assistance Expense Records** Records document a breakdown of the city's emergency management program expenses that are eligible for federal matching funds under the Emergency Management Assistance (EMA) program. Summaries are submitted to the Oregon Emergency Management Division annually. They identify the broad categories of emergency management program expenditure as "Personnel, Travel, and Other." Records include appropriate Federal Emergency Management Agency (FEMA) forms, copies of EMA checks issued by the state to the city as part of the pass-through funding procedure,

and related documents. (Minimum retention: 3 years after annual or final expenditure report submitted).

(7) **Emergency Management Assistance Fiscal Reports** Records documenting fiscal reports, submitted to Oregon Emergency Management Division, to receive federal matching funds under the Emergency Management Assistance (EMA) program. Reports document all funds spent by the city on emergency management functions. Records include appropriate federal forms and related documents. (Minimum retention: 3 years after annual or final expenditure report submitted).

(8) **Emergency Management Assistance Staff Pattern Records** Records document the city's personnel involved in the emergency management program. It is submitted annually to the Oregon Emergency Management Division and is the basis for determining eligibility for funded staffing support for Emergency Management Assistance jurisdictions. Records include appropriate Federal Emergency Management Agency (FEMA) forms and related documents. (Minimum retention: 3 years after annual or final expenditure report submitted).

(9) **Emergency Management Board Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(10) **Emergency Operations and Management Plans Records** document the development, implementation, and updating of emergency operations and management plans. The plans are required by the federal government as part of a Comprehensive Cooperative Agreement (CCA) and must be reevaluated and updated at least every four years. Records often include adopted plans, notes, outlines, drafts, correspondence, and related documents. SEE ALSO Disaster Preparedness Planning and Recovery Records in this section. (Minimum retention: (a) Adopted plans, retain until superseded or obsolete; (b) All other records, retain 3 years after annual or final expenditure report submitted).

(11) **Hazard Analysis Records** Records document potential natural and man-made hazards in the city. Used to formulate emergency plans, evaluate existing plans, and for general reference. The Federal Emergency Management Agency (FEMA) requires documentation for federally funded Emergency Management Assistance jurisdictions. Types of hazards include earthquakes, droughts, fires, floods, nuclear incidents, and others. Records include appropriate federal forms and related documents. Information includes geographic descriptions of locations, definitions of hazards, vulnerability identifications, hazard histories, potential maximum threats, probabilities, and related data. (Minimum retention: Until superseded or obsolete).

(12) **Hazard Shelter Records Records** document the condition of buildings designated to be used as hazard shelters in case of emergency. Used for emergency planning and reference. Records may include documents issued by federal and state emergency management agencies, as well as related materials such as sketches and photographs. Information usually includes address, building name, structural dimensions, building composition, potential occupancy, inspection results, and related data. (Minimum retention: Until superseded or obsolete).

(13) **Emergency Management Public Education Program Records** Records related to the design and implementation of emergency management educational and outreach programs and presentations provided to the public by the city. Often includes class descriptions, instructional materials, course outlines, class enrollment and attendance records, reports, speeches, audio-visual records, and related documentation. (Minimum retention: (a) Significant program records, retain 3 years; (b) Class enrollment and attendance records, retain 2 years; (c) All other records, retain 1 year).

(14) **Emergency Management Public Education** Publications Publications created by the city and distributed to the public as part of an emergency management outreach or public education effort. Often used in conjunction with presentations. Records may include brochures, pamphlets, booklets, newsletters, and other publications. Subjects often include emergency planning, warning systems, disaster response, and others. (Minimum retention: (a) Brochures, pamphlets, and leaflets, retain until superseded or obsolete; (b) One copy of all others, such as a book or publication, retain permanently).

(15) **Emergency Management Resource** Lists Lists document emergency resources such as manpower, equipment, supplies, and services. Includes names, daytime and nighttime phone numbers, and addresses of suppliers and vendors as well as contact names. (Minimum retention: Until superseded or obsolete).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0035
Financial-Assessment and Bonds Records

(1) **Assessment Balance Reports** Reports document the status of billings related to assessments for city improvements. Includes daily, weekly, monthly, quarterly, annual, and other reports showing account status by tax lot, ordinance, delinquent balances, and other criteria. (Minimum retention: (a) Annual reports or similar cumulative summaries, retain permanently (b) All other reports, retain 3 years).

(2) **Assessment Deferral Records** Records document various types of assessment deferrals for city improvements such as those for qualifying property owners 62 years of age or older as described in ORS 311.702 through 311.735. Includes applications, deferral claims, statements, financial documents, and other documentary proof showing satisfaction of requirements. Information includes name and address of property owner, age, income, signature, type of assessment, installment date and amount, and related data. (Minimum retention: 3 years after final payment).

(3) **Assessment Dockets, Ledgers, and Registers Dockets, ledgers, registers, or similar records** detailing payments made by property owners for assessments to finance city improvements. Includes bond lien dockets described in ORS 223.230. Information may include name and address of property owner, tax map and lot number of assessed property, description of property, total assessment, terms, amount paid, interest paid, principal balance paid, and related data. (Minimum retention: 3 years after final payment).

(4) **Bancroft Bond Applications** Applications submitted by property owners for installment financing of assessments levied for city improvements. Information may include account number, date received, assessment amount, name and address of property owner, description of improvement, waiver, lot and block numbers, interest rate, payment period, and related data. (Minimum retention: 3 years after final payment).

(5) **Bancroft Bond Foreclosure Records** Records document foreclosure actions, completed or not, taken by the city against property owners delinquent on their assessment payments. May include payment schedules, title reports, legal opinions, resolutions, lists of properties to be sold, receipts, correspondence, memoranda, and related documents. (Minimum retention: 3 years after final payment, redemption, sale, or action).

(6) **Bancroft Bond Receipts** Receipts document payment of property assessments. Information includes name and address of property owner, tax map and lot number of assessed property, Bancroft number, total payment made, principal amount, interest amount, outstanding balance, and related data. (Minimum retention: 3 years after annual audit report issued).

(7) **Bond Authorization Records** Records document the authorization to finance city improvements through bonded indebtedness. Includes authorizations, supporting financial documents, bond ratings, sample copies of bonds issued, and related records. SEE ALSO Council Records in the Recorder-General section for primary decision documents. (Minimum retention: 3 years after final payment).

(8) **Paid Bonds and Coupons Records** document paid bonds and coupons issued for capital improvements financed by property tax levies, special assessments, and city utilities user payments. Debt types include general obligation, special assessment, water and sewer, tax allocation, and others. The paid (canceled or redeemed) bonds and coupons are received from paying agents and include bond number, maturity date, series number, interest payable date, dollar amount, sale conditions, and related information. Series includes related information contained in official transcripts. (Minimum retention: 3 years after final payment).

(9) **Bonds Issued Registers** Registers or similar records document all city bond issues and related information. Useful for ensuring accurate information about the overall indebtedness of the city. Information often includes bond number, date paid, place of payment, maturity date, date registered, and related data. (Minimum retention: 3 years after annual audit report issued).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2001, f. & cert. ef. 2-15-01; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0040
Financial-Budget Records

(1) **Adopted Budget Records** document the final annual financial plan approved by the city council for all city expenditures. Information may include budget message, financial summaries, revenues and expenditures, operating programs, debt service, position and wage analysis, overhead allocations, organization charts, previous actual and budgeted amounts, and related data. (Minimum retention: Permanent).

(2) **Budget Committee Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(3) **Budget Preparation Records** Records document the preparation of department budget requests presented to the city council. Includes staff reports, budget instructions, worksheets, surveys, allotment reports, spending plans, contingency plans, budget proposals, financial forecasting reports, and similar records. (Minimum retention: 2 years).

(4) **Financial Impact Analysis Records** Records document the financial analysis of various city practices. Useful for planning future budget proposals. Records include reports, studies, worksheets, and similar records. Subjects may include the impact of specific ballot measures, proposals to increase permit fees, sick leave use analysis, and the city's relationship with various utilities. (Minimum retention: 3 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2001, f. & cert. ef. 2-15-01; SA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0045
Financial-Utility Billing Records

(1) **Utility Account Change Records** Records document routine information changes to customer accounts. Includes name, address, and similar change orders for current and final accounts. (Minimum retention: 2 years).

(2) **Utility Application/Disconnect Records** Applications completed by customers requesting or disconnecting water, sewer, power, garbage, or other city provided services. Information usually includes customer's name, address, and phone number, meter information, date, and approval signatures. (Minimum retention: 3 years).

(3) **Utility Bill Remittance Stubs** Bill stubs received with payments for water, sewer, power, garbage, and other city provided services. These document receipt and posting of customer payments. Information usually includes account number, name, service address, payment received, and receipt date and number. (Minimum retention: 3 years).

(4) **Utility Billing Adjustment Records** Records document adjustments to customer water, sewer, power, garbage, or other city provided service billings for debits, credits, refunds, returned checks, and related reasons. Information usually includes customer's name and address, type of adjustment, justification, amount changed, authorizing signatures, and other data. (Minimum retention: 3 years).

(5) **Utility Billing Register Records** document transactions on the water, sewer, power, garbage, or other city provided service account of each customer. Useful for reference to assure accurate customer billings. Information often includes customer's name, service address, meter reading, water or power usage, utility changes, payments, adjustments, prior balance due, current balance due, and related data. (Minimum retention: 3 years).

(6) **Utility Customer Security Deposit Records** Records document customer payment of a security deposit to receive water, sewer, power, garbage, or other services. Information usually includes date, amount of deposit, customer's name, address, and account number, date account closed, refund date, amount of deposit confiscated, reason for confiscation, and related data. (Minimum retention: 3 years after refund or last action).

(7) **Utility Meter Books Records** document the readings of customer water or power meters by city employees for billing purposes. Information usually includes name of meter reader, meter reading, date read, account number, billing code, final reading, reason for turnoff, meter changes, and related data (Minimum retention: 3 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2001, f. & cert. ef. 2-15-01; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0050
Financial-General Records

(1) **Accounts Payable Records** Records document payment of city bills for general accounts. Includes reports, invoices, statements, vouchers, purchase orders, payment authorizations, receipt records, canceled checks or warrants, and similar records. For other accounts, see City Improvement Administrative and Financial Records in Financial-Assessment and Bonds section for documents related to assessable and non-assessable city improvements. SEE ALSO Grant Records in this section for records documenting expenditure of grant funds. (Minimum retention: 3 years after annual audit report issued).

(2) **Accounts Receivable Records*** Records document revenues owed to the city by vendors, citizens, organizations, governments, and others to be credited to general accounts. Records also document billing and collection of moneys. May include reports, receipts, invoices, awards, logs, lists, summaries, statements, and similar records. Information often includes, receipt amount, date, invoice number, name, account number, account balance, adjustments, and similar data. For other accounts, see City Improvement Administrative and Financial Records in the Financial-Assessment and Bonds section for documents related to assessable and non-assessable city improvements. SEE ALSO Grant Records in this section for records documenting receipt of grant funds. (Minimum retention: 3 years after collected or deemed uncollectible).

(3) **Audit Reports, External Records** document annual audits of the financial position of the city conducted by external auditors in accordance with statutory requirements described in ORS 297.405 through 297.555. Subjects include accounting principles and methods, the accuracy and legality of transactions, accounts, etc., and compliance with requirements, orders, and regulations of other public bodies pertaining to the financial condition or operation of the city. Information includes accountant's summary, combined financial statements, schedules, balance sheet details, comments, recommendations, and related data. SEE ALSO Internal Audit Records in the Administrative section. (Minimum retention: Permanent).

(4) **Balance Status and Projection Reports** Reports created for internal use documenting the status of funds, bank accounts, investments, and other accountings of city funds. Includes budget allotment and fund reconciliation reports. Also includes projection records related to future receipts and disbursements. Reports are generated on a daily, weekly, monthly, quarterly or similar basis. Information includes date, account balances, type and summary of activity, and related data. (Minimum retention: 3 years after annual audit report issued).

(5) **Bank Transaction Records*** Records document the current status and transaction activity of city funds held at banks. May include account statements, deposit and withdrawal slips, checks, and related records. Information includes bank and account numbers, transaction dates, beginning balance, check or deposit amount, document numbers, adjustments, description of transaction, ending balance, and related data. (Minimum retention: (a) For retention of records documenting grant transactions, see Grant Records in this section (b) All other records, retain 3 years after annual audit report issued).

(6) **Bankruptcy Notices* Records** document the notification to the city that certain individuals have filed for bankruptcy. Used to determine if the individual owes money to the city and to file notice or claim with the court. Records may include notices of bankruptcy filings from U.S. Bankruptcy Court. Information may include debtors name, accounts information, prepared repayment plan, and related documentation. (Minimum retention: 3 years from discharge of debt or 3 years from last action, whichever is shorter).

(7) **City Improvement Administrative and Financial Records*** Records document the non-technical and financial administration of assessable and non-assessable city improvements including capital improvements, local improvement districts (LID), urban renewal, and economic improvement districts. Records often include affidavits of posting, notices of proposed assessment, certificates of mailing, interested party letters, bid quotes, reports, and awards, expense reports, purchase orders, requisitions, cost analyses, construction and maintenance bonds and insurance, and related administrative and financial records not located elsewhere in this schedule. SEE ALSO Assessment Dockets, Ledgers, and Registers; Bond Authorization Records; and other record series in the Financial-Assessment and Bonds section, and the Public Works-Engineering section for related information. Refer to the Recorder-General section for records documenting legislative actions such as resolutions of intent to assess and ordinances for improvements. (Minimum retention: (a) Records of project cost, retain 3 years after disposal or replacement of facility, structure, or system (b) All other improvement records, retain 10 years after substantial completion (as defined by ORS 12.135(3).

(8) **Competitive Bid Records** Records document the publication, evaluation, and awarding of quoted bids to vendors and other individuals or organizations. Provides recorded evidence of accepted and rejected bids. May include requests for proposals (RFP), bid exemption documents, bid and quote lists, notices of bid opening and award, comparison summaries, spreadsheets, tabulation worksheets, bid advertising records, tally sheets, bid specifications, correspondence, and related records. SEE ALSO Purchasing Records in this section. (Minimum retention: (a) Accepted city improvement bids 10 years after substantial completion (as defined by ORS 12.135(3)) (b) All other accepted bids 6 years after bid awarded or canceled (c) Rejected bids and bid exemptions, retain 2 years).

(9) **Employee Bond Records*** Records document the posting of fidelity, performance, or position bonds to guarantee the honest and faithful performance of elected officials, individual employees, or groups of employees. Details of bonds vary, however information usually includes name and position(s) of individual or group, amount of coverage, effective and expired dates, and related data. (Minimum retention: 6 years after expiration).

(10) **Employee Travel Records** Records document requests, authorizations, reimbursements, and other actions related to employee travel. Includes expense reports and receipts, vouchers, requests, authorizations, and related documents. Minimum retention applies to private vehicle usage as well. Information often includes estimated costs, prepayments, final costs, destination, method of transportation, travel dates, approval signatures, and related data. (Minimum retention: 3 years after annual audit has been completed).

(11) **Financial Reports Reports** document the general financial condition and operation of the city. Includes information on the value of all city owned property and an accounting of all income and expenditures in relation to the final budget. Records may include monthly, quarterly, annual, and similar reports. (Minimum retention: (a) Annual reports, retain permanently (b) All other financial reports, retain 3 years).

(12) **General Ledgers* Records** document the summary of accounts reflecting the financial position of the city. Information often includes debit, credit, and balance amounts per account, budget, fund, and department numbers, and totals for notes receivable, interest income, amounts due from other funds, federal grants received, bank loans received, cash in escrow, deferred loans received, cash, encumbrances, revenue, accounts receivable, accounts payable, and other data. SEE ALSO Subsidiary Ledgers this section (Minimum retention: (a) year-end ledgers*, retain 10 years (b) All other general ledger, retain 5 years).

(13) **Gift and Contribution Records** Records document gifts and contributions to the city. May include memorial donation records related to money to be used by the city in the name of an individual. Often contains donor and acknowledgment letters, acquisition lists itemizing purchases made with contributed money (books, art, equipment, etc.), checks, receipts, and related records. (Minimum retention: (a) For retention of conditional gift, contribution and donation records, see Contracts and Agreements in the Recorder-General section (b) All other records, retain 3 years).

(14) **Grant Records** Records document the application, evaluation, awarding, administration, monitoring, and status of grants in which the city is the recipient, grantor, allocator, or administrator. Grants may come from federal or state governments or foundations and other private funding sources. Records may include but are not limited to applications including project proposals, summaries, objectives, activities, budgets, exhibits, and award notifications; grant evaluation records and recommendations concerning grant applications; grant administration records including progress reports, budgets, project objectives, proposals, and summaries; records documenting allocation of funds; contracts; records monitoring project plans and measuring achievement; equipment inventories; financial reports, accounting records, audit reports, expenditure reports, and related correspondence and documentation. SEE ALSO the other Financial sections. (Minimum retention: (a) Final reports from significant (as defined by city policy) grants to the city, retain permanently (b) Records documenting the purchase and/or disposal of real property, retain 10 years after substantial completion (as defined by ORS 12.135(3)), or 3 years after final disposition, or as specified in agreement, whichever is longer (c) Other grant records, retain 3 years after annual or final expenditure report submitted and approved or, as specified in agreement, whichever is longer (d) Unsuccessful grant applications, retain 1 year after rejection or withdrawal).

(15) **Inventory Records*** Inventory records document the capitalized assets and expendable property of the city. Examples of capitalized assets may include but are not limited to buildings, real estate, infrastructure assets, vehicles, equipment, and furniture. Examples of expendable assets include office supplies and other small, office purchases. Information often contains asset number, description, purchase order number, location of asset, date received, purchase price, replacement cost, depreciation, and related data. This record series applies to routine property control inventories. SEE ALSO Grant Records for inventories of property purchased with grant funds. For inventories documenting other special uses, see Historic Structure Inventory Records in the Planning and Development section; Bridge Inspection Records in the Public Works-Engineering section; and Property and Evidence Control, and Disposition Records in the Police section. (Minimum retention: (a) Records of capitalized assets, retain 3 years after disposal or replacement of asset (b) Records of expendable property, retain 3 years or until superseded, whichever is longer).

(16) **Investment Records** Records document and tracking various investments made by the city. Often contains bank statements documenting investment information, journal entries, confirmations of purchase of U.S. Treasury Bills, confirmations of deposit in local investment pool, and deposit slips, correspondence, and memoranda related to specific investments. (Minimum retention: 3 years after investment ends).

(17) **Lien Search Records** Records document requests from title companies searching for liens against property within the city, which may include street improvements, water, storm sewer, and sewer. Information may include property owner, tax map and lot number, description of property, total assessment, and payments made. SEE ALSO Bancroft Bond Receipts in the Financial-Assessment and Bonds section and Lien Records in the Recorder-General section. (Minimum retention: 2 years after date of search).

(18) **Property Disposition Records** Records document disposition of city-owned non-real property, usually through public auction, competitive bidding, or destruction. Information often includes date, department, description of item, value, disposition, reason for disposition, condition, and authorization. SEE ALSO Real Property Transaction Records and Grant Records in this section for documents related to the disposition of real property. (Minimum retention: 3 years after disposition of property).

(19) **Purchasing Records Records** document orders, authorizations, and evidence of receipt of the purchase of goods and services by the city. Includes purchase orders and requests, purchase authorizations, requisitions, contract release orders, material and cost specifications, central stores or printing orders, telephone service orders, and similar records. SEE ALSO Grant Records in this section for records documenting the expenditure of grant funds and City Improvement Administrative and Financial Records and Competitive Bid Records in this section for related purchasing records. (Minimum retention: 3 years).

(20) **Real Property Transaction Records*** Records document acquisitions, dispositions, and relocations of real property and right-of-ways by the city for urban renewal projects, parks, sewers, streets, water lines, traffic signals, and other reasons. Records may include offer letters, options, agreements of short duration, staff reports, appraisal reports and reviews, inspection reports, letters of transmittal, summaries, and related records. For records documenting transactions involving grant funds, see Grant Records in this section. SEE ALSO Deeds To City-Owned Land in the Recorder-General section. (Minimum retention: 10 years after substantial completion (as defined by ORS 12.135(3).

(21) **Revenue Sharing Records*** Evidence of receipt and administration of federal and/or state revenue sharing funds including those from state liquor and cigarette taxes. Used to track how funds are spent, for budgeting future funds and for other uses. May include transmittals, affidavits of publication, planned and actual use reports, supporting documentation used to qualify for revenue sharing funds, and related records. (Minimum retention: 3 years).

(22) **Signature Authorization Records*** Records document the authorization of designated employees to sign fiscal and contractual documents. Useful as an aid for management control over expenditures. Information usually includes authorization date, name, sample signature, position, remarks, conditions, and related data. (Minimum retention: 6 years after authorization superseded or expired).

(23) **Subsidiary Ledgers, Journals, and Registers Records** document details of transactions such as those related to receipts and expenditures on a daily, monthly, quarterly or similar basis. Includes journals, ledgers, registers, day books, and other account books that provide backup documentation to the general ledger. May include details of revenues, expenditures, encumbrances, cash receipts, warrants, and others. Information often includes date, payee, purpose, fund credited or debited, check number, and similar or related data. Refer to Grant Records in this section for records documenting transactions of grant funds. SEE ALSO Financial — General Records General Ledgers and Financial-Assessment and Bonds section for related records. (Minimum retention: (a) Year-end payroll register, retain 75 years (b) Trust fund ledgers, retain 3 years after trust fund closed (c) Other subsidiary ledgers, journals, and registers, retain 3 years).

(24) **Trust Fund Records** Records document bequests to the city. Used to determine trust fund spending for reporting to trustees. May include wills, other legal documents, expenditure records, chronologies, resolutions establishing trust funds by the city, records documenting subject matter approved for purchase, acquisition lists, and related records. Some records may have historic value. For appraisal assistance, contact the State

Archivist. (Minimum retention: Records not duplicated elsewhere in city records, retain 3 years after trust fund closed).

(25) **Vendor Lists** Lists document vendors providing goods and services to the city. Information usually includes vendor name of person or company, address, and phone number, name of contact person, as well as a description of goods or services provided. (Minimum retention: Until superseded or obsolete).

(26) **Credit Slips** Slips issued to citizens who have withdrawn from city-sponsored classes or activities and are due credit for all or part of fees paid. Information usually includes name of class or activity, date, expiration date, name and address of citizen, and related data. (Minimum retention: 3 years after credit expired or redeemed).

(27) **Vehicle Usage and Expense Records** Records document usage and expense associated with city-owned vehicles. Used for maintenance, budgeting, and planning. Information can include vehicle number, make and model, beginning and ending mileage, driver's name and signature, fuel used, repairs needed, and other data. (Minimum retention: 3 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2001, f. & cert. ef. 2-15-01; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 2-2005, f. & cert. ef. 5-10-05; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0055
Fire and Emergency Medical Services Records

(1) **Fire and Emergency Medical Services (EMS) Activity Reports** Individual, shift, project, or other activity reports or logs filed on a daily, weekly, monthly, or similar basis. Useful for reference, performance monitoring, compiling annual reports, planning and budgeting, and briefing subsequent shifts. Information usually includes name, shift, date, description of activities, and various statistical categories for tracking department emergency responses, training, public outreach, inspections, maintenance, and other work. (Minimum retention: (a) Reports summarizing activities on an annual basis, retain permanently; (b) Other reports, retain 2 years).

(2) **Ambulance Licensing Records** Records document application by the city to the Oregon Health Division for licenses to operate ambulances. May also include records related to applications submitted to the city by private ambulance services for operation in cities that have ordinances regulating ambulance services as defined in ORS 820.300 through 820.380. Records often include applications, licenses, affidavits of compliance, certificates of insurance, bonds, and related documents. Information includes name and address of city, person, or company, and a description of the ambulance, including make, year, registration number, and related data. (Minimum retention: 2 years after denial, revocation, or expiration).

(3) **Automobile Display Permits** Permits issued to allow the display of automobiles or any vehicles, which carry fuel inside public or commercial buildings. Permits usually include date of display or expiration date, location, name, address, and telephone number of person or organization requesting the permit, conditions related to the display, comments, and other information. (Minimum retention: 2 years after permit denied, revoked or expired).

(4) **Burning Permits** Permits issued to individuals for open air burning within the area serviced by the city fire department. Information may include name, phone number, address, amount and location of burn, fire protection equipment and conditions required, date, and signatures of permittee and issuing officer. (Minimum retention: 2 years after denial, revocation, or expiration).

(5) **Emergency Medical Incident Records** Records document services provided by the city fire and emergency medical services department to sick or injured people. May include pre-hospital care reports, medical aid liability release forms, and related documents. Information often includes name and address of patient, location of incident, description of illness or injury, actions taken, and related data. (Minimum retention: 10 years).

(6) **Explosives Storage and Use Permits Records** document the issuance of permits authorizing the use of explosives for construction and demolition projects, fireworks, theatrical pyrotechnics, and other applications. Records may include permits, applications, insurance verifications, and related documents. Information often includes name and address of permittee, location of use, amount and type of explosives used, conditions, and related data. SEE ALSO Engineering Project Technical Records in the Public Works-Engineering section for permits related to explosives use on city projects. (Minimum retention: 2 years after permit denied, revoked, or expired).

(7) **Fire and Security Alarm System Records** Records document the city fire department role in issuing permits, testing, and maintaining fire and security alarms that connect to a city alarm system. May include permits, applications, malfunction reports, maintenance reports, and related documents. Permit information often includes name and address of property owner, name and address of company installing the system, permit number, alarm location, and date. Maintenance information often includes date, malfunction (if any), tests conducted, corrective actions taken, location of alarm, and related data. (Minimum retention: (a) Permit records, retain 2 years after expiration; (b) Other records, retain 2 years).

(8) **Fire and EMS Advisory Board Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(9) **Fire Investigation Records** Records document investigations conducted by the city fire department. May include investigative reports, supplemental reports, photographs, maps, drawings, correspondence, laboratory reports, notes, and related records. (Minimum retention: (a) Records documenting fires involving loss of life, retain 75 years; (b) Other records, retain 10 years).

(10) **Fire Reports** Reports document each fire responded to by the city fire department. These reports are required by the State Fire Marshal. Subjects include cause, casualties, and property loss. Information includes date, run number, location of fire, weather conditions, owner's name and address, property damage, loss estimate, and other data. Includes additional reports if injuries occurred. (Minimum retention: 10 years).

(11) **Grass and Weed Control Records** Records document city enforcement of ordinances designed to help prevent fires caused by overgrown grass, weeds, or shrubs. May include complaints, inspection reports, notices, violations, contractor mowing bills, receipts, and related records. Information includes name of property owner, address of property, name of complainant, date and expiration of notice, name of fire personnel inspecting property; date, time, and method of grass and weed removal; charges, signature of contractor, and related data. SEE ALSO Ordinance Violation Case Files in the Municipal Court section. (Minimum retention: 3 years after last action or final payment).

(12) **Hazardous Material Emergency Incident Records** Records document city response to hazardous material emergencies. Subjects usually pertain to spills and other accidental releases. Includes reports, complaints, and similar documents. Information often includes location, date and time, type of pollutant, extent of pollution, cause, action taken, person reporting pollution, witnesses, related injuries, name and address of responsible party and related data. (Minimum retention: Permanent).

(13) **Hazardous Substance Employer Survey Summaries Records** document the storage and use of hazardous materials within the area served by the fire department. Usually consists of summaries of employer surveys conducted by the State Fire Marshal as well as related records generated by the city. Information includes employer name and location, emergency phone numbers and procedures, location, type, and quantity of hazardous substances, and related data. State employer surveys are updated each year. (Minimum retention: Until superseded or obsolete).

(14) **Inspection and Occupancy Records** Records document fire prevention inspections performed periodically by the city fire department. Inspections determine if any violations of fire code are present in premises within the area served by the department. Usually filed by address. Inspection records may include reports, notices, citations, and related documents. Information often includes occupant name, location, person contacted, violations found, inspector's name, number of days to correct violations, comments, and other data. Also may include occupancy and pre-fire planning records such as floor plans, sketches, reports, lists, and related documents. Information often includes address, name of property owner, description and fire history of property, name of occupant, potential hazards or exposures, regulated substances, fire escapes, water supply, sprinklers, roof construction, and other data useful in fire fighting situations. (Minimum retention: Retain current and previous inspection reports or 10 years, whichever is longer).

(15) **Fire and Emergency Medical Services Maps** Maps and related records maintained by the city fire department for address location reference and for tracking various trends such as fire frequency and location, arson fires, and others. Includes lists, books, and other methods of address location. Some maps may have historic value. For appraisal assistance, contact the Oregon State Archives. (Minimum retention: Until superseded or obsolete).

(16) **Fire and EMS Public Education Program Records** SEE Seminar and Conference Records, City Sponsored in the Administrative Records section.

(17) **Fire and EMS Public Education Publications** SEE Publications in the Administrative Records section.

(18) **Regulated Substances Storage and Use Records** Records document the storage and use of regulated substances such as gasoline, crude

oil, fuel oil, and diesel oil in the city. May include applications, permits, inspection reports and related records for city regulation of above ground storage tanks as well as reports of substance releases from underground storage tanks. Cities that administer their own underground storage tank program as described in ORS 466.730 may have additional records such as underground storage tank applications, permits, inspection reports, documentation of corrective procedures undertaken in the event of spills, leaks, or corrosion, and related documents. SEE ALSO Inspection and Occupancy Records in this section for regulated substance storage and use records related to structures. (Minimum retention: (a) Records related to underground storage tanks, retain 25 years after tank removed; (b) Records related to above ground storage tanks, retain 5 years).

(19) **State Fire Marshal Exemption Records** Records document partial or full city exemption from statutes, rules, and regulations administered by the State Fire Marshal. Exemptions are granted if the city enacts and enforces adequate regulations to conform with to state and national fire standards defined in ORS 476.030(3). Certificates are renewed every two years. Usually includes applications, supporting documentation, reports, exemption certificate, and related documents. (Minimum retention: 2 years after denial, revocation, or expiration of exemption).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0060
Information and Records Management Records

(1) **Computer System Maintenance Records** Records document the maintenance of city computer systems and used to ensure compliance with any warranties or service contracts, schedule regular maintenance and diagnose system or component problems, and document systems backups. Records may include but are not limited to computer equipment inventories, hardware performance reports, component maintenance records (invoices, warranties, maintenance logs, correspondence, maintenance reports, and related records), system backup reports and procedures, and backup tape inventories, and related documentation. SEE ALSO Technical Manuals, Specifications, and Warranties in the Administrative section. (Minimum retention: (a) Records related to system or component repair or service, retain for the life of the system or component; (b) Records related to regular or essential records backups, retain 1 year after superseded or obsolete).

(2) **Computer System Program Documentation Records** document the addition, modification, or removal of software from a city computer system. Records usually fall into six categories: records that document (1) operating systems; (2) the in-house creation and modification of application programs; (3) the structure and form of data sets; (4) the use of commercial software packages; (5) the structure of the system; and 6) system-to-system communication. Records may include but are not limited to system overviews, operation logs, job listings, operator instruction manuals, system development logs, system specifications and changes (including narrative and flow chart descriptions), conversion notes, data set logs, data set inventories, data set record layouts, hard copies of tables, data dictionaries, data directories, programming logs, program specifications and changes, record layouts, user views, control program table documentation, program listings, commercial software manuals, and related correspondence and documentation. SEE ALSO Software Management Records in this section. (Minimum retention: (a) Migration plans, retain until superseded or obsolete; (b) Other records, retain 1 year after system superseded).

(3) **Computer System Security Records** Records document the security of the city's computer systems. Includes employee access requests, (initial access requests and subsequent requests that change an employee's access rights) passwords, access authorizations, and related documentation. (Minimum retention: 3 years after superseded).

(4) **Computer System Wiring Records** Records document the wiring of the city's computer network system. Includes blueprints or drawings of building computer system wiring, cables, computer equipment connections, and related documentation. (Minimum retention: Current plus previous).

(5) **Filing System Records** Records document the establishment, maintenance, alteration, or abolition of city filing systems. Records may include but are not limited to include master file lists, organizational charts, program descriptions, and correspondence. SEE ALSO Recorder — General Records section. (Minimum retention: 5 years after superseded or abolished).

(6) **Forms Development Records** Records document the development of new or revised forms used by a city. Records may include but are not limited to sample forms, drafts, revisions, form logs/listings, proposals, authorizations and illustrations. SEE ALSO Recorder – General Records Section. (Minimum retention: Until superseded or obsolete).

(7) **Information Service Subscription Records** Records document city subscriptions to information services. Records may include but are not limited to subscriptions, invoices, and correspondence. (Minimum retention: 2 years).

(8) **Information System Planning and Development Records** Records document the planning and development of city information systems. Although these records typically document computerized information systems, they may also document manual filing systems and microfilm systems. The records are used to insure that planned systems will help the institution fulfill its missions, are cost-effective, conform to adopted information standards, and integrate with existing institution information systems. Records may vary according to the level of documentation required for each system, but may include information technology plans, feasibility studies, cost-benefit analyses, institution studies and surveys, information management project records, system specifications and revisions, software evaluations, component proposals, technical literature, vendor literature and proposals, and correspondence. (Minimum retention: (a) Implemented systems, retain for the life of the system; (b) Unimplemented systems, retain 3 years).

(9) **Microfilm Quality Control Records** Records document that microfilm produced by or for cities conforms to the specifications required by Oregon Administrative Rules 166-025-0005 to 166-025-0030. Records may include but are not limited to microfilmed records lists, microfilm reel indexes, service bureau transmittals, film inspection reports, methylene blue certifications, camera/processor/duplicator inspection reports, equipment and operator logs, and correspondence. SEE ALSO Recorder — General Records section. (Minimum retention: Same as related microfilm).

(10) **Records Management Records** Records document the authorized retention, scheduling, inventory, and disposition of city public records. Records may include but are not limited to records retention schedules, inventory worksheets, schedule authorizations, procedure guidelines, transmittals, destruction authorizations, reports, and correspondence. (Minimum retention: (a) Destruction records, retain permanently; (b) Other records, retain 5 years after superseded).

(11) **Software Management Records** Records document the use of software in city information systems to insure that institution software packages are compatible, that license and copyright provisions are complied with, and that upgrades are obtained in a timely manner. Records may include but are not limited to software purchase records, software inventories, software licenses, site licenses, and correspondence. (Minimum retention: 2 years after software disposed of or upgraded).

(12) **Telecommunications System Management Records** Records document the creation, modification, or disposition of city telecommunications systems. Records may include but are not limited to equipment records, Federal Communications Commission records, repair order forms, system planning records, telecommunications maintenance contracts, telecommunications service orders, and correspondence. SEE ALSO Administrative Records section. (Minimum retention: 1 year after system superseded or obsolete).

(13) **User Support Records** Records document troubleshooting and problem-solving assistance provided by the city's information systems personnel to users of the systems (computer, telecommunications, etc.) Records may include assistance requests, resolution records, and related documentation. Information may include name of requester, date, time, location, and description of problem and resolution. (Minimum retention: 1 year).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0065
Library Records

(1) **Accession Records** Records document the accession of all library acquisitions into the library's holdings. Information may include author, title, publisher, jobber, year purchased, purchase price, and other bibliographic and accession data. Non-book media contain other pertinent information. May include accession registers and documentation of materials deaccessioned from the library collection. Usually filed by accession control number. (Minimum retention: Until superseded or obsolete).

(2) **Borrower Registration Records** Records used to grant citizens library cards and privileges as well as to control circulation of library holdings. Individual borrower registration information may include name,

address, telephone number, date of birth, signature, expiration date, identification number, and related data. (Minimum retention: Until superseded or 1 year after expiration or non-use).

(3) **Catalogs Finding aids, usually in card or computer form**, which provide patrons with access to library holdings by subject, title, and author. Usually includes author's name, title of book or other media, call number, bibliographic description, and related information. (Minimum retention: Until superseded or obsolete).

(4) **Circulation Cards Book cards** document information pertinent to the circulation of materials such as books, magazines, record albums, audio and videotapes, and computer software. May include patron name, date circulated and date due. Usually filed by due date and classification number. (Minimum retention: Until superseded or obsolete).

(5) **Inter-Library Loan Records** Records document materials borrowed and loaned by the city library through an inter-library loan program in response to patron and other library requests. May include requests, notices, tracking logs, and other records. (Minimum retention: 6 months after materials returned to owner library).

(6) **Library Board Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(7) **Library Publications Publications** distributed to the public to advertise library services, programs, and activities. May include brochures, newsletters, activities calendars, bookmobile schedules, special events flyers, and other records. (Minimum retention: (a) Brochures, pamphlets, and leaflets, retain until superseded or obsolete; (b) One copy of all others, retain permanently).

(8) **Library Reports** Statistical and narrative reports documenting collection, registration, circulation, lost books, children's programs, and other activities. Useful in program planning and budget preparation. May include various reports such as circulation statistics by category (non-fiction, fiction, magazines, etc.), books reserved, photocopies made, overdue notices mailed, borrowers registered, and volunteer hours. May also include narrative reports addressing new activities, services, events, and issues. (Minimum retention: (a) Reports summarizing activities on an annual basis, retain permanently; (b) All other reports, retain 2 years).

(9) **Master Shelf Lists/Inventories** Inventories of all library holdings, including volumes and titles added or withdrawn from the collection. Usually arranged by shelf, showing title, author, accession number, publisher, date bought, cost, and number of copies. Used as an inventory control by library personnel. (Minimum retention: Until superseded or obsolete).

(10) **Oregon State Library Annual Reports** City copy of a report filed with the Oregon State Library in satisfaction of ORS 357.520 to monitor library programs. Includes statistics on circulation, patrons served, inter-library loan transactions, children's programs, and other subjects. (Minimum retention: Permanent).

(11) **Overdue Book Records** Records used to monitor status of overdue books and other media. Also used to notify patrons to return overdue library materials. Often includes notices and lists. Lists document long overdue materials and can be useful in collection action. (Minimum retention: Until materials returned or debts reconciled or deemed uncollectible).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0070
Mayor/City Manager Records

(1) **Appointment Records** Appointments made by the City Council for Mayor or Councilor positions to fill vacancies. May also include appointments made by the city to committees, boards, commissions, task forces, and other advisory groups. Often includes applications, interview notes, resumes, staff reports, letters of recommendation, letters of appointment, and related non-routine correspondence. section. (Minimum retention: (a) Mayor or councilor appointments, retain permanently; (b) Commissioners and other positions, if appointed, retain 6 years after separation; (c) All Other positions, if not appointed, retain 1 year).

(2) **Citizen Awards** Awards presented by the city to honor volunteers for civic contributions. May include award nominations, award certificates, presentation or ceremony records and photographs, lists of past recipients, and related records. Some records in this series may have historic value. For appraisal assistance contact the Oregon State Archives. SEE ALSO Council Records in the Recorder-General section. (Minimum retention: 6 years).

(3) **Legislative Issues Records** Records monitoring federal or state legislation affecting the city. Used to develop official positions and lobbying strategies for pending legislation. Also used for reference. Typically includes copies of bills, reports, position papers, impact statements, meeting notes, and related correspondence. (Minimum retention: 4 years).

(4) Proclamations Statements issued by the mayor or city manager on matters affecting the city, usually dedications, openings, and other ceremonial occasions. SEE ALSO Council Records in the Recorder-General section. (Minimum retention: (a) Proclamations requested by outside groups or organizations, retain 1 year; (b) All other proclamations, retain permanently).

(5) **Sister City Records** Records of city participation in sister programs with cities in other countries. Includes documentation of the selection of sister cities and the administration of programs. Records often include minutes, agendas, correspondence, ceremonial agreements, proclamations, exchange visit records, expense statements, photographs, and important related documents. In some cities, non-public groups are responsible for sister city arrangements and events. (Minimum retention: (a) Ceremonial agreements, retain permanently; (b) Financial records, retain 3 years).

(6) **State of The City Addresses** Annual addresses by the mayor or city manager reviewing accomplishments of the preceding year and stating goals for the next year. Drafts may be retained as needed. These records may be maintained in complete form in the council minutes. (Minimum retention: (a) Final copy of address and drafts with significant changes to content and context, retain permanently; (b) Drafts, retain 1 year after final copy prepared).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0075
Municipal Court Records

(1) **Appeals Records** Records related to municipal court decisions appealed to higher courts. Can include copies of original citations, reports, driving records, evidence, original dispositions of cases, judgment orders, judge's trial notes, jury lists, jury verdict sheets, correspondence, and related records. (Minimum retention: (a) DUII case records, retain 10 years after case closed, dismissed, or date of last action; (b) All other records, retain 5 years after case closed, dismissed, or date of last action).

(2) **Court Appointed Attorney Application Records** Letters of application submitted by attorneys requesting to be included on lists of court appointed attorneys designated by the court to defend certain individuals. Usually includes letters of application, letters of acceptance, and related records. (Minimum retention: 1 year).

(3) **Court Appointed Attorney Lists** Lists of court appointed attorneys designated by the court to defend certain individuals. Information often contains attorney's name, address, and telephone number, date of last appointment to a case by the court, and related information. (Minimum retention: Until superseded or obsolete).

(4) **Court Appointed Attorney Time and Billing Records** Records document the amount of time spent on a case by the submitting court appointed attorney. Used to verify time and authorize payment. Records often include affidavits, bills, and related records. Information may include attorney's name and address, defendant's name, charge, docket number, time spent on case, beginning and ending date of appointment, signature of judge authorizing fee payment, and amount to be paid. (Minimum retention: 3 years).

(5) **Court Orders and Procedural Rules Records** documenting the guidelines and implementation of the State Uniform Trial Court Rules and local variations written by the judge to establish guidelines and clarify procedures for court clerks to perform duties of the court. Records may include municipal court orders and court procedural rules. (Minimum retention: Current plus previous orders and rules).

(6) **Municipal Court Criminal Case Files Records** documenting the prosecution of non-traffic related criminal misdemeanor offenses and the disposition of cases before the court. Records may also document the preliminary hearing of felony offenses then remanded to circuit court. Action may be initiated by either citation or private complaint. Records often include citations to appear in court, complaints, warrants, police reports, subpoenas, defendant information, and related records. (Minimum retention: 10 years after case closed or dismissed, or date of last action).

(7) **Docket/Trial Calendars** Lists of dates and times set for court appearances. Information usually includes defendant's name, charge, attorney's name, officers, and the time the case is scheduled to begin. SEE ALSO Trial Proceedings Records in this section for documentation of action taken. (Minimum retention: 90 days).

(8) **DUII Case Files Records** related to DUII (driving under the influence of intoxicants) cases brought before the court and agreements by defendants to enter DUII diversion programs. Can include citations, complaints, chemical analyses, diversion agreements, sentencing orders, commitment orders, license suspension notices, community service referrals, alcohol program referral notices, and related records. (Minimum retention: 10 years after case closed or dismissed, or date of last action).

(9) **DUII Diversion Program/Conviction Summary Records** Summaries documenting the number of convicted DUII cases and DUII cases diverted to court ordered medical or mental health programs. Can include summaries of fines, forfeitures, and fees charged to individuals in relation to conviction or diversion. Summary information may include total numbers of DUII cases filed, first offenses filed, diversion petitions approved and revoked, diversion cases convicted or dismissed, and non-compliance cases. Other summaries may document agreement fees, conviction fees, and related information. (Minimum retention: 5 years).

(10) **Municipal Court Expunged or Sealed Records** Records document the arrest and/or conviction of a person who petitions and is granted by the court an order sealing or otherwise disposing of any related records (according to ORS 137.225) maintained by the Municipal Court. "Upon entry of such an order, the applicant for purposes of the law shall be deemed not to have been previously convicted, or arrested as the case may be, and the court shall issue an order sealing the record of conviction or other official records in the case, including the records of arrest whether or not the arrest resulted in further criminal proceeding." Also applies to records related to juveniles as outlined in ORS 419A.260 through 419A.262. SEE ALSO Expunged or Sealed Records, Police in the Police section. (Minimum retention: (a) Expunged records, retain according to the directive of the court; (b) Expungement orders, retain 10 years or according to the directive of the court; (c) Sealed records, retain 10 years or according to the directive of the court).

(11) **Jury Records Records** related to selecting and overseeing jurors for the court. Process includes selection of jurors and documentation of services rendered by jurors. Records can include lists of potential jurors, questionnaires, requests to be excused, juror notification cards, juror registers and sign-in sheets, jury pool statistical documentation, and related records. (Minimum retention: 3 years).

(12) **Ordinance Violation Case Files Records** of citations issued and disposition of cases in court involving violations of city ordinance or code. Examples include building code violations, dogs running at large, nuisances, and other non-traffic violations. Records may include citations to appear in court, complaints, warrants, police reports, subpoenas, defendant information, and other related records. SEE ALSO Building Code Violation Records in Building Records section. (Minimum retention: (a) Citations issued, retain 5 years after case closed or dismissed or date of last action; (b) Records of citations not issued, retain 1 year after date of last action).

(13) **Parking Citation Records** Records of the issuance and disposition of parking citations. May include citations, correspondence, and related records. Information may include citation number, name, vehicle license number, time of citation, violation category, and related data. (Minimum retention: 3 years after satisfied, dismissed, or deemed uncollectible).

(14) **Supreme Court Statistical Reports** City copies of monthly reports that were required to be filed with the Oregon State Supreme Court documenting court activity. These reports were discontinued in 1995. Statistical information includes pending cases carried over from previous month, cases filed, cases tried, other terminations (dismissed, transferred, bail forfeited, diversion, etc.) and other data. (Minimum retention: Destroy).

(15) **Traffic Citation Case Files Records** of citations issued (including citations generated from photo radar records) and disposition of cases in court for moving violations such as hit and run and reckless driving, and infractions such as speeding and improper signaling. May include citations to appear in court, complaints, warrants, driving records, police reports, suspension records, disposition slips, subpoenas, and other related records. Does not include DUII citation records. SEE ALSO DUII Case Files in this section and Photo Radar Records in the Police section. (Minimum retention: 5 years after case closed or dismissed or date of last action).

(16) **Trial Proceedings Records/Register** of Actions Records documenting the actions of all cases brought before the court. Types of cases may include criminal misdemeanors, including misdemeanor traffic crimes, with limited penalties; other minor traffic infractions; certain minor liquor and drug violations, parking violations; and municipal code violations such as animal and fire violations. Records may include a register of actions as described per ORS 7.020. Records usually document the prosecution of individual cases including arraignments, motions, orders, and judgments. Information may include date of offense, case number, docket number, pleas, disposition, court date, attorneys' names, defendant and plaintiff names, addresses, and dates of birth, and judgments. May also include indexes. (Minimum retention: (a) Criminal cases, retain 10 years after case closed, dismissed, or date of last action; (b) non-criminal cases, retain 5 years after case closed, dismissed, or date of last action).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0080
Parks and Recreation Records

(1) **Chemical Application Records** Records document the application of chemicals such as pesticides, herbicides, and fertilizers to city parks and other property. Information usually includes date used, weather conditions, application area, chemical applied, mix ratio, and coverage rate. (Minimum retention: 3 years after application).

(2) **Park and Facility Inspection Records** Records document periodic inspection of parks and facilities to check for damage and recommend repairs and maintenance. Includes inspections of play equipment, lighting, sidewalks, restrooms, storage areas, picnic tables, swimming pools, and other property and equipment. Records often include inspection worksheets or checklists, reports, and related documents. Information includes property or equipment location and description, type of inspection, recommended repair, dates of inspection, and other data. (Minimum retention: 2 years).

(3) **Park and Facility Use Permits** Permits issued to individuals or organizations for special uses of city parks and facilities. Examples include fun runs, bicycle races, events with more than a specified number of participants, events including amplified sound, and those at which alcoholic beverages will be served. May also include other special use permits such as for the use of metal detectors and other equipment on park property. (Minimum retention: 2 years after denial, revocation, or expiration of permit).

(4) **Parks and Recreation Board Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(5) **Participant Registration and Attendance Records** Records document registration and attendance of participants in various city sponsored events, activities, and classes. Records may include registration forms or cards, class or activity rosters, and related documents. Information usually includes name, dates, and times of class or activity, fee paid, and name, address, phone number, and signature of participant. Further information may include pertinent medical data, date of birth, signature of parent or guardian, and other data. (Minimum retention: 3 years).

(6) **Rental and Loan Records Records** document the rental or loan of city-owned facilities or equipment. Examples include short term rental of facilities and structures as well as rental or loan of sports equipment, tools, gardening implements, and other items. Records often include applications, calendars, lists, receipts, and related documents. Information usually includes name, address, and phone number of renter or borrower, description of facility or equipment, date and time rental or loan expires, signature, and other data. (Minimum retention: 3 years).

(7) **Swimming Pool Operation and Maintenance Records** Records document the operation and maintenance of city swimming pools. Information includes results of pool water quality tests described in OAR 333-060-0200(3), date and time of filter backwash, dates during which the pool was emptied and/or cleaned, and periods of recirculation equipment operation and/or malfunction and repair. May also include records documenting inspection and maintenance of safety equipment. (Minimum retention: 2 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0085
Payroll Records

(1) **Deduction Authorization Records** Records document employee application and authorization for voluntary payroll deductions, direct bank deposits, and related actions. Payroll deductions are directly deposited or remitted to the authorized financial institution, insurance company, or other agency or vendor. Records may include insurance applications, enrollment cards, deduction authorizations, approval notices, deduction terminations, and related records. (Minimum retention: 3 years after superseded, terminated, or employee separates).

(2) **Deduction Registers** Registers or records serving the same function of documenting voluntary and/or required deductions from the gross pay of city employees. Types of deductions include federal income and social security taxes, state tax, workers' compensation, union dues, insurance, deferred compensation, credit union, parking permit, pre-written checks, garnishments, levies, charitable contributions, and others. Information may include employee name and number, pay period, social security number, total deductions, net pay, check number, and related data. (Minimum retention: (a) Registers documenting state and federal taxes, retain 5 years; (b) Other registers, retain 3 years).

(3) **Employee Time Records** Records document hours worked, leave hours accrued, and leave hours taken by city employees. Information usually includes employee name and social security number, hours worked, type and number of leave hours taken, total hours, dates, and related data. SEE ALSO Leave Applications in this section. (Minimum retention: (a) For the retention of records documenting the expenditure of grant funds, see Grant Records in the Financial-General section; (b) Other records, retain 4 years).

(4) **Federal and State Tax Records** Records, in addition to those itemized in this section, used to report the collection, distribution, deposit, and transmittal of federal and state income taxes as well as social security tax. Examples include the federal miscellaneous income statement (1099), request for taxpayer identification number and certificate (W-9), employers' quarterly federal tax return (941, 941E), tax deposit coupon (8109), and similar federal and state completed forms. SEE ALSO Wage and Tax Statements and Withholding Allowance Certificates in this section for related records. (Minimum retention: 5 years).

(5) **Garnishment Records** Records document requests and court orders to withhold wages from employee earnings for garnishments, tax levies, support payments, and other reasons. Usually includes original writs of garnishment, orders to withhold for the Oregon Department of Human Resources, federal or state tax levies, recapitulations of amounts withheld, and related records. Information usually includes employee name and number, name of agency ordering garnishment, amount, name of party to whom payment is submitted, dates, and related data. (Minimum retention: 3 years after resolution).

(6) **Leave Applications** Applications or requests submitted by city employees for sick, vacation, compensatory, personal business, family and medical leave, long term leave, and other leave time. Information usually includes employee name, department, date, leave dates requested, type of leave requested, and related data. SEE ALSO Employee Time Records in this section. (Minimum retention: 3 years).

(7) **Leave Balance Reports** Reports document individual city employee accrual and use of sick, vacation, compensatory, personal business, family and medical leave, and other leave time. Information usually includes employee name and number, social security number, leave beginning balance, leave time accrued, leave time used, ending balance, and related data. SEE ALSO Employee Benefits Records in the Personnel section. (Minimum retention: (a) Year-end leave balance reports, retain 75 years after date of hire; (b) All other reports, retain 4 years).

(8) **Payroll Administrative Reports** Reports, statistical studies, and other records designed and used for budget preparation, projections, workload and personnel management, research, and general reference. Often consists of recapitulation reports organizing wages, deductions, and other data into categories such as quarter-to-date, year-to-date, fiscal year-to-date, department, division, section, employee/employer contributions, and others. (Minimum retention: 3 years).

(9) **Payroll Registers** Registers or records serving the same function of documenting the earnings, voluntary and required deductions, and withholdings of city employees. Information usually includes employee name and number, social security number, hours worked, rate, overtime, vacation value, various allowances, gross pay, federal and state withholding, voluntary deductions, net pay, and related data. (Minimum retention: (a) Year-end, or month-end if no year-end payroll registers, retain 75 years; (b) All other payroll registers, retain 2 years).

(10) **Unemployment Compensation Claim Records** Records document claims submitted by former city employees for unemployment compensation. Usually includes claims, notices, reports, and related records. May also include records generated by the appeal of claim determinations. (Minimum retention: 3 years).

(11) **Unemployment Reports** Records document employee earnings on a quarterly basis. Used to document costs and charges in the event of an unemployment compensation claim. Information includes employee name, social security number, quarterly earnings, days worked, totals, and other data. (Minimum retention: 3 years).

(12) **Wage and Tax Statements** Annual statements document individual employee earnings and withholdings for state and federal income taxes and social security tax. Also known as federal tax form W-2. Information includes city name and tax identification number, employee name and social security number, wages paid, amounts withheld, and related data. SEE ALSO Federal and State Tax Forms in this section for related records. (Minimum retention: 5 years).

(13) **Withholding Allowance Certificates** Certificates document the exemption status of individual city employees. Also described as W-4 forms. Information includes employee name and address, social security number, designation of exemption status, and signature. SEE ALSO Federal and State Tax Forms in this section for related information. (Minimum retention: 5 years after superseded or employee separation).

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Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 1-2007, f. & cert. ef. 5-8-07; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0090
Personnel Records

(1) **Affirmative Action Records** Records document city compliance with the statutes and regulatory requirements of the U.S. Equal Employment Opportunity Commission. May include plans, updates, policy statements, reports, and supporting information. (Minimum retention: (a) Plans, updates, and policy statements, retain permanently; (b) Other records, retain 3 years).

(2) **Collective Bargaining Records** Records documenting negotiations between the city and employee representatives. May include contracts, reports, negotiation notes, letters of agreement, arbitration findings, cost analyses, minutes, tape recordings, and related records. SEE ALSO Contracts and Agreements in the Recorder-General section. (Minimum retention: (a) Contracts and minutes, retain 75 years after contract expires; (b) Other records, retain 6 years after contract expires).

(3) **Comparable Worth Study Records** Records document the analysis, study, and resolution of pay equity, alleged job discrimination, and related issues involving the city and its employees. May include job content questionnaire summaries, position allocation reports, personnel reclassification studies, job category listings, study outlines, graphs, tables, and related records. (Minimum retention: (a) Final study or report, retain permanently; (b) All other records, retain 5 years).

(4) **Disciplinary Action Records** Records document dismissal, suspension, progressive disciplinary measures, and other actions against employees. May include statements, investigative records, interview and hearing records, findings, and related records. May be filed with Employee Personnel Records. (Minimum retention: (a) Investigations resulting in termination, retain 10 years after employee separation; (b) Investigations resulting in disciplinary action or exoneration, retain 3 years after resolution; (c) Unfounded investigations, retain 3 years).

(5) **Employee Benefits Records** Records document an individual city employee's benefit information such as selection of insurance plans, retirement, pension, and disability plans, deferred compensation plans, and other benefit program information. Records may include but are not limited to plan selection and application forms, enrollment records, contribution and deduction summaries, personal data records, authorizations, beneficiary information, year-end leave balance reports, notices of disability payments made, and related documentation. Records may be filed with the Employee Personnel Record. SEE ALSO the Payroll section. (Minimum retention: (a) Year-end leave balance reports and official copy of retirement enrollment records, retain 75 years after date of hire; (b) All Other records, retain 3 years after employee separation or eligibility expired).

(6) **Employee Medical Records** Records document an individual employee's work related medical history. These records are not personnel records and must be kept in a separate location from employee personnel records as required by the Americans with Disabilities Act. Records may include but are not limited to medical examination records (pre-employment, pre-assignment, periodic, or episodic), X-rays, records of significant health or disability limitations related to job assignments, documentation of work related injuries or illnesses, hearing test records, hazard exposure records, first-aid incident records, physician statements, release consent forms, and related correspondence. SEE ALSO Hazard Exposure Records in this section. (Minimum retention: (a) Hazard exposure records, retain 30 years after separation [29 CFR 1910.1020]; (b) Other records, retain 6 years after separation).

(7) **Employee Personnel Records** Records document an individual employee's work history. Records may include but are not limited to applications; notices of appointment; employment applications; training and cer-

tification records; records of health limitations; salary schedules; tuition reimbursement records; personnel actions; performance appraisal evaluations; letters of commendation and recommendation; letters of reprimand; notices of disciplinary action; notices of layoff; letters of resignation; home address and telephone disclosures; emergency notification forms; oaths of office; grievance and complaint records; and related correspondence and documentation. Records may be exempt from public disclosure per ORS 192. 502 (2). SEE ALSO Disciplinary Action Records, Employee Benefits Records, Employee Medical Records, Grievance and Complaint Records, Recruitment and Selection Records, and Volunteer Worker Records in this section. (Minimum retention: (a) Letters of reprimand and notices of disciplinary action, retain 3 years; (b) All other records, retain 6 years after separation).

(8) **Employee Recognition Program Records** Records document the recognition of employees for special service to the city. May include service awards, recognition certificates, commendations, award nominations, lists of past recipients, and presentation or ceremony records and photographs. Some records in this series may have historic value. For appraisal assistance contact the Oregon State Archives. SEE ALSO Employee Suggestion Award Records in this section. (Minimum retention: 6 years).

(9) **Employee Suggestion Award Records** Records document an employee suggestion program where employees may submit suggestions that improve effectiveness, efficiency, and economy in city government. Employees may receive awards for adopted suggestions. Records may include suggestion forms and evaluations, award information, and related documentation. SEE ALSO Employee Recognition Records in this section. (Minimum retention: (a) Adopted suggestions, retain 2 years; (b) Suggestions not adopted, retain 1 year).

(10) **Employment Eligibility Verification Forms (I-9) Records** document the filing of U.S. Immigration and Naturalization Service Form I-9 form, which verifies that an applicant or employee is eligible to work in the United States. Information includes employee information and verification data such as citizenship or alien status and signature, and employer review and verification data such as documents, which establish identity and eligibility, and employer's signature certifying that documents have been checked. (Minimum retention: 3 years after date of hire or 1 year after employee separation, whichever is longer (8 CFR 274a.2).

(11) **Equal Employment Opportunity Complaint Records** Case files maintained in relation to discrimination complaints made against the city. Records may include complaints, reports, exhibits, withdrawal notices, copies of decisions, hearings and meetings records, and related documentation and correspondence. (Minimum retention: 3 years after final decision issued).

(12) **Equal Employment Opportunity (EEO) Compliance Records** Reports and related records maintained by cities with 15 or more employees in compliance with U.S. Equal Employment Opportunity Commission regulations. Contains EEO-4 reports and all records related to the completion of the reports. (Minimum retention: 3 years).

(13) **Equal Employment Opportunity Policy Development Records** Records document the adoption and administration of city programs to set personnel policies and procedures within the scope of the Civil Rights Act of 1964 and the Equal Employment Opportunity Act of 1972. May contain anti-discrimination committee meeting records and reports, workplace analyses, discrimination complaint policies and procedures, and related records. (Minimum retention: (a) Plans, updates, and policy statements, retain permanently; (b) All other records, retain 3 years).

(14) **Grievance and Complaint Records** Grievances or complaints filed by current employees, terminated employees, applicants, or private citizens regarding employment practices. Often relates to interpretations and alleged violations of employment contracts. Records often include complaints, investigation records, interview and hearing reports, arbitrator's findings and decisions, tape recordings and related records. (Minimum retention: 3 years).

(15) **Hazard Exposure Records** Records document a city employee's exposure to hazardous conditions such as chemicals, toxic substances, blood-borne pathogens, biological agents, bacteria, virus, fungus, radiation, noise, dust, heat, cold, vibration, repetitive motion, or other dangerous work related conditions. These records are not personnel records and should be maintained in an Employee Medical File. Records may include but are not limited to hearing test records, radiation measurement records, blood test or other laboratory results, incident reports, first-aid records, X-rays, work station air sampling reports, and correspondence. SEE ALSO Employee Medical Records in this section. (Minimum retention: 30 years after separation [29 CFR 1910.1020]).

(16) **Photo Identification Records** Photographs and other records used to identify city employees, private security personnel, contract workers, and others. May include photographs taken for city identification cards, driver's license photographs, and information such as name, date of birth, physical description, identification number, driver's license number, and other data. (Minimum retention: Until superseded or obsolete).

(17) **Position Description, Classification, and Compensation Records** Records document the description, classification, and compensation of city jobs and positions. Usually includes details of duties and responsibilities of each position, time percentage breakdowns of tasks, skills and abilities needed for each position, and related records documenting the development, modification, or redefinition of each job or position. Records often include reports, position descriptions, position evaluations, compensation studies, job analyses, interview data, selection criteria, authorizations, agreements, and related records. (Minimum retention: 3 years after obsolete or superseded).

(18) **Recruitment and Selection Records** Records document the recruitment and selection of city employees. Records may also document the recruitment and selection of contracted service providers such as attorneys, auditors, insurance agents, labor consultants, and others. Records may include but are not limited to job announcements and descriptions, applicant lists, applications and resumes, position advertisement records, civil service and other examination records, classification specifications, affirmative actions records, interview questions, interview and application scoring notes, applicant background investigation information, letters of reference, civil service records, position authorization forms, certifications of eligibles, recruitment summary records (job announcement, position description, documentation relating to the announcement and test, and test items and ratings levels), and related correspondence and documentation. SEE ALSO Employee Personnel Records and Employment Eligibility Verification Forms (I-9) in this section. (Minimum retention: (a) Announcement records, position description, and test and rating records, retain 10 years; (b) Unsolicited applications and resumes, retain 3 months if not returned to the solicitor; (c) Unsuccessful applications and other records, retain 3 years after position filled or recruitment canceled).

(19) **Training Program Records** Records related to the design and implementation of training programs provided to employees by the city. May include class descriptions, instructor certifications, planning documentation, instructional materials, course outlines, class enrollment and attendance records, and related records. SEE ALSO Employee Personnel Records for training records related to individual employees. (Minimum retention: (a) Significant program records, retain 5 years; (b) Class enrollment and attendance records, retain 2 years; (c) All other records, retain 1 year).

(20) **Volunteer Program Records** Records document the activities and administration of volunteer programs in the city. Useful for program planning. May include volunteer hour statistics, volunteer program publicity records, insurance requirement information, inactive volunteer files, and related records. For records related to individual volunteers, see Volunteer Worker Records in this section. (Minimum retention: 4 years).

(21) **Volunteer Worker Records** Records document work performed for the city by citizens without compensation for their services. May include agreements, applications, skills test results, training documentation, task assignment and monitoring records, and related information. (Minimum retention: 4 years after separation).

(22) **Benefits Continuation Records** Records document notifications to employees or dependents informing them of their rights to continue insurance coverage after termination or during disability or family leave. Continuation may be under COBRA or another provision. Notice is also sent to a third party administrator who administers the extended coverage. The records typically consist of notices sent and correspondence. Records may be filed with the Employee Benefits Records or Employee Personnel Records. SEE ALSO Employee Payroll Records in the Payroll section. (Minimum retention: 3 years after employee separation or eligibility expired).

(23) **Criminal Background Check Records** Records document the pre-employment or periodic criminal record checks performed on prospective or current staff, faculty, and volunteers. Records may include but are not limited to a log recording when background checks are done and who they are done on, and a fingerprint-based criminal history verification form documenting the result of a criminal history background check coordinated by the Oregon Law Enforcement Data System (LEDS). The form includes name and other personally identifiable information, indication of existence or absence of criminal record, and related documentation. (Minimum reten-

tion: (a) Background check log, retain until superseded or obsolete; (b) All other records, retain 90 days).

(24) **Drug Testing Records** Records document the testing of current and prospective employees for controlled substances prohibited by policy, procedure, or statute. Records may include but are not limited to the documentation of test results, the collection process, the random sample process, and those documenting the decision to administer reasonable suspicion drug testing. (Minimum retention: (a) Positive test results, retain 5 years; (b) Negative test results, retain 1 year).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0095
Planning and Development Records

(1) **Comprehensive Plan Records** Records indicate the types of uses and activities allowed in particular land designations. Used to guide long-term city growth and development, including planning urban growth boundaries, and to comply with state and federal laws. Usually contains public hearings records, plans, amendments, staff reports, periodic review records, maps, photographs, and other related records. (Minimum retention: Permanent).

(2) **Conditional Use Records** Applications and decisions related to requests for certain land uses within a zone that require special review and approval. May include applications, site plans, zoning maps, staff reports, administrative action reports, and related records. (Minimum retention: 10 years after expiration, revocation, or discontinuance of use).

(3) **Design and Development Review Records** Reviews of exterior renovations or new construction within particular city zones or the entire city. Used to ensure integration of visual standards. May include design review board or commission records such as minutes, agendas, and exhibits. Records also may include applications, site plans, staff reports, maps, review and appeal records, tape recordings, and related documents. Three-dimensional exhibits such as sample boards of brick, tile, and other building materials are not public records. (Minimum retention: (a) Minutes, agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records), retain permanently; (b) Audio or visual recording, retain 1 year after minutes prepared and approved; (c) Exhibits not pertinent to minutes, retain 5 years; (d) If no permit issued, retain 180 days; (e) If permit issued, but structure not started or completed, retain 2 years; (f) All other records if permit issued and structure completed, retain 2 years after substantial completion [as defined by ORS12.135(3)]).

(4) **Enterprise Zone Records** Records document the creation and management of enterprise zones by the city or in conjunction with other cities and counties. Designation used to encourage business growth by providing tax, permit, and regulatory relief to development within the zone. May include reports, applications for zone status, nominations for federal status, and related records. (Minimum retention: (a) Reports summarizing results or activities, retain permanently; (b) All other records, retain 4 years after zone designation expires).

(5) **Flood Plain Permit Records** Permits issued for construction within a flood plain zone. Records also may include elevation certificates, applications, review records, checklists, and other documents. Permit information usually includes date, permit holder's name and address, U.S. map number, type of structure, and related data. (Minimum retention: (a) Permits and elevation certificates, retain 10 years after the life of structure or until area determined not to be a flood plain, whichever is longer; (b)All other records, retain 10 years).

(6) **Historic Structures Commission Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(7) **Historic Structures Inventory Records** Records document the results of inventory projects to designate historic properties within the city. Inventory is in conjunction with Oregon Land Conservation and Development Commission Goal 5 procedures. Information usually includes street address, legal description, neighborhood, owner's name and address, date constructed, historic and architectural significance, and references used. (Minimum retention: Until superseded or obsolete).

(8) **Historic Structures Rehabilitation Project Reviews** Routine reviews of proposals for rehabilitation of structures that have been designated historically significant or are 50 years old. Used to meet grant-funding conditions and to protect the historical integrity of structures. Reviews often include address of structure, legal description, owner's name and address, proposed work, rehabilitation specialist's evaluation, violations noted, photographs, and related information and correspondence. (Minimum retention: 3 years after project closed).

(9) **Housing Authority Bylaws, Rules, and Policies Documents** defining the powers and purposes of the housing authority, as well as implementation policies in accordance with federal and state laws. Includes bylaws. May also include rules and policies on confidentiality, purchasing, tenant grievances, and other subjects. (Minimum retention: Permanent).

(10) **Housing Authority Commission Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(11) **Housing Authority Individual Tenant History Records** Files document the history of individual tenant and housing authority actions from application to separation from the program. May contain application, landlord references, rental agreements, leases, periodic re-examination and hardship data, income verification, billing statements, maintenance requests, damage complaints, eviction notices, grievance hearing records, and related material. (Minimum retention: 5 years after separation from program).

(12) **Housing Authority Program Management Records** Records document the activities and status of various programs administered by the housing authority (Section 8, etc.). Records may include staff meeting records and reports, waiting lists, maintenance records, tenant statistics, and related records generated in the administration of housing authority programs not specified elsewhere in the schedule. (Minimum retention: 3 years after annual or final expenditure report submitted).

(13) **Housing Authority Property Management Records** Records document the actions of the housing authority in managing housing not owned by the city. May include applications for funding, sub-grants, insurance policies, contracts, and non-profit organization records such as articles of incorporation, bylaws, budgets, minutes, agendas, and related records. (Minimum retention: 6 years after expiration).

(14) **Housing Authority Rejected Assistance Application Records** Rejected applications and related records from individuals seeking assistance from the housing authority. Application information may include name, age, occupation, social security number, size of unit needed, assets, annual income, and related information. Records may also include verification forms and related records. (Minimum retention: 3 years).

(15) **Land Use Hearings Records** Records document hearings or appeals to a city body or hearings officer and decisions reached concerning subdivisions, variances, and changes to the zoning code and comprehensive plan. May refer to conditional uses, zone changes, partitions, code variances, and other proposed actions. Records may include applications, hearings minutes, findings of fact, agendas, exhibits such as maps, reports, photographs, etc., tape recordings, and related records. (Minimum retention: (a) Minutes, agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records), retain permanently; (b) Audio or visual recordings, retain 1 year after minutes prepared and approved; (c) All other records and exhibits not pertinent to minutes, retain 5 years).

(16) **Neighborhood/Citizen Association Charters and Bylaws** Charters and bylaws documenting the creation and organization of neighborhood associations designed to meet citizen involvement requirements and goals set by state and federal agencies concerned with urban development and land use issues. Usually includes articles of incorporation, amendments, and related records. (Minimum retention: Permanent).

(17) **Neighborhood/Citizen Involvement Records** Meeting minutes and related records of neighborhood associations, community planning organizations, or other citizen involvement committees. Usually includes agendas, minutes, tape recordings, and exhibits. Exhibits may include staff and subcommittee reports and recommendations, lists of participants, materials distributed by citizens, and related correspondence. (Minimum retention: (a) Retain minutes, agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records) permanently; (b) Audio or visual recordings, retain 1 year after minutes prepared and approved; (c) All other records and exhibits not pertinent to minutes, retain 5 years).

(18) **Partition Records** Records document the partitioning of land into two or three parcels. Includes both major and minor partitions. Records often contain applications, staff reports, technical notes, approval orders, maps, and related records. (Minimum retention: (a) If approved and city conditions met, retain permanently; (b) If not approved, retain 10 years after expiration or revocation).

(19) **Planning Commission Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(20) **Sign Review Records** Records document planning department review of sign construction. Often contains descriptions, drawings, photo-

graphs, reports, applications, and related records. SEE ALSO Building Permits, Building Board of Appeals Records, and Building Code Violation Records in the Building section and Street Banner Records in the Public Works-Traffic Engineering section. (Minimum retention: Life of the structure).

(21) **Subdivision Records** Records document actions on requests to divide one piece of land into four or more lots. Often includes applications, site locations, descriptions of requests, site plans, staff reports, appeals reports, decision statements, maps, and related records. (Minimum retention: (a) If approved and city conditions met, retain permanently; (b) If not approved, retain 10 years after expiration or revocation); (c) Withdrawal request letters, retain 3 years; (d) Withdrawn applications, retain 180 days if not returned to applicant at time of withdrawal).

(22) **Temporary Use Records** Records document action on permits for temporary activities in commercial and industrial zones such as allowing temporary placement of structures incidental to construction. Records often contain applications, permits, staff reports, technical notes, approval orders, and other documents. (Minimum retention: 5 years after permit expiration).

(23) **Urban Renewal Agency Board Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(24) **Urban Renewal Plans and Reports Plans** and reports mandated by ORS 457.085 to provide descriptions and justifications for proposed development in urban renewal areas within the city. Includes plans, amendments, reports, hearings records, impact statements, feasibility studies, maps, relocation studies, and related records. (Minimum retention: Permanent).

(25) **Urban Renewal Project Records** Records document individual renewal projects within urban renewal areas. Projects include but are not limited to construction, demolition, and rehabilitation of buildings, streets, and utilities. May include project area committee documents, reports, project plans, design reviews, maps, photographs, consultant studies, feasibility studies, agreements, and other related records. Some records may have historic value. For appraisal assistance, contact the Oregon State Archives. (Minimum retention: (a) Agreements, retain 10 years after substantial completion or 50 years, whichever is longer; (b) All other records, retain 50 years).

(26) **Variance Records** Applications and decisions in cases of minor deviations from zone code requirements. Often includes applications, site locations, description of requests, site plans, zoning maps, staff reports, and related records. (Minimum retention: 10 years after life of structure or expiration, revocation, or discontinuance of use).

(27) **Zone Change Records** Applications and decisions related to rezoning land within the scope of an existing comprehensive plan. Often includes applications, staff reports, technical notes, approval orders, and related records. (Minimum retention: (a) Applications, findings of fact, and decision documents, retain permanently; (b) All other records, retain 10 years after approval or denial).

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166-200-0100
Police Records

(1) Activity Reports, Police Individual officer, shift, and other activity reports usually filed on a daily, weekly, monthly, or similar non-annual basis. Useful for reference, performance monitoring, compiling annual reports, planning and budgeting, and for briefing subsequent shifts or activities. Applies to various duties such as dispatch, confinement, investigations, and patrol. Information usually includes name, shift, date, activities, and various statistical categories for tracking the number of arrests, phone calls, mileage, and other indicators. SEE ALSO Law Enforcement Activity Reports in this section for annual summaries of police activities. (Minimum retention: 2 years).

(2) **Alarm Records** Records document the licensing, use, and response to security alarms in the city. Licenses and permits usually contain name and address of holder, type of alarm, location, instructions to officers responding to call, names of individuals to be contacted when alarm sounds, fee charged, and related data. Other records may include alarm response reports and false alarm reports. False alarm reports are used to document ordinance violations concerning the number of false alarms in a given period. SEE ALSO Incident Case Files in this section for records related to actual intrusions or burglaries. (Minimum retention: (a) Alarm licensing and permit records, retain 3 years after expiration; (b) All other records, retain 2 years).

(3) **Animal Control Records** Records document police department activities related to animal control. Often includes reports, logs, lists, cards, receipts, and related records. Subjects may include dog licenses, lost animals, found animals, animals running at-large, dog bite reports, animals turned over to county animal control programs or humane society programs, and others. Dog license information usually includes name, address, and phone number of owner, name and description of dog, vaccination dates, and related data. Includes records that do not merit inclusion in Incident Case Files. (Minimum retention: (a) Dog licenses, retain 3 years after expiration; (b) Other records, retain 2 years).

(4) **Arrest Warrant Log Records** Records document the status of arrest warrants as served, unserved, or recalled by the court. May include logs, validation listings, checkout sheets, and related records. Logs usually include date of warrant, subject's name, charge, date, warrant served or recalled, and related information. (Minimum retention: Until superseded or obsolete).

(5) **Arrest Warrant Records** Records related to a written order made by the court on behalf of the city or state commanding law enforcement officials to bring a specified individual before the court. May also include detainer requests, informational documents related to the wanted person, teletypes, and other records relevant to the service of warrants. Warrant information includes date, court, judge's name, individual's name and date of birth, charge, and related data. (Minimum retention: Until served, recalled, or cancelled by the court).

(6) **Block Home Program Records** Records document the application for and review, denial, or approval of block home designations. The Block Home Program is designed to provide safety and protection to school age children. The police department conducts background checks on applicants. Information often includes date, name, address, date of birth, Social Security number, educational and work background, police record check, approval or denial decision, and related data. (Minimum retention: (a) Approved application records, retain 2 years after withdrawal from program; (b) Denied application records, retain 2 years).

(7) **Booking Records** Books, logs, or other records document the confinement and release of individuals held in the city jail. Information usually includes name, charges, date of confinement, date of release, physical condition, and related data. Booking records related to individuals known to be dead need not be retained. SEE ALSO Fingerprint Cards and Mug Shots in this section. (Minimum retention: (a) Homicides, retain 20 years; (b) Felonies, retain 10 years; (c) Misdemeanors, retain 5 years).

(8) **Bulletins From Other Agencies Bulletins**, circulars, and related records received from federal, state, other state, and local law enforcement agencies. Usually contains descriptions and photographs of fugitives, missing persons, or stolen property. May also include other information of interest to the police department. Some bulletins may merit inclusion in Incident Case Files. (Minimum retention: Until superseded or obsolete).

(9) **Communications Logs** Logs document incoming and outgoing communications including radio, telephone, computer aided dispatch, and teletype. Information may include date and time, subject, location, response, message, and other data depending on type of transmission. (Minimum retention: 1 year).

(10) **Community Policing and Problem Solving Records** Records document community policing efforts, services, and programs by the city's police department to enhance communication and partnerships between the police and citizens. Services and programs may include but are not limited to those to help locate, identify, and return memory impaired people, install home security devices and locks to eligible recipients, send courtesy notices to people who violated traffic laws, or other ordinances as observed by a citizen, enter into authorization agreements with merchants to enforce trespass laws, and other problem solving services. Records may include problem solving tracking forms, program applications, courtesy notices for violations, and authorization agreements. (Minimum retention: (a) Agreements, retain 6 years after expiration; (b) All other records, retain 2 years).

(11) **Computer Inquiry Records** Logs or other records documenting requests made to other agencies involving missing persons, wanted persons, stolen vehicles, and other subjects. (Minimum retention: Until superseded or obsolete).

(12) **Computer Validation Records** Logs or similar hard copy records detailing validation requests and proof of verification for National Crime Information Center (NCIC) or other law enforcement information networks. Useful to document maintenance of network standards.

(Minimum retention: 5 years or until audited by NCIC or other applicable law enforcement network, whichever is shorter).

(13) **Crime Analysis Records Records** documenting police efforts to anticipate, prevent, or monitor possible criminal activity. May include reports, statistical summaries, photographs, sound and videotape recordings, and related documents. Subjects often include crime patterns or modes of operation, analysis of particular crimes, criminal profiles, forecasts, movements of known offenders, alerts from other agencies, and others. Some records may have historic value. SEE ALSO Criminal Intelligence Records in this section for related records. (Minimum retention: (a) Major crime analyses or studies, retain 10 years; (b) All other records, retain 1 year).

(14) **Crime Prevention Community Organization Records** Mailing lists, plans, evaluations, notes, reports, and other records documenting community organizations, associations, individual volunteers, and others engaged in or interested in crime prevention efforts. Useful in developing community support for police programs. (Minimum retention: Until superseded or obsolete).

(15) **Crime Prevention Program Records** Records document police department efforts to train citizens in crime prevention. May contain training and media presentation records including lesson plans, outlines, tests, evaluations, speeches, and related records. Subjects usually include neighborhood watches, home security, and others. (Minimum retention: (a) Significant program records, retain 5 years; (b) Class enrollment and attendance records, retain 2 years; (c)All other records, retain 1 year).

(16) **Crime Prevention Security Survey Records** Records document citizen requested police surveys of homes and businesses and subsequent recommendations related to security. Usually contains a detailed checklist of problems or security defects. Subjects often include areas of potential break in, blocked exits, landscaping that can hide crime, and similar topics. Survey usually is compiled into a report that is sent to the owner or renter. (Minimum retention: 2 years).

(17) **Crime Prevention Vacation House Inspection Records** Records document the inspection of homes and other properties while the occupants are away. Information often includes name, address, date received, vacation beginning and ending dates, emergency contact information, special conditions at the house or property, dates and times officers checked the house or property, and related data. (Minimum retention: 30 days after inspections end).

(18) Criminal Arrest History Records Records document information on the accumulated criminal arrest history of individuals, which may be useful in current or future investigations. Records may include summary sheets or cards, arrest reports, fingerprint cards, mug shots, and related documents. Information often includes name, aliases, residence, sex, age, date and place of birth, height, weight, hair and eye color, race, scars, marks, tattoos, abnormalities, date of arrest, offense committed, habits, closest relatives or friends, and more. Records may be destroyed earlier if individual is known dead. (Minimum retention: (a) Homicides, retain 20 years; (b) felonies, retain 10 years; (c) Misdemeanors, retain 5 years).

(19) **Criminal History Dissemination Records** Logs and other records documenting the dissemination of criminal histories and other law enforcement information to other agencies or criminal information systems. May include teletype and computer message logs. Information includes date of release, subject of information, recipient of information, reason information was requested, and identification numbers. (Minimum retention: Until case completed or suspended).

(20) **Criminal Intelligence Records** Records document possible and proven criminal activity by individuals, groups, organizations, and businesses for use by local government law enforcement agencies. Information is categorized into file groupings as defined by OAR 137-090-0080 after collection and evaluation. Includes investigatory reports, statistical reports, correspondence, memoranda, and related records. Information includes suspect identification, alleged activity, location, date, source validity, and other data. Sources include law enforcement and regulatory agencies, and private citizens. SEE ALSO Crime Analysis Records in this section. (Minimum retention: (a) "Permanent files" as defined by OAR 137-090-0080, retain 5 years; (b) "Temporary files" as defined by OAR 137-090-0080, retain 1 year; (c) "Working files" as defined by OAR 137-090-0080, retain 30 working days).

(21) **Detoxification Confinement Logs** Logs listing names of individuals held because of drunkenness and released when sober. Includes dates and times confined and released, name of individual, and related information. (Minimum retention: 2 years).

(22) **Emergency Telephone Calls Continuous Audio Tapes** Audio tapes that record incoming emergency calls, police and emergency dispatches, radio activity, and 9-1-1 calls. Tapes are maintained on a 24-hour basis. Recordings of serious incidents may warrant longer minimum retention for legal reasons. These may be transferred onto a separate tape and retained until legal action is resolved. (Minimum retention: 7 months).

(23) **Equipment Issued Records** Records document equipment issued to police department and other city personnel. Items include but are not limited to handcuffs, keys, uniforms, badges, personal protective and fire fighting equipment, and lockers. May include inventories, optional equipment lists, data sheets, and other records. Information often includes date, employee name, number, and section, description of equipment, and related data. SEE ALSO Officer Weapon Registration Records in this section. (Minimum retention: Until superseded or obsolete).

(24) **Expunged or Sealed Records**, Police Records document the arrest and/or conviction of a person who petitions and is granted by the court an order sealing or otherwise disposing of any related records (according to ORS 137.225) maintained by the Police Department. "Upon entry of such an order, the applicant for purposes of the law shall be deemed not to have been previously convicted, or arrested as the case may be, and the court shall issue an order sealing the record of conviction or other official records in the case, including the records of arrest whether or not the arrest resulted in further criminal proceeding." Also applies to records related to juveniles as outlined in ORS 419A.260 through 419A.262. (Minimum retention: (a) Dispose of expunged records according to the directive of the court; (b) Expungement orders, retain 10 years or according to the directive of the court; (c) Sealed records, retain 10 years or according to the directive of the court).

(25) **Field Interrogation Reports** Informational reports written by a police officer related to individuals, groups, events or vehicles for which the officer does not have probable cause for enforcement. Information usually includes name and address of person contacted, physical description of person or vehicle, officer's name, location of contact, date and time, witnesses, reason for contact, and related data. (Minimum retention: 1 year).

(26) **Fingerprint Cards** Cards containing fingerprints, palmprints, toeprints, and other personal identifiers of arrested individuals. Used for identification and apprehension of suspects in criminal investigations. May also include fingerprints of private security personnel working in the city. Information often includes name, address, date and place of birth, Social Security number, alias, occupation, employer, name of individual taking prints, and related data. Fingerprint cards of individuals known to be dead need not be retained. SEE ALSO Latent Fingerprint Cards in this section. (Minimum retention: (a) Homicides, retain 20 years; (b) Felonies, retain 10 years; (c) Misdemeanors, retain 5 years; (d) Retain other cards until superseded or obsolete).

(27) **Handgun Dealers' Sales Records** Records document purchases of handguns from dealers. May include duplicate register sheets mailed by the dealer to the city police department and triplicate register sheets mailed by the dealer to the State Police for criminal records checks and then forwarded to the city police department. Information includes series number, sheet number, sales person, date and time, city, make, serial number, caliber, name of purchaser, date of birth, address, height, occupation, race, color of eyes and hair, local address (if traveling), and signatures of purchaser and sales person. As of 1996, these records are retained by the State Police. (Minimum retention: Destroy).

(28) **Impounded and Abandoned Vehicle Records Records** document vehicles impounded by the police department related to accidents, abandonment, recovered stolen vehicles, vehicles used in the commission of crimes, and other reasons. May include reports, notifications, information cards or sheets, receipts, and related records. Information often includes the make, model, year, color, identification number, tag number, and condition of the vehicle and contents, reason for impounding, location of impoundment, charge (if any), towing company used, release conditions, name and address of individual to whom vehicle was released, and other data. (Minimum retention: Retain records not included in Incident Case File 2 years after disposition of vehicle).

(29) **Incident Case File** Indexes Indexes to incident case files used as cross-references between case numbers, names, dates, modus operandi, and other descriptive information. (Minimum retention: Until superseded or obsolete).

(30) **Incident Case Files** Central case files document complaints or other actions or incidents investigated by the police department. Usually filed by case number. Records may include investigative reports, fingerprint cards, arrest reports, supplemental reports, photographs, correspondence, teletypes, court orders, court dispositions, officer notes, laboratory reports, DUII test records including chemical analyses (also known as intoxilyzer or breathalyzer test records), physical force records, citizen arrest certificates,

warrants, search warrants and booking sheets, property/evidence reports, custody reports, and other related documents. Information usually includes suspect identification, alleged activity, location, date, validity of source information and other data. Sources include law enforcement and regulatory agencies and private citizens. Refer to ORS 131.125-131.155 for statute of limitations. (Minimum retention: (a) Cases involving crimes with no statute of limitations, retain 75 years after case closed; (b) Protective custody files, retain until minor's age of majority or emancipation; (c) All other cases, retain until statute of limitations expires).

(31) **Informant Case Files Records** document information about informants used by the police department. May include reports, correspondence, payment records, fingerprint cards, signature cards, letters of understanding on informant activities, and related records. (Minimum retention: Until superseded or obsolete).

(32) **Inmate Accountability Records** Logs, lists, rosters, and other records document inmate counts, cell locations, and status, as well as related information. May include logs detailing status of individual inmates such as those awaiting action or on hold status, released on their own recognizance, or released on security. May also include rosters documenting the location of all inmates by head counts at regular intervals. (Minimum retention: 1 year).

(33) **Inmate Case File** Indexes Indexes used to access inmate case files. Usually cross-referenced by name, case number, and other identifiers. (Minimum retention: Until superseded or obsolete).

(34) **Inmate Case Files Records** document non-medical information on inmates confined in the city jail. Often contains date of entry, date of release, incident reports, release receipt indicating return of property, court commitment and release orders, behavioral information, physical force records, and other relevant information concerning the arrest and confinement of an individual. Some records included in case files may be listed elsewhere in this section (e.g. fingerprint cards, inmate visitor records, etc.). (Minimum retention: 5 years).

(35) **Inmate Meal Records** Records document menus used to plan and schedule inmate meals. May include listings of those inmates who received meals. Information may include month, day, meal, menu, inmates served, and related data. (Minimum retention: 6 months).

(36) **Inmate Medical Records** Records document outpatient medical treatment given to inmates. Often contains treatment log, prescriptions, health questionnaires, laboratory reports, x-ray reports, medical reports from other facilities, and related records. Information may include inmate's name, date of treatment, description of treatment, and related data. (Minimum retention: 7 years).

(37) **Inmate Medication Records** Records document medications kept by the jail and dispensed to inmates. Often contains logs and related records. Information may include name of medication, date and time issued, name of inmate to whom medication was dispensed, name of individual dispensing medication, amount dispensed, amount remaining in stock, and related data. (Minimum retention: 7 years).

(38) **Inmate Telephone and Mail Logs** Logs and other records documenting telephone calls and mail sent and received by inmates. Information may include name of inmate, date and time of telephone call or mail, and related data. (Minimum retention: 1 year).

(39) **Inmate Visitor Records** Records document information about visitors to inmates confined in the city jail. May include logs, request slips, and related records. Information often includes date, time in, visitor's signature and address, object of visit, time out, and related data. (Minimum retention: 1 year).

(40) **Internal Investigations Case Files Records** document investigations of police department personnel for violations of laws, rules, or policies and may include findings and dispositions of investigations. Records often contain complaints, correspondence, investigatory reports, interviews, hearing summaries and testimony, and related documents. Information usually includes name of employee investigated, reason, location of violation, date, accomplices' names and addresses, witnesses' names and addresses, action taken, and related data. SEE ALSO Requests and Complaints in the Administrative section. (Minimum retention: (a) Investigations resulting in termination, retain 10 years after employee separation; (b) Investigations resulting in disciplinary action or exoneration, retain 3 years after resolution; (c) Unfounded investigations, retain 3 years).

(41) **Juvenile Offender/Victim Restitution Records** Records document the facilitation of restitution for crime victims of first time juvenile offenders. Typical cases may include criminal mischief, vandalism, minor assault, theft, and harassment. Information may include name, address, and phone number of person filing complaint, case number, date of activity, narration of the complaint, name of offender, date case closed, and other data. (Minimum retention: 5 years after last action, or youth reaches age of majority, whichever is longer).

(42) **Juvenile Temporary Custody Records** Records document children taken into temporary custody by the police department as defined in ORS 419B.150 through 419B.171. The action is not considered an arrest. Information may include the name, age, and address of the child, the name and address of the person having legal or physical custody of the child, reasons for and circumstances under which the child was taken into temporary custody, and other data. (Minimum retention: 3 years).

(43) **Latent Fingerprint Cards** Cards containing latent fingerprints and palmprints found at crime scenes without identification of suspects. These are compared against cards on file at the police department. Usually contains information related to the crime, location, date and time, and other details of the case. SEE ALSO Fingerprint Cards in this section. (Minimum retention: (a) Cases involving crimes with no statute of limitations, retain 75 years after case closed; (b) All other cases, retain 1 year after statute of limitations expires).

(44) **Law Enforcement Activity Reports** Monthly and annual law enforcement or uniform crime reports summarizing statistics on criminal activity and office operations. Information includes date, categories, totals, and related data. SEE ALSO Activity Reports, Police in this section. (Minimum retention: (a) Annual reports and monthly reports for years in which no annual report exists, retain permanently; (b) Other reports, retain 2 years).

(45) **Lost and Found Property Records** Records document city receipt and maintenance of lost and found or abandoned property such as money, bicycles, automobiles, and other items not related to a crime. Includes receipts, inventory lists, destruction logs, property reports, and related records. SEE ALSO Property and Evidence Control and Disposition Records for records documenting property related to or held as evidence to an alleged crime. SEE ALSO Property Disposition Records in the Financial-General section for records of the disposition of lost and found or abandoned property. (Minimum retention: 2 years after disposition).

(46) **Maps, Police Maps and related records** maintained for reference and for tracking various trends. Examples include but are not limited to Neighborhood Watch Program maps, Block Home Program maps, street number location maps and books, parking meter maps, and maps plotting reported crimes in a given area. Some maps may have historic value. For appraisal assistance, contact the Oregon State Archives. (Minimum retention: Until superseded or obsolete).

(47) **Master Name Index Records** Records document information on each individual who has been field interrogated or arrested, suspects or accomplices in crimes, victims, complainants, and witnesses to incidents. Information may include name, address, date of birth, race, sex, date and time of incident or contact, incident number, and related data. (Minimum retention: Until superseded or obsolete).

(48) **Mug Shots Photographs** and negatives of arrested individuals used for identification and apprehension of suspects in criminal investigations. Mug shots of individuals known to be dead need not be retained. SEE ALSO Photo Identification Records in the Personnel section for non-arrest identification photographs. (Minimum retention: (a) Retain homicides 20 years; (b) Retain felonies 10 years; (c) Retain misdemeanors 5 years).

(49) **Neighborhood Dispute Resolution Records** Records document the city's dispute resolution program to handle complaints by citizens about concerns or disputes with neighbors or merchants. Typical cases may include animal control, landlord/tenant issues, noise, harassment, property disputes, and business/consumer issues. Records may include budget, activity, and statistical reports, mediation training information, evaluation and intake records, service referrals, resolution agreements, and follow-up surveys. Information may include name, phone number, and address of person filing complaint, case number, date of activity, narration of request or complaint, name and address of offender, action taken, and other data. SEE ALSO Ordinance Violation Case Files in the Municipal Court Records section. (Minimum retention: (a) Case records, retain 5 years after last action; (b) All other records, retain 2 years).

(50) **Officer Notes** Notes written by officers during the course of a shift containing information which may or may not be included in an official report. May pertain to contacts, incidents, unusual circumstances, and other subjects. Useful for referral in writing reports and testifying in court. Information includes names, dates, times, vehicles, activities, locations, and related data. Officer notes created on handheld electronic organizers (ex. Palm Pilots) are public records under ORS 192. Information on electronic organizers is subject to the same retention as the paper record unless the information is kept in another format for the duration of the required minimum retention period. (Minimum retention: 2 years).

(51) **Officer Weapon Registration Records** Records document weapons assigned to city police officers. Information includes officer's name, and the make, model, serial number, and caliber of the weapon. (Minimum retention: Until superseded or obsolete).

(52) **Pawn Broker and Second Hand Dealer Reports** Reports submitted to the police department documenting merchandise bought and sold by dealers. Useful in tracing stolen items. Information includes name, address, identification, and personal description of pledgor, date, dealer's name, and description of article. (Minimum retention: 2 years).

(53) **Peer Court Records** Records document the city's peer court program where youths who have committed certain first time misdemeanors or violations are judged through a court system of their peers (aged 12-17 years). Records may include policy and procedure manuals, budget, activity, and statistical reports, guidelines and instructions for participants, applications to participate in the program, juvenile consent form, intake interview form, defendant questionnaire, summary report, attorney's analysis, jury verdict record, bailiff record, clerk's record, community service log, judge's notes, officer's status report, defendant evaluation, parent evaluation, and related documentation. SEE ALSO Policy and Procedure Manuals in the Recorder-General section. (Minimum retention: (a) Case records, retain 5 years after final disposition of case, or youth reaches age of majority, whichever is longer; (b) Participant guidelines and instructions, retain until superseded or obsolete; (c) All other records, retain 2 years).

(54) **Photo Radar Logs Records** documenting the use of photo radar and red-light cameras by the city's police department. Logs may include the date, time, location, number of photographs taken, and related information. SEE ALSO Photo Radar Records in this section. (Minimum retention: 3 years).

(55) **Photo Radar Records** Records document traffic infractions by drivers that have been photographed by the police department's photo radar equipment. Records may include photographic negatives and prints, copies of citations, copies of drivers' licenses, forms to dismiss, and related documentation. SEE ALSO Photo Radar Logs, Traffic and Other Citation Logs, and Traffic and Other Citations in this section, and Traffic Citation Case Files in the Municipal Court section. (Minimum retention: (a) Photo radar citations issued, retain 2 years; (b) Photo radar citations not issued, retain 30 days).

(56) **Polygraph Records** Records document polygraph tests given to criminal suspects, prospective employees and others. Includes pre-examination records, examination questions for individuals interviewed, statements of consent, polygraph analysis reports, examiner's original test questions, examination chart tracing reports, polygraph results charts, conclusions, interviewee statements, and background information. (Minimum retention: (a) Case involving crimes with no statute of limitations, retain 75 years after case closed; (b) All other cases, retain 1 year after statute of limitations expires).

(57) **Property and Evidence Control and Disposition Records** Records used to track property and evidence coming into police department possession. Documents receipt, storage, and disposition of personal property and physical evidence from defendants, victims, and others. May include evidence photographs documenting crime scenes, accidents, and other incidents. Records often include receipt forms, evidence control sheets, property reports, destruction lists, property consignment sheets, seized firearm logs, homicide evidence inventories, and other documents. Information usually includes case number, tag number, date and time, property or evidence description, storage location, release date, and other data. Often filed with Incident Case Files. SEE ALSO Lost and Found Property Records in this section for documents related to lost and found or abandoned property not related to or held as evidence of an alleged crime. (Minimum retention: (a) Cases involving crimes with no statute of limitations, retain 75 years after case closed; (b) All other cases, retain 1 year after statute of limitations expires).

(58) **Property Registration Records** Records document the registration of property for identification in case of theft, loss, or burglary. Property includes but is not limited to bicycles, televisions, cameras, stereos, and guns. Information may include name, address, and phone number of owner, date, description of property, serial number, and related data. (Minimum retention: Until registration is expired, superseded, or obsolete).

(59) **Radar Equipment Certification and Maintenance Records** Records document the calibration and maintenance of radar equipment that may be useful in documenting the accuracy of the readings. Often includes original factory certification of calibration. If tuning fork tests reveal an inaccuracy, the equipment is removed from service for repair and recalibration. Information related to maintenance and repair may include a description of work completed, parts used, date of service, equipment number, make, model, and related data. (Minimum retention: 2 years after disposition of equipment).

(60) **Teletype Messages Incoming and outgoing teletype messages** concerning a variety of subjects of interest to the department. Subjects include incidents, meetings, arrests, warrant confirmation and others. Information includes date, time, originating agency, and text. (Minimum retention: Retain messages not warranting inclusion in Incident Case Files (or other record series) 30 days).

(61) **Towed Vehicle Records** Rotation lists and related records documenting tow truck requests and responses. Information usually includes date, name of requester, name of towing company called, location, and other data. Records may also include documentation of vehicles towed from private property at the request of citizens. This information is used to prevent towed vehicles from being reported as stolen. (Minimum retention: 1 year).

(62) **Traffic and Other Citation Logs** Logs listing various information related to citations issued by the police department. Usually includes type of citation, ticket number, name of violator, date of issue, and officer's name. (Minimum retention: 1 year).

(63) **Traffic and Other Citations Police department** copies of citations issued for traffic, motor vehicle, and other violations. Includes Uniform Traffic Citations, parking citations, and others. Information includes city and county, date and time, name and address, date of birth, sex, occupation, license number, state, year, make and model of vehicle, location of violation, state or city law alleged violated, conditions, name of officer issuing citation, and related data. (Minimum retention: 3 years).

(64) **Traffic Violation Warning Records** Records document warnings issued for traffic violations. Often used to determine repeat offenders and for follow-up investigations. Information usually includes date, time, category, name, address, phone number, date of birth, race, sex, hair and eye color, height, weight, Social Security number, drivers license number, make and model of vehicle, location of violation, violation, signatures, and related data. (Minimum retention: 1 year).

(65) **Concealed Weapons Permits Records** document the application for the issuance of a concealed weapon permit and the determination of whether to authorize the permit. The permit is valid for one year and the process must be completed again for renewal. Records may include applications, fingerprint cards, copy of issued permit, and listing of permits issued. Information may include date of application, applicant's name and background information, date issued or denied, reasons for denial, permit numbers issued, and names of individuals issued permits. (Minimum retention: (a) Denied applications and list of permits issued, retain 5 years; (b) All other records, retain 2 years).

(66) **Patrol Car Video Files Records** document patrol activities. Patrol officers may manually activate cameras when calls come in or cameras may automatically activate upon rapid vehicle acceleration or deceleration. (Minimum retention: (a) Tapes used as evidence, retain until case reaches final disposition; (b) Tapes used for internal investigations, retain until investigation ends; (c) All other tapes, retain 30 days).

(67) **Used Firearm Transfer Records** Records document the sale or transfer of a firearm. Information includes business name and address, individual purchasing or trading firearm, time and date of transaction, firearm description, including serial number, caliber, form of identification presented by the seller/trader, and dealer and seller/trader signatures and phone numbers. (Minimum retention: 1 year).

(68) **Video Surveillance Tapes Records** document fire scene activities and the monitoring of park areas. Fire scene recordings document individuals present at the scene and may be used to identify suspects. (Minimum retention: (a) Tapes used as evidence, retain until case reaches final disposition; (b) Tapes used for internal investigations, retain until investigation ends; (c) All other tapes, retain 30 days).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0105
Public Works — Engineering Records

(1) **Aerial Photographs** Color and black and white photographs and negatives documenting topographical and physical features of the city and surrounding area. Useful for planning and land management purposes. Information often includes date, location, frame sequence numbers, and other descriptive information. Photographs that are duplicates of originals held by state, county, federal, or other sources may be retained as needed. (Minimum retention: Permanent).

(2) **Bridge Inspection Records Records** related to bridge inspections required by the U.S. Department of Transportation per 23 CFR 650.305. Inspections generally are done every two years. Records may include reports prepared in accordance with federal standards, photographs, correspondence and related documents. May also include bridge inventory records described in 23 CFR 650.311. (Minimum retention: 2 years after bridge removed from service).

(3) **City Benchmark Records Benchmarks** placed by the city or the U.S. Geological Survey to denote elevations above sea level. Records may include books, maps, cards, and other documents. Information includes location monument number, elevation, description, and related data. Usually filed numerically by benchmark number. (Minimum retention: Permanent).

(4) **Engineering Project Technical Records** Records related to the planning, design, and construction of various city improvement projects, including facilities, structures, and systems. Examples include those documenting both assessable and non-assessable improvements such as but not limited to streets, sidewalks, traffic lights, streetlights, bikeways, water lines and wells, water and wastewater treatment facilities, buildings, and sewers. May be useful for litigation, reference, or budget planning. Records often include impact statements, feasibility studies, plans, amendments, field test and laboratory reports, inspector reports, change orders, status reports, and related records. May contain historically significant records. *For appraisal assistance, contact the Oregon State Archives*. SEE ALSO Maps, Plans, and Drawings in this section. For records documenting non-technical administrative and financial actions related to engineering projects, refer to City Improvement Administrative and Financial Records and other record series in the Financial-General section. SEE ALSO the Recorder-General section for records documenting city council legislative actions. (Minimum retention: (a) Records of project cost, retain 3 years after disposal or replacement of facility, structure, or system; (b) All other records, retain 10 years after substantial completion [as defined by ORS 12.135(3)]).

(5) **Maps, Plans, and Drawings Maps**, plans, and drawings created by the city or contracted specifically for the city. These include various types of maps such as system schematic, as-built, topographic, planemetric, orthophoto, resource, and others. System schematic maps represent locational and other information about major systems such as water and sewer. Other maps are often derived from aerial photographs and represent physical features such as building footprints, edge of pavement, and contours. Series also includes as-built plans, drawings, and details documenting city engineering and construction projects. Copies of maps, plats, drawings, details, plans, photographs, and similar records obtained from federal, state, county, and other sources that are used for research and reference purposes may be retained as needed. (Minimum retention: (a) Final as-built versions, retain permanently; (b) Draft and working copy versions, retain until superseded or obsolete).

(6) **Master Plans** Records document the present and projected needs of the city for water, sewer, storm drainage, street, bike path, and other systems. Often includes an implementation schedule for construction. Records often include plans, reports, evaluations, cost analyses, drawings, and related documents. Subjects may include rates, inventory evaluations, system rehabilitation or replacement, distribution of services, and others. (Minimum retention: Permanent).

(7) **Public Works Commission Meeting** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(8) **Right-of-Way Permit Records** Permits issued for private use or construction on public rights-of-way such as streets, sidewalks, and adjacent land. Examples of activities may include house moving, and block parties and other uses. Information can include owner's name, address, and phone number, contractor's name, address, and phone number, location and description of activity, permit conditions, fee amount, date, signatures, and related data. (Minimum retention: (a) Construction related records, retain 10 years after substantial completion [as defined by ORS 12.135(3)] of project; (b) All other records, retain 2 years after expiration, revocation, or discontinuance of use).

(9) **Survey Field Records** Detailed field notes and other records related to surveys done for boundary work, local improvement districts, special requests, and other purposes. May include investigative surveys made of crime or accident scenes at the request of law enforcement officials. May also include notes on traverses, right-of-way location, construction (including levels, cuts, and grades), sketches related to the survey, and other information. (Minimum retention: (a) General surveys and right-of-way location records, retain permanently; (b) All other construction records, retain 10 years after substantial completion [as defined by ORS 12.135(3)] of project; (c) For retention of law enforcement surveys, see Incident Case Files in the Police section).

(10) **Wetlands Conservation Planning Records** Records document the identification, delineation and management of wetlands on city property or right-of-ways. May include plans, amendments, annual reports, consultant reports, and related records. Wetlands conservation plans include descriptions, maps, inventories, and assessments of wetlands, as well as mitigation plans, policies, specifications, and monitoring provisions for managing wetlands. See ORS 196.678 for further description. SEE ALSO Wetlands Removal and Fill Permits in this section. (Minimum retention: Permanent).

(11) **Wetlands Removal and Fill Permits** Records document city application and receipt of permits regulating the removal or fill of material from wetlands on city property or right-of-ways. Permits are issued by the Oregon Division of State Lands for up to five years before renewal is required. Includes applications, permits, and related records. Applications may include maps, project plans, spoils disposal plans, public use and need analyses, impact studies, and related records and information described in OAR 141-085-0025. Permits may include approvals and any attached conditions. (Minimum retention: 30 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0110
Public Works — Operations and Maintenance Records

(1) **Backflow Prevention Device Test Records** Records document test results on backflow prevention devices designed to protect the city water system from pollution related to substances backing into water lines. Information usually includes date, type and size of device, serial number, location, test records, line pressure, name of tester, name and address of device owner, and related data. (Minimum retention: 10 years).

(2) **Bridge and Culvert Maintenance and Repair Records** Records document maintenance and repairs on city bridges and culverts. Includes pedestrian and bicycle bridges. May include summaries, reports, logs, and related records usually compiled from daily work records on a monthly or quarterly basis. Information often includes location, narrative of work completed, materials used, personnel completing work, authorization, dates of activities, and related data. SEE ALSO Daily Work Records in this section. (Minimum retention: (a) Records with engineering stamps documenting structural maintenance or repairs, retain 2 years after bridge or culvert permanently removed from service; (b) All other records, retain 2 years).

(3) **Buildings and Grounds Maintenance and Repair Records** Records of all minor maintenance and repairs to buildings and grounds owned or leased by the city. Used to verify that repairs were made. May include summaries, logs, reports, and similar records usually compiled from daily work records on a monthly or quarterly basis. Information often includes location, narrative of work completed, materials used, personnel completing work, authorization, dates of activities, and related data. SEE ALSO Daily Work Records in this section, and City Improvement Administrative and Financial Records in the Financial-General section. (Minimum retention: (a) Records requiring engineering stamps, retain 2 years after life of structure; (b) All other records, retain 2 years).

(4) **Cross Connection Control Survey Records** Records document the monitoring of potential or actual water system health hazards from pollution entering water pipes from other pipes. Records may include reports, surveys, checklists, and related documents. Information often includes address, contact person, business name, date, inspector, type of facility, description of protection, comments, corrections made, and other data. (Minimum retention: 1 year after disconnection or 10 years, whichever is longer).

(5) **Daily Work Records** Records document work completed by each city employee or crew on a daily basis. These may include logs, notes, or similar records. Information often includes personnel performing work, date and time completed, description of work, location, equipment and materials used, and additional pertinent data. SEE ALSO various maintenance and repair records series in this section (e.g., Buildings and Grounds Maintenance and Repair Records) for summaries or reports of information often included in this record series. (Minimum retention: 1 year).

(6) **Delivery Tickets** Tickets issued by suppliers to verify delivery of supplies or materials (concrete, road base, gravel, topsoil, etc.) Information usually includes date, time, amount and type of supplies received, and related data. (Minimum retention: 2 years).

(7) **Equipment Maintenance and Repair Records** Records document the inspection, maintenance, and repair of all city-owned equipment not listed elsewhere in this schedule. Examples include but are not limited to mowers, trailers, edgers, blowers, generators, sewage lift pumps, water pumps, office equipment, and furniture. Records may include summaries, reports, and similar records usually compiled from daily work records on a monthly or quarterly basis. Information often includes description of work completed, parts and supplies used, date of service, date, purchase price, equipment number, make, and model, and related data. SEE ALSO Daily Work Records in this section and Work Orders in Administrative section. (Minimum retention: 2 years after disposition of equipment).

(8) **Fill and Leaf Delivery Records** Records document citizen requests and city delivery of fill material and leaves to private property. Often includes conditions, signature, address, and phone number of property owner, number of loads requested, desired dumping location, and related information. SEE ALSO Street Surface Maintenance Records in this section for records documenting the removal of leaves from city streets. (Minimum retention: 2 years).

(9) **Fuel Records** Records document the amount of gasoline, diesel, and oil used by city-owned vehicles. Often includes logs, reports, and related documents. (Minimum retention: 2 years).

(10) **Hydrant Records** Records document the location, specifications, maintenance, testing, and repair of water hydrants in the city water system. May include lists, charts, logs, reports, and related records. Information often includes location, make, description (main size, valve size, flow capacity, etc.), maintenance and repair narratives, dates, authorizations, and related data. (Minimum retention: (a) Retain location and specification records until hydrant permanently removed from service; (b) Retain maintenance, test, and repair records 2 years).

(11) **Maintenance Request/Complaint Records** Records document complaints or requests concerning a variety of maintenance responsibilities carried out by the public works department. Examples include but are not limited to brushing and limbing; road grading, rocking, sealing, patching, and marking; traffic signals and signs; city-owned buildings and equipment; streetlights; high grass or weeds; and water and sewer system problems. Information often includes name, phone number, and address of person making request/complaint, narration of request/complaint, name of person responding to request/complaint, dates of related activities, and other data. (Minimum retention: 2 years after last action).

(12) **Sewer and Storm Drainage Maintenance and Repair Records** Records document the maintenance and repair of city sewers and storm drains. May include summaries, reports, and similar records usually compiled from daily work records on a monthly or quarterly basis. Information often includes location, narrative of work completed, amount and type of material used, personnel completing work, dates of activities, authorization, and related data. SEE ALSO Daily Work Records and Sewer Television/Videoscan Inspection Records in this section. (Minimum retention: (a) Records requiring engineering stamps, retain 2 years after life of structure; (b) All other records, retain 2 years).

(13) **Sewer Smoke Test Records** Records document smoke tests undertaken to verify hookup to main sewer lines, check condition of pipes, or determine effectiveness of backflow prevention devices. Information often includes maps or diagrams of lines tested, location of leaks detected, inspector's name, pipe size, and related data. (Minimum retention: 10 years).

(14) **Sewer Television/Videoscan Inspection Records** Reports document television inspections used to determine the condition of sewer lines. Inspections locate problems and defects so that corrective measures can be taken. Often consists of periodic inspections of existing lines, final inspections of newly constructed lines, and inspections at the end of warranty periods. Records usually contain videotapes and written reports. Information often includes date, type of inspection, conditions found, repairs needed, distances from manholes, and related data. (Minimum retention: (a) Written reports, retain 1 year after the life of the sewer line; (b) Videotapes, retain 1 year after written report submitted).

(15) **Street and Road Condition Inventory Records** Inventory records document the condition of city streets, roads, curbs, shoulders, sidewalks, bikeways, alleys, etc. Useful for reference and planning. Information can include street or road name, location, year surveyed, constructed, and surfaced, bed and surface type, surface size, condition, and other data. (Minimum retention: 5 years after annual audit report issued).

(16) **Streetlight Maintenance and Repair Records** Records document maintenance and repairs on city streetlights. May include reports, summaries, and similar records usually compiled from daily work records on a monthly or quarterly basis. Information often includes location, narrative of work completed, equipment repaired or replaced, supplies used, personnel completing work, authorization, dates of activities, and related data. SEE ALSO Daily Work Records in this section. (Minimum retention: 3 years after annual audit report issued).

(17) Street Maintenance and Repair Records Records document maintenance and repairs of city-owned streets and sidewalks. May include reports, summaries, and similar documents usually compiled from daily work records on a monthly or quarterly basis. Information often includes location, narrative of work completed, amount of materials used, personnel involved, authorization, dates of activities, and related data. SEE ALSO Daily Work Records in this section. SEE ALSO Contracts and Agreements in the Recorder-General section for contract records related to private companies working on city maintenance and repair projects. (Minimum retention: (a) Records requiring engineering stamps, retain 10 years after substantial completion; (b) All other records, retain 2 years).

(18) **Street Surface Maintenance Records** Records document routine and special street sweeping, cleaning, snow removal, sanding, leaf removal, and similar work. Often includes reports, summaries and similar records. Information can include date and time, area covered, broom down time and mileage, traveling time and mileage, operator's name, equipment used, amount of sand applied, amount of leaves removed, weather conditions, and related data. (Minimum retention: 3 years after annual audit report issued).

(19) **Temporary Access/Construction Easement Records** Records document temporary easements allowing entrance and work on property or streets not owned by the easement holder. Permits usually apply to city crews and utility workers. Information can include applicant name, address, and phone number, contractor name and license number, utility involved, location, description of work, security deposit, surface restoration material used, signature, date, comments, permit number, and related data. SEE ALSO Easements in the Recorder-General section for long-term easements. (Minimum retention: 2 years after easement expires).

(20) **Traffic Control Equipment Maintenance and Repair Records** Records document maintenance and repair of traffic signals and signs in the city. May include reports, summaries, and similar records. Information often includes location, narrative of work completed, equipment repaired or replaced, supplies used, personnel completing work, dates of activities, and related data. SEE ALSO Contracts in the Recorder-General section for contract records related to private companies working on city maintenance and repair projects. SEE ALSO Daily Work Records in this section. (Minimum retention: (a) Traffic signal records, retain 2 years after equipment permanently removed from service; (b) Traffic sign records, retain 2 years).

(21) **Utility Installation and Connection Records** Records document installation of city utility systems or the connection of specific properties to city water, sewer, power, or similar systems. Does not apply to temporary stoppages or disconnections service. May include applications, permits, and similar records. Information often includes applicant's name and address, permit number, fee charged, service level, type of structure, pipe size, meter size and number, and related data. (Minimum retention: 2 years after physical disconnection).

(22) **Utility Line Location Request Records** Records document requests and city action to locate underground lines in the vicinity of a construction site. Information often includes name of person requesting location; planned and actual date and time of location; notations of water, sewer, storm drains, and other line locations; name and signature of person locating lines; and related data. If city uses a private contractor to locate lines, SEE ALSO Contracts and Agreements in the Recorder-General section. (Minimum retention: 2 years).

(23) **Utility Meter Installation, Maintenance, and Repair Records** Records document the installation, maintenance, and repair of city operated water and power meters. May include logs, summaries, and similar records usually compiled from daily work records on a monthly or quarterly basis. Information often includes address, narrative of work completed, personnel completing work, dates, and related data. (Minimum retention: 5 years).

(24) **Utility Meter Test and Calibration Records** Records document the testing and calibration of city operated water and power meters for accuracy. May include logs, reports, lists, charts, and similar records. Information can include address, test and calibration results, repairs needed, comments, and related data. (Minimum retention: Life of the equipment).

(25) **Valve Maintenance Records** Records document the location, specifications, maintenance, and repair of valves in the city water and sewer systems. May include lists, charts, drawings, reports, logs, and related records. Information often includes valve location, identification number,

run of pipe, size, make, year installed, depth, turns to open and normal position, narratives of valve maintenance and repair, tests run, personnel completing work, dates, and related data. (Minimum retention: (a) Location and specification records, retain until valve permanently removed from service; (b) Maintenance and repair records, retain 2 years).

(26) **Water Line Maintenance and Repair Records** Records document the maintenance and repair of city-owned water lines. May include reports, summaries, and similar documents usually compiled from daily work records on a monthly or quarterly basis. Information often includes, location, narrative of work completed, amount and type of materials used, personnel completing work, dates of activities, authorization, and related data. SEE ALSO Water Valve Maintenance Records, Water Hydrant Maintenance Records, and Daily Work Records in this section. (Minimum retention: (a) Records requiring an engineering stamp, retain 2 years after water line permanently removed from service; (b) All other records, retain 2 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0115
Public Works — Traffic Engineering Records

(1) **Bicycle Committee Meeting Records** SEE Meeting Records, Board, Commission and Committee and Meeting Records, Governing Body in the Administrative Records section.

(2) **Crosswalk Records** Records document the location and use of crosswalks in the city. Useful in determining the need for and placement of existing and proposed crosswalks. May include striping records, reports, maps, studies, and related records. (Minimum retention: 2 years after superseded or obsolete).

(3) **Railroad Crossing Records** Records document city activities in relation to railroad crossings. Records may include crossing plans and drawings, PUC/ODOT public hearings records and rulings, reports and studies, accident records, and related documentation and correspondence. Records may also include documentation of corrective action taken in response to PUC/ODOT inspection reports. Oversight responsibility of railroad and rail safety responsibilities was transferred from the Oregon Public Utility Commission (PUC) to the Oregon Department of Transportation (ODOT) in 1995. (Minimum retention: Permanent).

(4) **Special Event Records** Traffic Records document preparation for and implementation of traffic changes related to special events such as parades, motorcades, and demonstrations. Includes situations resulting in heavy traffic or street use requiring street closures, traffic rerouting, barricades, signal timing changes, and other variations. May include notifications, planning documents, reports, and related records. (Minimum retention: 2 years after event).

(5) **Speed Zone Records** Records document the establishment and review of speed zones in the city. Includes zones established by the city under OAR 734-020-0015. Records may include reports, photographs, proposals, orders, maps, accident summaries, and related documents. Considerations include pedestrian and bicycle movements, environmental impact, adjacent land use, and other factors. (Minimum retention: 2 years after superseded or obsolete).

(6) **Street Banner Records** Records document proposals for and installations of banners on city streets, often in relation to civic events or celebrations. Records may include plans, maps, proposals, reports, applications, and other documents. Applications usually include applicant's name, address, and phone number, organization name, banner message, display period requested, signature of city official approving permit, and related information. (Minimum retention: 2 years).

(7) **Streetlight Inventory Records** Inventory records of all streetlights in the city. Information can include addresses, pole numbers, and map numbers of lights, types of lights, dates of purchase and installation, notes, and other data. SEE ALSO Streetlight Maintenance Records in the Public Works-Operations and Maintenance section. (Minimum retention: Until superseded or obsolete).

(8) **Streetlight Request and Survey Records** Records document requests by citizens for the installation of streetlights, as well as city surveys to assess need and feasibility. Often includes request forms, correspondence, surveys, reports, and related records. (Minimum retention: 2 years after last action).

(9) **Traffic Accident Analysis Records** Records document the study of traffic accidents in the city. Useful in identifying hazardous locations and determining possible corrective action. Records may include various statistical data on accidents related to fixed objects, parked automobiles, complicated intersections, bridges, pedestrians, city streets/state highways, and other factors. May also include records of individual accidents documenting site, date, direction, driver's sex and age, weather, vehicle type, and related information. SEE ALSO Survey Field Records in the Public Works-Engineering section. (Minimum retention: (a) Reports and summaries, retain 10 years; (b) All other records, retain 5 years).

(10) **Traffic Control Equipment Inventory Records** Records document the location, type, and use of traffic control equipment in the city. Often includes an inventory of all traffic signs and signal equipment. Also may include information noting the timing intervals of traffic signals for red, green, yellow, and pedestrian cycles, type of equipment, date of purchase and installation, location, notes, and other data. (Minimum retention: 2 years after superseded or obsolete).

(11) **Traffic Research and Study Records** Records document data gathering and analysis concerning traffic patterns, speed, direction, and other topics. May include information on vehicles, bicycles, and pedestrians for a given location and period of time. Usually includes machine and manual traffic counts, reports, summaries, and related records. SEE ALSO City Improvement Administrative and Financial Records in the Financial-General section and Engineering Project Technical Records in the Public Works-Engineering section. (Minimum retention: (a) Reports and summaries, retain 10 years; (b) All other records, retain until information is summarized or obsolete).

(12) **Transit System Records** Records document the location of transit system stops, stations, and crossings in the city. Also may contain records related to city review and approval or denial of individual stops or crossings proposed by a transit district. These may include reports, traffic surveys, decision statements, notifications to affected property owners, and related records. (Minimum retention: (a) Review records, retain 2 years after denied or approved and stop or crossing removed; (b) Transit system maps, retain until superseded or obsolete).

(13) **Transportation Board Meeting Records** Records document the proceedings of boards or committees responsible for overseeing or advising the city council on transportation issues, as described in Oregon's Public Meetings Law (ORS 192.610 to 192.710). Records can include minutes, agendas, exhibits, tape recordings, and related documents. Subjects include traffic problems, grants, policies, procedures, and related topics. (Minimum retention: (a) Minutes, agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records), retain permanently; (b) Audio or visual recordings, retain 1 year after minutes prepared and approved; (c) All other records and exhibits not pertinent to minutes, retain 5 years).

(14) **Truck Route Records** Records document the designation of truck routes for transporting goods within and through the city. May include reports, maps, studies, and related documents. Subjects often include hazardous materials, triple trailer trucks, log trucks, buses, and others. (Minimum retention: 2 years after superseded or obsolete).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0120
Public Works — Wastewater Treatment Records

(1) **Annual Inspection Records** Records document annual inspections of city wastewater treatment operations by the Oregon Department of Environmental Quality to monitor compliance with National Pollution Discharge Elimination System (NPDES) permit conditions. May include reports and supporting documentation. Information includes date, location, areas evaluated during inspection, summary of findings, pre-treatment requirements review, sampling checklists, flow measurements, laboratory assurance checklists, and related data. (Minimum retention: (a) Reports, retain permanently; (b) All other records, retain 5 years).

(2) **Discharge Monitoring Records** Records document the amount of pollution discharged from the city wastewater treatment facility. Reports are submitted to the U.S. Environmental Protection Agency and the Oregon Department of Environmental Quality. May also include supporting documentation. Information includes date, period covered, permit number, discharge number, frequency of analysis, sample type, and average and maximum quantities and concentrations of solids, ammonia, chlorine, nitrogen, and other chemicals, and other data. (Minimum retention: (a) Reports, retain permanently; (b) All other records, retain 5 years).

(3) **Equipment Maintenance and Calibration Records** Records document the maintenance and calibration of equipment and instruments used to undertake and monitor wastewater treatment operations. Useful to verify equipment reliability and for reference by regulatory agencies. May

include logs, reports, and related records. Information often includes date, type of equipment maintained or calibrated, tests performed, repairs needed, comments, and related data. (Minimum retention: Life of the equipment).

(4) **Industrial Pretreatment Permits** Permits issued by the city to private industries allowing the discharge of specific pollutants under controlled conditions. Often contains applications, permits, addenda, modifications, and related supporting documentation. Information may include influent and effluent limits, chemical analysis data, water flow, test and recording requirements, definitions and acronyms, compliance schedules, and related data. (Minimum retention: (a) Permits, addenda, and modifications, retain permanently; (b) All other records, retain 5 years after expiration or revocation).

(5) **Mobile Waste Hauler Dumping Records** Records document the dumping of septic pumpings and other wastes from various sources at the city waste treatment facility. Usually includes logs, manifests, and similar documents. Information often includes name and signature of hauler, quantity of wastes dumped, location at which wastes were pumped, and related data. (Minimum retention: 5 years).

(6) **National Pollution Discharge Elimination System Permits Records** document the application for and issuance of a permit to the city under the Clean Water Act allowing discharge of specific pollutants under controlled conditions. Often contains applications, permits, addenda, modifications, and related supporting documentation. Information includes influent and effluent limits, chemical analysis records, water flow, test and recording requirements, definitions and acronyms, compliance schedules, and related data. SEE ALSO Annual Inspection Records in this section. (Minimum retention: (a) Permit, addenda, and modifications, retain permanently; (b) All other records, retain 5 years after expiration or revocation).

(7) **Public Facilities Grease Trap Inspection Records** Records series document the city's inspection and licensing of grease traps in public facilities such as restaurants, mini marts, delicatessens, hospital and school cafeterias, daycare and long-term care food services, tourist and traveler's facilities, and other food service organizations. Series may include applications: inspection reports listing type of inspection, any deficiencies, inspection score, date and time of inspection, and signatures; copies of the license issued; and other related records. (Minimum retention: (a) 1 year after date of inspection (b) Closed facilities, retain 2 years after closure.

(8) **Sewage Sludge Application Landowner Agreements** Agreements between the city and landowners related to the application of sewage sludge to approved sites. Records may include signed agreements, exhibits, amendments, and related documents. Information usually includes agreement number, date, conditions or terms, parties involved, period covered, and signatures. (Minimum retention: 6 years after expiration).

(9) **Sewage Sludge Application Site Logs** Logs documenting the agricultural application of sewage sludge to approved sites. Subjects include agronomic loading calculations related to maximum application of nitrogen in pounds per acre per year, and ultimate site life loading calculations tracking the amount of heavy metals applied. (Minimum retention: Permanent).

(10) **Sewage Sludge Management Plans** Plans submitted to the Oregon Department of Environmental Quality by the city to engage in sludge disposal or application activity. Information includes method of sludge removal, land application or disposal sites, sludge stability determination methods, projected sludge storage basin use, sludge analyses, application rates, and heavy metal limitations. (Minimum retention: Permanent).

(11) **Strip and Circle Chart Records** Records document the continuous monitoring of various wastewater treatment operations. May include strip charts, circle charts, and similar monitoring records. Information often pertains to pump flows, influent and effluent water flows, secondary total flow, influent pH, chlorine residue, and related subjects. (Minimum retention: 3 years).

(12) **Wastewater Treatment Operations Records** Program records not listed elsewhere in this schedule which document wastewater treatment operations. Created on a daily, monthly, and annual basis. Usually consists of reports, logs, log sheets, and related records. (Minimum retention: (a) Annual reports, retain permanently; (b) All Other records, retain 5 years).

(13) **Water Pollution Control Facilities (WPCF) Permit Records** Records document the application for and issuance of a Water Pollution Control Facilities permit to the city by the Oregon Department of Environmental Quality. The permit authorizes the city to construct and operate a disposal system with no discharge to navigable waters. Examples include sewage lagoons, septic tanks, and drain fields. Records often include applications, permits, addenda, modifications, and related supporting documentation. (Minimum retention: (a) Permit, addenda, and modifications, retain permanently; (b) All other records, retain 5 years after expiration or revocation).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0125
Public Works — Water Treatment Records

(1) **Equipment Maintenance and Calibration Records** Records document the maintenance and calibration of equipment and instruments used to monitor water treatment operations. Useful in verifying reliability and for reference by regulatory agencies. May include logs, reports, and related records. Information often includes date, type of equipment maintained or calibrated, tests conducted, repairs needed, comments, and related data. (Minimum retention: Life of the equipment).

(2) **Non-Compliance Corrective Action Records** Records document action taken by the city to correct violations of primary drinking water regulations. May include reports, logs, and related records. (Minimum retention: 3 years after last action).

(3) **Sanitary Survey Records** Records document surveys examining the overall sanitary condition of the city water system. May be conducted by the city, private consultants, or county, state, or federal agencies. Records may include written reports, summaries, and related documents. (Minimum retention: (a) Reports, retain permanently; (b) All other records, retain 5 years).

(4) **Secondary Contaminant Reports** Reports document the analysis of water samples to determine the level of secondary contaminants. Secondary contaminants are those, which, at levels generally found in drinking water, do not present a health risk but may affect taste, odor, and color of water, as well as stain plumbing fixtures and interfere with water treatment processes. Information may include date, report number, analyst, time of sample collection, contaminant levels, and related data. (Minimum retention: 10 years).

(5) **Strip and Circle Chart Records** Records document the continuous monitoring of various water treatment operations. May include strip charts, circle charts, and similar monitoring records. Information often pertains to reservoir levels, pump flows, distribution line pressure, and related subjects. (Minimum retention: 3 years).

(6) **Variance and Exception Records** Records document variances and exceptions granted to the city by regulatory agencies concerning water treatment operations. Information may include date, conditions of variance or exception, expiration date, and related data. (Minimum retention: 5 years after expiration or revocation of variance or exception).

(7) **Water Bacteriological Quality Analysis Reports** Reports document water samples taken from various locations throughout the city water system and supply sources for bacteriological tests. Information includes location, collection date, person taking samples, sample type, analysis date, laboratory name, person performing analysis, analytical method used, and the results of the analysis. (Minimum retention: 5 years).

(8) **Water Chemical and Radiological Analysis Reports** Records document water samples taken from various locations throughout the city water system and supply sources for chemical and radiological tests. Information includes location, collection date, person collecting sample, sample type, analysis date, laboratory name, person conducting analysis, analytical method used, and results of the analysis. (Minimum retention: 10 years).

(9) **Water Consumption Reports** Reports document statistics of daily water consumption. Useful for prediction of future flows and peak demands. Information may include water consumption in millions of gallons and cubic feet from treatment plants, springs, artesian wells, pumped wells, and reservoirs. (Minimum retention: (a) Annual reports, retain permanently; (b) Information summarized in annual report, retain 1 year; (c) Information not summarized in annual report, retain 10 years).

(10) **Water Quality Complaint Records** Records document complaints received from the public about the quality of city provided water. Information often includes name, address, and phone number of complainant, nature of complaint, location, description of water, name of person responding to complaint, narrative of investigation, and resolution. (Minimum retention: 3 years after last action).

(11) **Water Treatment Operations Records** Program records not listed elsewhere in this schedule which document water treatment operations, created on a daily, monthly, or annual basis. Records may include state or federal required reports. Usually consists of reports, logs, log sheets, and related records. Subjects may include amount and types of

chemicals used, filter rates, and others. (Minimum retention: (a) Annual reports, retain permanently; (b) All other records, retain 5 years).

(12) **Water Turbidity Reports** Reports document the analysis of water samples to determine the level of cloudiness caused by suspended particles. Information may include date, report number, analyst, time of sample collection, turbidity unit values for routine and check samples, and related data. (Minimum retention: 10 years).

(13) **Consumer Confidence Reports** Records document the presence of any contaminants identified by the city in city water over the course of a year. Reports are mailed to city residences and businesses receiving city water. (Minimum retention: 5 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0130
Recorder — Election Records

(1) **Abstract of Votes (Record of Elections) Records** document election results for General, Primary, Emergency, and Special Elections. Information includes candidate name/ballot title, precinct name, total votes per candidate/ballot title, total per precinct, under/over votes, and certification by County Clerk. (Minimum retention: Permanent).

(2) **Contribution and Expenditure Reports** Records document contributions and expenditures by candidates or political action committees if filed with the City. Includes statement of organization, amount, source, and detail of expenditures over the amount of fifty dollars. May also include receipts for expenditures and supplemental reports. (Minimum retention: (a) Statement of organization, retain permanently (b) All other records, retain 4 years after the date required to file update reports).

(3) **Election Filings** Includes all necessary papers required to be filed by a candidate or governing body for primary, general, emergency, and special elections. May include petition of nomination, declaration of candidacy, certification of nomination, filing forms for city and county voters' pamphlet, notice of measure election, and withdrawal of candidates. (Minimum retention: 4 years).

(4) **Election Preparation Records** Used to prepare and administer elections within each precinct in the city. Records may include such information as number of ballots going to each precinct, number and type of pages for each voting machine for each precinct, listing of issues and candidates by precinct order, guides to preparing voting machines, ballot layout records, and public certification test notice. Also may include guides to assist Election Board personnel in reconciling votes cast with eligible voters. (Minimum retention: 2 years).

(5) **Initiative, Referendum, and Recall Records** Records document the initiative, referendum, and recall process by which voters propose laws and amendments to the State Constitution, refer an act of the Legislature or other governing body to a vote of the electorate, or recall a public official. Includes petitions, signature sheets, summaries of signature verification, text of proposed law, amendment, or response from public official. (Minimum retention: (a) Signature verification records, retain 6 years (b) Signature sheets including verification, if measure approved, retain 6 years after election (c) Signature sheets, if measure not approved, retain 90 days after election or 90 days after deadline for sufficient signatures (d) Petitions qualified to ballot, retain permanently (e) Petitions not qualified to ballot, retain 6 years).

(6) **Legal Notices and Publications Records** document required pre-election legal notices by the City Recorder. May include publication of ballot title, notice of election, sample ballot, and the City voters' pamphlet. (Minimum retention: (a) One copy of city voters' pamphlet, retain permanently (b) All other records, retain 4years).

(7) **Poll Books Records** document issuance of ballot to eligible voter in an election. Includes name of elector, party affiliation, home address, ballot number, precinct number, and signature of voter. Cover includes number of voters casting ballots for the election and names, signatures, and oaths of Election Board members. May also include certificates of registration. Some records may have historical value. For appraisal assistance, contact the Oregon State Archives. (Minimum retention: (a) Records created prior to 1931, retain permanently (b) All other records, retain 2 years).

(8) **Vote-By-Mail Records** Records are used to prepare, administer, and abstract elections conducted by mail. Records include: counted, duplicated, rejected and/or defective ballots; Envelopes - returned signed envelopes, non-deliverable envelopes, and secrecy envelopes; and other documents used to prepare, administer and abstract elections conducted by mail. (Minimum retention: (a) Counted, duplicated, rejected and/or defective ballots, retain 22 months for elections containing federal candidates and 90 days after the last day to contest the election for all other elections (b) returned signed envelopes two years for elections containing federal candidates and 90 days after the last day to contest for all other elections (c) Secrecy and non-deliverable envelopes, retain for 60 days after the last day to contest for all elections regardless of federal/nonfederal candidates (d) All other documents used to prepare, administer and abstract elections conducted by mail, retain 2 years following the election to which it relates).

(9) **Voter Registration Records** Records document registration or cancellation of registration of eligible voters. Voter Registration Cards include the following information: name, signature, mailing and residence address, previous registration information, if ever registered in Oregon, date of birth, affirmation of citizenship, state residency, and political party. May also include records canceling or making inactive voter registration such as the notice of deceased list from Secretary of State, notice of change of address from Department of Motor Vehicles, U.S. Postal Service notice, and related correspondence. (Minimum retention: 2 years after canceled).

(10) **Help America Vote Act Identification Records** Records used to verify the identity and county residency of individuals registering to vote. Records include but are not limited to current and valid photo identification containing voter name and address, or a current copy of a utility bill, bank statement, government check, paycheck, or other government document that shows their name and address. The address listed must match the residence or mailing address submitted on their voter registration card. (Minimum retention: Until verified by county elections official).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 4-2003, f. & cert. ef. 11-24-03; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0135
Recorder — General Records

(1) **Annexation Records** Records document the annexation of areas into municipal boundaries. Used to fulfill legal requirements and document the acquisition process. May include staff reports, petitions, service district withdrawal records, surveys, boundary commission recommendations and judgments, census reports, franchise notices, maps, and documentation and correspondence. (Minimum retention: Permanent).

(2) **City Charter Constitution**, bylaws, and all amendments to city charters approved by the State Legislature. Generally includes original charter, amendments, and related records. (Minimum retention: Permanent).

(3) **City Code Codified** ordinances passed by the city council. Provides reference to all city laws for both information and enforcement. Information may include ordinance numbers, amending ordinance numbers, code numbers, and text. (Minimum retention: Permanent).

(4) **Contracts and Agreements** Official contracts enforceable by law to acquire services, equipment, or maintenance. Records document the terms and conditions of contracts and agreements between the city and private companies and individuals. Contract records may include contracts, exhibits, bid documents, change orders and amendments, and related correspondence. Information in contracts usually includes contract number, certificate of required insurance, dates, terms, parties involved, period covered, and signatures. SEE ALSO Collective Bargaining Records in the Personnel section, and Grant Records in the Administrative Records section. (Minimum retention: (a) Collective bargaining contract records, retain 75 years after contract expires; (b) Construction contract records, retain 10 years after substantial completion; (c) All other contract records, retain 6 years after expiration).

(5) **Council Records Official** proceedings of regularly scheduled, special, executive session, and emergency city council meetings. Records include agendas, minutes, and meeting packets (which may include agenda bills and attachments, memoranda, staff and subcommittee reports and recommendations, materials submitted by citizens, cards or sheets signed by citizens wishing to address the council, and related records). Information includes date, time, and location of meeting, names of members present and absent, subjects discussed, statements of intent, and records of actions taken. (Minimum retention: (a) Minutes (except executive session minutes), agendas, resolutions, indexes, and exhibits (not retained permanently elsewhere in city records), retain permanently; (b) Executive session minutes, retain 10 years; (c) Audio or visual recordings, retain 1 year after minutes prepared and approved; (d) All other records and exhibits not pertinent to minutes, retain 5 years).

(6) **Council Resolutions** Formal statements of decisions or expressions of opinions adopted by the city council. Information includes date, number, and text. (Minimum retention: Permanent).

(7) **Deeds To City-Owned Land Recorded** evidence of city ownership of public lands and right-of-ways. Exhibits may include maps and legal descriptions, title transfers, and related correspondence. Information typically includes a description of property, signatures of previous owner and city representative, and date of transfer. SEE ALSO Real Property Transaction Records and Grant Records in the Financial-General section. (Minimum retention: (a) Record of sale or property transfer and legal property description, retain permanently; (b) All other records, retain until property sold and any applicable audits have been completed).

(8) **Easements Recorded** grants by property owners to the city for the use of private property for public uses. Examples consist of street, utility, bike path, sewer, storm drain, and landscaping easements. May include maps or other exhibits. Information includes property owner's name and signature, location of property, type of easement, terms, and date of signing. SEE ALSO Temporary Access/Construction Easement Records in the Public Works-Operations and Maintenance section. (Minimum retention: Permanent).

(9) **Franchise Records** Franchise agreements with utilities, railroads, cable television, telephone, water, solid waste, bus, and other services. May include agreements, reports, and related documentation and correspondence. (Minimum retention: 6 years after expiration).

(10) **Lease Records** Lease agreements made between the city and a second party. May contain leases and subleases. Information typically includes names and addresses of lessor and lessee, description of property, payment amount, purpose for which property may be used, options to renew, and any additional conditions or terms. (Minimum retention: (a) Leases denied or not completed, retain 2 years; (b) All other leases, retain 6 years after expiration).

(11) **Liquor License Records** City endorsement of liquor licenses prior to Oregon Liquor Control Commission (OLCC) approval. Endorsements are required for new businesses, annual renewals, and changes in ownership or location. Information in application is used to investigate applicant before making recommendation to OLCC for approval or denial of license. May include OLCC liquor license applications, fee receipts, public hearings records, affidavits, administrative logs, and related records. (Minimum retention: 2 years after approval or denial).

(12) **Oaths of Office Signed** oaths taken by various elected and appointed officials before discharging duties of office. Information typically includes date, name, office held, text, and signatures. (Minimum retention: 6 years after most recent oath expired).

(13) **Ordinances Legislative** action of the city council to regulate, require, prohibit, govern, control, or supervise any activity, business, conduct, or condition authorized by Oregon Revised Statutes. Ordinances typically include a title, preamble, ordaining clause, subject clause, penalty for violation (when applicable), effective date, signature of mayor, and municipal seal. May also include indexes, calendars, and documentation presented to support action. (Minimum retention: Permanent).

(14) **Policy and Procedure Manuals** Written instructions, rules, and guidelines in manual form documenting current and past authorized city policies and procedures. Used for new employee orientation and for ongoing reference. Also useful in establishing past policies or procedures in liability cases, personnel disputes, and other instances. Includes manuals documenting the procedures of departments with higher risk or exposure to liability such as police, fire, emergency medical services, public works, etc. Moreover, this series includes routine documentation and basic secretarial/clerical instructional procedures covering such subjects as formatting letters, data entry, telephone etiquette, and others. Information often includes policy and procedure numbers, revision dates, subject identification, narrative description, authorization information, and effective date. The minimum retention periods refer only to city-generated manuals. Manuals from other sources should be retained as needed or as mandated by a specific regulating body (federal or state agency, etc.), usually until superseded or obsolete. SEE ALSO Policy Statements and Directives in this section, and Correspondence, Policy and Historical in the Administrative section. SEE ALSO Technical Manuals, Specifications, and Warranties in the Administrative section for published technical manuals and related materials. (Minimum retention: (a) Routine clerical manuals, retain 2 years after superseded or obsolete; (b) One copy of all other manuals, retain permanently).

(15) **Policy Statements and Directives** Administrative and legislative review, assessment, and development of the city's purpose and procedural policy. Often includes bulletins and advisories issued by the mayor, city manager, or council, mission and goal statements, and finalized policy statements and directives. SEE ALSO Policy and Procedure Manuals in this section, and Correspondence, Policy and Historical in the Administrative section. (Minimum retention: Permanent).

(16) **Property Dedication Records** Recorded dedication of private property to the city for public uses such as transportation facilities (streets, sidewalks, bikeways) and parks. May include dedication agreements, maps, correspondence, and important related materials. (Minimum retention: Permanent).

(17) **Property Vacation Records** Recorded property vacations by the city, including streets, alleys, easements, public utilities, subdivisions, and right-of-ways. May include petitions to vacate, maps, descriptions of property, staff reports, approval orders, and related correspondence. (Minimum retention: Permanent).

(18) **Waivers of Remonstrance Agreements** made by private citizens/property owners to forego their rights to remonstrate (oppose/protest) against certain city actions in exchange for other considerations. Often relates to the extension of water or sewer service beyond the city limits in areas that later may be annexed or formed into local improvement districts. Waivers usually include name and signature of grantor, location of property, purpose of document, date, and signature of city representative. (Minimum retention: (a) If waiver has an expiration date, retain 6 years after expiration date; (b) If waiver carries no expiration date,retain 6 years after completion of project).

(19) **Lien Records** Records document liens issued by the city to collect for unpaid assessments or services. Examples of services may include but are not limited to enhancements associated with local and special improvement districts or nuisance abatements. Information usually includes notice to property owner, copies of bills, description of property, amount of assessment, and payments made. (Minimum retention: 3 years after lien paid in full).

(20) **Vehicle Title and Registration Records** Records document the ownership and registration of all city vehicles with the Oregon Division of Motor Vehicles. (Minimum retention: (a) Titles, retain until vehicle is sold or disposed of; (b) Registration records, retain until superseded or disposition of vehicle).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0140
Risk Management Records

(1) **City Vehicle Accident Records** Records document accidents involving city vehicles. May include dispatch reports with information such as name and address of parties involved, date and time, complaint, description of damage, and other data. Records may also contain motor vehicle accident reports which include the driver's name, address, phone number, date of birth, and driver's license number, as well as passenger and witness names, description of events, make and model of vehicle(s), vehicle identification number, and related data. Photographs and correspondence also may be part of these records. (Minimum retention: (a) If litigated, see Civil Case Files in the Attorney section for retention; (b) If not litigated, retain 3 years).

(2) **Contractor Liability Insurance Verification Records** Letters or certificates of coverage provided by insurance companies declaring that specific contractors are covered by appropriate liability insurance. Information usually includes insurance company name and address, issue date, expiration date, amount of coverage, type of coverage, special provisions, signature of insurance company representative, and related data. (Minimum retention: (a) If related to city improvement project, retain 10 years after substantial completion, as defined by ORS 12.135(3); (b) All other records, retain 6 years after expiration).

(3) **Contractor Performance Bond Records** Records document the posting of performance guarantees or surety bonds by contractors performing work for the city. May include letters, certificates, copies of bonds, and similar records. Information usually includes name of individual or company covered, amount of coverage, effective and expiration dates, name of bonding agent, authorized signatures, and related data. (Minimum retention: (a) If related to city improvement project 10 years after substantial completion, as defined by ORS 12.135(3); (b) All other bond records, retain 6 years after expiration).

(4) **Hazard Communications Program Records** Records document city participation in the Hazard Communications Program as required by the Oregon Occupational Safety and Health Administration (OR-OSHA). These records may be useful as documentation for exposure and other claims because they include chemical content, safe handling instructions, and other facts about a product at a given time in the past. Usually includes

plans, reports, and material safety data sheets (MSDS). Information included in the material safety data sheets includes product name, manufacturer's address and phone number, hazardous ingredients contained, ingredient description, carcinogenicity, quantity of ingredients, fire and explosion data, health hazard data, radioactivity data, spill and leak pressures, safe handling and use information, special use precautions and related data. (Minimum retention: 75 years after superseded or obsolete).

(5) **Injury Reports, Public Use Records** document injuries sustained by non-employees on city property such as parks, swimming pools, libraries, and senior centers. Information usually includes date, time, location, and description of injury, name, address, phone number, sex, and age of injured person, witnesses, date reported, and related data. (Minimum retention: (a) If claim filed, see Liability Claims Records in this section for retention; (b) If no claim filed, retain 3 years).

(6) **Insurance Policy Records** Records document the terms and conditions of insurance policies between the city and insurers. Types of insurance include liability, property, group employee health and life, motor vehicle, workers' compensation, flood, and others. Records usually include policies, endorsements, rate change notices, agent of record, and related documents. (Minimum retention: (a) Group employee health and life, property, and liability insurance, retain 75 years after expiration if no claims pending; (b) All other insurance records, retain 6 years after expiration if no claims pending).

(7) **Liability Claims Records** Records document various types of liability claims filed against the city. These include personal injury, property damage, motor vehicle accident, false arrest, and others. Records often include reports, photographs, summaries, reviews, notices, audio and videotapes, transcriptions of recorded statements, memoranda, correspondence, and related documents. Some records may be duplicated in the Civil Case Files record series in the Attorney section. Duplicate records should be retained as needed. (Minimum retention: (a) If action taken, retain 10 years after case closed, dismissed, or date of last action; (b) If no action taken, retain 3 years).

(8) **Liability Waivers Records** document the release of the city from liability related to various activities that include citizen involvement. Examples include but are not limited to riding in police or emergency medical services vehicles, participating in city sponsored runs or other activities such as recreational classes including canoeing, kayaking, tennis, basketball, and others. Information usually includes release terms, date, signatures, and related information. (Minimum retention: 3 years).

(9) **Occupational Injury and Illness Reports** Records document the activities of the workers' compensation program as required by Oregon Occupational Safety and Health Administration (OR-OSHA). Includes OR-OSHA logs and summaries, claims summary reports, status reports, financial reports, and supplemental records. Information includes calendar year, dates, file numbers, date and description of each injury, illness, or death, names, occupations, types of diseases, totals, and related data. (Minimum retention: 6 years).

(10) **Property Damage Records** Reports, photographs, and other records document damage to city property such as signs, trees, picnic tables, buildings, fountains, and fences. Information often includes type and location of property damaged, description of damage, date and time of damage (if known), name and address of individual who caused damage (if known), value of damage, billing costs, and related data. SEE ALSO Incident Case Files in the Police section for related vandalism records and Flood Plain Permit Records in the Planning and Development section. (Minimum retention: (a) If litigated, see Civil Case Files in the Attorney section for retention; (b) If not litigated, retain 3 years after date of last action).

(11) **Risk Survey and Inspection Records** Records document surveys, inspections, and other actions designed to identify potential hazards and liabilities to the city related to buildings, grounds, or services. Useful for preventing liability claims and for illustrating a pattern of responsible action regarding hazards. Records may include survey summaries and reports, safety audit and inspection reports, memoranda, and correspondence. Subjects may include the design, and use of parks, playgrounds, buildings, etc., video display terminals, hazardous materials, and others. (Minimum retention: (a) Records documenting the formation or change of policy, retain permanently; (b) All other records, retain 5 years).

(12) **Safety Program Records** Records document the city's program to promote a safe work environment for its employees. Records may include safety policies, plans and procedures, workplace safety committee records, reports on inspections conducted by the safety officer, evacuation rosters and reports, and related documentation and correspondence. (Minimum retention: (a) Safety policies, plans, and procedures, retain 5 years after superseded; (b) Inspection reports, reports, evaluations, and recommendations, retain 10 years; (c) Committee minutes, exhibits, and agendas, retain 3 years; (d) All other records, retain 5 years).

(13) **Workers' Compensation Claim Records** Records document the processing of individual employee claims of job related injuries or illnesses, but not those describing actual medical conditions. Includes records satisfying the procedural requirements of the State Workers' Compensation Division and the State Workers' Compensation Board, as well as those of (depending on city arrangements) the State Accident Insurance Fund (SAIF), private insurance providers, or self insurance. Records may include claim disposition notices, claim reporting and status forms; injury reports; determination orders; insurance premium data; hearing requests; safety citations; inspection reports; medical status updates and reports; investigation reports; reimbursement and payment records; and related correspondence and documentation. SEE ALSO Employee Medical Records in the Personnel section for records describing the job related injury or illness and the related subsequent medical condition of the employee. These often include workers' compensation accident reports, medical reports, vocational rehabilitation evaluations, disability determinations and related records. (Minimum retention: (a) For retention of records describing injuries and illnesses, see Employee Medical Records in the Personnel section; (b) All other records, retain 6 years after claim closed or final action).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 1-1998, f. & cert. ef. 1-7-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

166-200-0145
9-1-1/Public Safety Answering Point Records

(1) **Briefing Records** Records document internal communication between supervisors and shift workers or between staff on different shifts to alert them to problems, issues, or activities. Records may include but are not limited to briefing logs, teletype messages, and bulletins from other agencies. (Minimum retention: 7 days).

(2) **Data Management System Records** Records document the maintenance and update of current information used to provide and direct incident response within a 9-1-1/public safety answering point service area. Information may include but is not limited to address data, response unit assignments, response codes, responsible person data, and related documentation. (Minimum retention: Until superseded or obsolete).

(3) **Dispatch Incident Records** Records document specific incidents when a call is received by the 9-1-1/public safety answering point and subsequent response activities. Information may include but is not limited to caller's name, address, and telephone number; details of incident or complaint; call taker/dispatcher name; which agency responded and when; and incident disposition. Additional information received through an enhanced system is the Automatic Number Identification and Automatic Location Identification (ANI/ALI) which includes the telephone subscriber name, subscriber's telephone number, and subscriber's telephone service location. (Minimum retention: 2 years).

(4) **Enhanced 9-1-1 Service Plans Records** document the planning, development, and implementation of enhanced 9-1-1/public safety answering point systems. Plans and any subsequent amendments are required to be submitted to the Oregon Emergency Management in the Oregon Military Department for approval. The plan may be periodically revised and updated. Records may include but are not limited to preliminary and final plans, drafts and worksheets, correspondence, and other records described in OAR 104-080-0020. (Minimum retention: (a) Approved plans and amendments, retain 5 years after superseded; (b) Preliminary plans, drafts, worksheets, and supporting materials, retain until plan approved by Oregon Emergency Management).

(5) **Master Street Address Guide (MSAG) Maintenance Forms Records** document the 9-1-1/public safety answering point's notification to the phone service provider about the addition of new streets or revision to existing streets on the Master Street Address Guide (MSAG). The MSAG is maintained by the phone service provider or its independent contractor. Forms are usually maintained by the agency's MSAG Coordinator. Information may include but is not limited to new or updated address, customer, and responder information. (Minimum retention: 2 years).

(6) **Master 24-Hour Audio Tapes Records** document recorded incoming emergency and non-emergency calls; law enforcement, fire, and emergency medical services dispatches; radio activity; and 9-1-1/public safety answering point calls. Tapes are maintained on a 24-hour basis. (Minimum retention: 7 months.) [Note: Specific recordings of incidents may warrant longer retention for legal reasons.]

(7) **Operational Logs Records** document chronological tracking of activities related to 9-1-1/public safety answering point operations. Records may include but are not limited to radio logs, telephone logs, tow logs, and criminal background check request logs. (Minimum retention: 1 year).

(8) Premise Information Records Records document information about specific premises or locations that emergency responders need to know in advance of arrival at an incident site. Information may include but is not limited to hazardous materials storage locations, whether building plans were submitted to the fire department, unique information about buildings such as utility shut-offs, and related documentation. (Minimum retention: 2 years, or until renewed, superseded, or expired, whichever is sooner).

(9) **Quality Assurance Records** Records document the evaluation, analysis, and assessment of the performance and quality of services provided by the 9-1-1/public safety answering point system. Records may include but are not limited to system evaluations, system performance reports, satisfaction surveys and questionnaires, quality improvement reports and recommendations, quality assurance committee minutes, and related documentation. (Minimum retention: (a) Survey instruments, retain 2 years, or until summary report completed, whichever is sooner; (b) All other records, retain 2 years).

(10) **Statistical Reports Records** document the compilation of statistical data about the actions and activities of the 9-1-1/public safety answering point system. Data may be compiled on a daily, weekly, monthly, quarterly, and/or annual basis and may be used for analysis, evaluation, and budget development purposes. Information may include but is not limited to data about response times, number of calls received and dispatched, and responses by individual agency. (Minimum retention: (a) Data instruments used to compile statistics, retain until statistical report completed; (b) Daily and weekly reports, retain until compiled into monthly reports; (c) Monthly and quarterly reports, retain 1 year; (d) Annual reports, retain 10 years).

(11) **System Error/Malfunction Records** Records document 9-1-1/public safety answering point electronic systems errors or malfunctions and subsequent corrective action. Records may include but are not limited to enhanced system error reports, trouble logs, work orders, correspondence, and related documentation. (Minimum retention: 2 years).

Stat. Auth.: ORS 192 & 357
Stats. Implemented: ORS 192.005–192.170 & 357.805–357.895
Hist.: OSA 7-1998, f. & cert. ef. 10-29-98; OSA 3-2002, f. & cert. ef. 7-2-02; OSA 3-2008, f. & cert. ef. 12-10-08

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Veterinary Medical Examining Board
Chapter 875

Rule Caption: Certified Veterinary Technicians may obtain all required Continuing Education via 'interactive' media.
Adm. Order No.: VMEB 13-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 9-1-2008
Rules Amended: 875-010-0090
Subject: Allows Certified Veterinary Technicians to obtain entire 15 hours of Continuing Education through 'interactive' media. (The Board filed this as a temporary rule in April 2008.)
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-010-0090
Continuing Education Requirements (CE)

(1) All active licensees, including veterinarians and certified veterinary technicians, must comply with the CE provided in this rule in order to renew their licenses. An active licensee is one who practices in Oregon for 30 calendar days or more in each year.

(2) "Inactive" veterinary and certified veterinary technician licensees need not comply with the educational requirements, and may renew their licenses in an "inactive" status. An "inactive" licensee is one who practices in Oregon for less than 30 calendar days in each year.

(3) Active licensees wishing to obtain a renewal of their license must complete the minimum required number of CE hours every two years. Veterinarians shall report 30 hours of CE to the Board with license renewals for every odd-numbered year. Certified veterinary technicians shall report 15 hours of CE to the Board for every even-numbered year beginning January 2008. The required hours may be satisfied with any combination of the following continuing education activities:

(a) Attendance at scientific workshops or seminars approved by the Board.

(b) A maximum of four hours for veterinarians or two hours for certified veterinary technicians reading approved scientific journals. One subscription to an approved journal is equal to one hour of credit.

(c) A maximum of six hours for veterinarians or three hours for certified veterinary technicians of workshops or seminars on non-scientific subjects relating to the practice of veterinary medicine such as communication skills, practice management, stress management, or chemical impairment.

(d) A maximum of 15 hours for veterinarians of audio or video recordings, electronic, computer or interactive materials or programs on scientific or non-scientific subjects, as set forth in subsection (3)(c) above, and prepared or sponsored by any of the organizations defined in subsection (4) below. The sponsor must supply written certification of course completion. Certified veterinary technicians may report all required 15 hours of required CE under the provisions of this subsection.

(4) Workshops, seminars, and prepared materials on scientific and non-scientific subjects relating to veterinary medicine sponsored by the following organizations are approved:

(a) American Veterinary Medical Association (AVMA) and Canadian Veterinary Medical Association (CVMA);

(b) Specialty and allied groups of the American Veterinary Medical Association and Canadian Veterinary Medical Association;

(c) Regional meetings such as the Inter-Mountain Veterinary Medical Association, Central Veterinary Conference, and Western Veterinary Conference;

(d) Any state or province veterinary medical association;

(e) Any local or regional veterinary medical association;

(f) The American Animal Hospital Association;

(g) American and Canadian Veterinary Schools accredited by the American Veterinary Medical Association;

(h) All state veterinary academies;

(i) Animal Medical Center , New York;

(j) Angel Memorial Medical Center;

(k) Other programs receiving prior approval by the Board;

(l) The Board may approve other sponsors for lectures or prepared materials upon written request by the attending veterinarian or the sponsor.

(5) The following scientific journals are approved by the Board to satisfy all or a portion of the two hours of non-lecture CE activities:

(a) Journal of the American Veterinary Medical Association;

(b) Journal of the Canadian Veterinary Medical Association;

(c) The Journal of Veterinary Research;

(d) Veterinary Medicine;

(e) Small Animal Clinician;

(f) Modern Veterinary Practice;

(g) Publications of the AVMA/CVMA Approved Constituent Specialty Groups;

(h) Compendium of Continuing Education;

(i) Journal of American Animal Hospital Association;

(j) Other publications approved in advance by the Board.

(6) Study in a graduate resident program at an AVMA-approved veterinary school will satisfy the CE requirements for the year in which the veterinarian is enrolled in such program.

(7) Reporting CE credits:

(a) At the time of making application for license renewal in years when CE reporting is required, the veterinarian shall certify on the application form that 30 hours of CE, and the veterinary technician shall certify on the application form that 15 hours of CE, as set forth in this rule have been satisfied. Proof of participation in such CE programs must be kept by the licensee for a period of at least two years, and the licensee must permit the Board or any of its agents or designees to inspect CE records. Any such failure to keep these records or produce them to the Board, its agents or designees shall constitute grounds for non-renewal of the license, or, if the license has been issued for that year, for revocation of the license;

(b) Proof of compliance with the CE requirement of this rule may be supplied through registration forms at lectures, certificates issued by the sponsors of lectures, subscriptions to journals, and other documentation approved by the Board.

(8) The Board may approve CE programs presented by non-veterinarians, if program content is pertinent or complementary to veterinary medicine.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.410 - 686.420
Hist.: VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 2-2006, f. & cert. ef. 5-11-06; VMEB 1-2008, f. & cert. ef. 2-11-08; VMEB 2-2008(Temp), f. & cert. ef. 2-11-08 thru 8-9-08; Administrative correction 8-21-08; VMEB 13-2008, f. & cert. ef. 12-15-08

Rule Caption: Certified Euthanasia Facilities may use vendor or licensed veterinarian to train and certify euthanasia technicians.
Adm. Order No.: VMEB 14-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 9-1-2008
Rules Amended: 875-020-0005
Subject: Allows animal control agencies and shelters certified as euthanasia agencies to obtain employee training in proper methods of animal euthanasia from private vendors or licensed Oregon veterinarians with prior approval by the Board. (The Board filed this as a temporary rule in April 2008.)
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-020-0005
Exceptions

(1) A person who is not certified and is employed by an agency may administer a lethal drug under the direct supervision of a C.E.T. or Oregon licensed veterinarian until the next scheduled Task Force training session.

(2) Other drugs approved by the Board of Pharmacy for the purpose of euthanasia may also be submitted to the Board for approval. If approved by the Board, the drug may be used by C.E.T.'s.

(3) With prior approval by the Board, an agency may obtain euthanasia training, examination and certification for employees from a vendor or licensed Oregon veterinarian.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 475.190, 609.405, 686.255 & 686.510
Hist.: VME 1-1986(Temp), f. & ef. 7-21-86; VME 1-1989, f. 1-12-89, cert. ef. 2-1-89; VMEB 4-2008(Temp), f. 4-11-08, cert. ef. 4-21-08 thru 10-18-08; Administrative correction 11-18-08; VMEB 14-2008, f. & cert. ef. 12-15-08

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Rule Caption: Adds provision of on-the-job experience in Oregon for VTNE applicants.
Adm. Order No.: VMEB 15-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 9-1-2008
Rules Amended: 875-030-0010
Subject: Requires on-the-job applicants for the Veterinary Technicians National Exam to have obtained required work experience in Oregon.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-030-0010
Criteria for Becoming a Certified Veterinary Technician

In order to become a certified veterinary technician, an individual must:

(1) Pass the examinations referred to in OAR 875-030-0020; and

(2)(a) Hold a certificate in veterinary technology (or a comparable certificate) from a college accredited by the American Veterinary Medical Association, or other program approved by the Board; or

(b) Have received at least 6,000 hours of on-the-job training in the following technical procedures as verified by a veterinarian or veterinarians with valid Oregon veterinary licensure:

(A) Medical Terminology;
(B) Basic Comparative Animal Anatomy and Physiology;
(C) Veterinary Office Procedures;
(D) Basic Pharmacology;
(E) Practical Animal Nutrition;
(F) Nursing Care and Handling of Animals;
(G) Animal Behavior;
(H) Applied Radiography;
(I) Applied Anesthesiology;
(J) Applied Clinical Laboratory Procedures;
(K) Principles and Practices of Medical and Surgical Assistance;
(L) Animal Diseases.

(3)(a) Have at a minimum a Bachelor's degree in a field approved by the Board, e.g., Veterinary Technology, Animal Technology, Animal Husbandry, Zoology, etc., and a minimum of 1,500 hours of on-the-job training that meets the requirements of (2)(b); or

(b) Have at a minimum an Associate's degree in a field approved by the Board, e.g., Veterinary Technology, Animal Husbandry, Zoology, etc., and a minimum of 3,000 hours of on-the-job training and that meets the requirements of (2)(b); or

(c) Have acquired a minimum of 30 credit hours of training from a school or program approved by the Board in a field approved by the Board, e.g., Veterinary Technology, Animal Husbandry, Zoology, etc., and a minimum of 4,500 hours of on-the-job training that meets the requirements of (2)(b);

(d) Any other combination of Board-approved education and experience. For purposes of this section, on-the-job experience must have been obtained in Oregon and must be verified by a licensed Oregon veterinarian.

(e) On-the-job applicants shall provide proof of on-the-job experience such as W2 forms or other proof approved by the Board. A form, available from the Board, with a notarized signature of an Oregon-licensed veterinarian(s), describing period(s) of employment and total hours worked, is acceptable in lieu of other proof.

(4) The Board may waive the requirement of passing the VTNE (875-030-0020(1)) for applicants who:

(a) Graduated from an accredited veterinary technology college program prior to 1990;

(b) Hold an active certified veterinary technician license or animal health technician license in another state, province or territory of the United States; and

(c) Have a minimum of 7,500 hours of on-the-job training and experience as specified in subsection (b) of this section.

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.350 - 686.370
Hist.: VE 5, f. & ef. 8-3-76; VME 3-1983, f. & ef. 1-21-83; VME 2-1989, f. 8-29-89, cert. ef. 10-1-89; VME 1-1991, f. & cert. ef. 1-24-91; VME 3-1991, f. & cert. ef. 12-9-91; VME 3-1992, f. & cert. ef. 10-9-92; Renumbered from 875-010-0025; VMEB 2-2000, f. & cert. ef. 6-21-00; VMEB 1-2006, f. & cert. ef. 2-8-06; VMEB 2-2006, f. & cert. ef. 5-11-06; VMEB 10-2008, f. & cert. ef. 7-22-08; VMEB 15-2008, f. & cert. ef. 12-15-08

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Rule Caption: Allows persons not certified as veterinary technicians to intubate in emergencies.
Adm. Order No.: VMEB 16-2008
Filed with Sec. of State: 12-15-2008
Certified to be Effective: 12-15-08
Notice Publication Date: 9-1-2008
Rules Amended: 875-030-0050
Subject: Allows persons not certified as veterinary technicians to place an endotracheal tube to establish an airway in emergency situations.
Rules Coordinator: Lori V. Makinen—(971) 673-0224

875-030-0050
Practice Limitations for Individuals not Certified as Veterinary Technicians

Persons who are not certified by this Board as veterinary technicians may perform under the supervision of a licensed veterinarian all acts that a certified veterinary technician may perform except for OAR 875-030-0040(2)(b)(E), (induce anesthesia, except to place an endotracheal tube to establish an airway in emergencies), (2)(b)(G) (place an endotracheal tube), (2)(e)(D) (operate X-ray equipment) unless the person has completed 20 hours training in radiograph safety as required by the Oregon State Health Division (OAR 333-106-0055)(2)(e)(G) (perform dental extractions), (2)(e)(H) (administer rabies vaccine) and (875-030-0040(I)) (inject or implant a permanent identification device).

Stat. Auth.: ORS 686.210
Stats. Implemented: ORS 686.350 - 686.370
Hist.: VE 5, f. & ef. 8-3-76; VME 3-1983, f. & ef. 1-21-83; VME 2-1989, f. 8-29-89, cert. ef. 10-1-89; VME 1-1991, f. & cert. ef. 1-24-91; VME 3-1991, f. & cert. ef. 12-9-91; VME 3-1992, f. & cert. ef. 10-9-92; Renumbered from 875-010-0025; VMEB 1-2002(Temp), f. & cert. ef. 4-23-02 thru 10-20-02; Administrative correction 12-2-02; VMEB 1-2008, f. & cert. ef. 2-11-08; VMEB 5-2008, f. & cert. ef. 5-12-08; VMEB 12-2008, f. & cert. ef. 7-22-08; VMEB 16-2008, f. & cert. ef. 12-15-08

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
122-060-0020	12-11-2008	Adopt(T)	1-1-2009
141-001-0000	12-10-2008	Amend	1-1-2009
141-001-0005	12-10-2008	Amend	1-1-2009
141-001-0010	12-10-2008	Amend	1-1-2009
141-001-0020	12-10-2008	Amend	1-1-2009
141-040-0020	1-1-2009	Amend	1-1-2009
141-040-0030	1-1-2009	Amend	1-1-2009
141-040-0035	1-1-2009	Repeal	1-1-2009
141-040-0040	1-1-2009	Repeal	1-1-2009
141-040-0211	1-1-2009	Amend	1-1-2009
141-040-0212	1-1-2009	Amend	1-1-2009
141-040-0213	1-1-2009	Adopt	1-1-2009
141-040-0214	1-1-2009	Amend	1-1-2009
141-045-0010	1-1-2009	Amend	1-1-2009
141-045-0021	1-1-2009	Amend	1-1-2009
141-045-0031	1-1-2009	Amend	1-1-2009
141-045-0041	1-1-2009	Amend	1-1-2009
141-045-0061	1-1-2009	Amend	1-1-2009
141-045-0100	1-1-2009	Amend	1-1-2009
141-045-0115	1-1-2009	Amend	1-1-2009
141-045-0126	1-1-2009	Amend	1-1-2009
141-045-0130	1-1-2009	Amend	1-1-2009
141-050-0500	12-10-2008	Amend	1-1-2009
141-050-0530	12-10-2008	Repeal	1-1-2009
141-050-0535	12-10-2008	Repeal	1-1-2009
141-050-0890	12-10-2008	Renumber	1-1-2009
141-050-0900	12-10-2008	Amend	1-1-2009
141-050-0905	12-10-2008	Amend	1-1-2009
141-050-0910	12-10-2008	Repeal	1-1-2009
141-050-0920	12-10-2008	Amend	1-1-2009
141-050-0940	12-10-2008	Amend	1-1-2009
141-050-0945	12-10-2008	Repeal	1-1-2009
141-050-0965	12-10-2008	Amend	1-1-2009
141-050-0972	12-10-2008	Amend	1-1-2009
141-050-0976	12-10-2008	Amend	1-1-2009
141-050-0982	12-10-2008	Amend	1-1-2009
141-086-0185	1-1-2009	Amend	1-1-2009
141-086-0190	1-1-2009	Repeal	1-1-2009
141-086-0200	1-1-2009	Amend	1-1-2009
141-086-0210	1-1-2009	Amend	1-1-2009
141-086-0220	1-1-2009	Amend	1-1-2009
141-086-0222	1-1-2009	Adopt	1-1-2009
141-086-0225	1-1-2009	Amend	1-1-2009
141-086-0228	1-1-2009	Amend	1-1-2009
141-086-0230	1-1-2009	Amend	1-1-2009
141-086-0240	1-1-2009	Amend	1-1-2009
141-091-0005	12-10-2008	Amend	1-1-2009
141-091-0015	12-10-2008	Amend	1-1-2009
166-200-0005	12-10-2008	Amend	1-1-2009
166-200-0010	12-10-2008	Amend	1-1-2009
166-200-0015	12-10-2008	Amend	1-1-2009
166-200-0020	12-10-2008	Amend	1-1-2009
166-200-0025	12-10-2008	Amend	1-1-2009
166-200-0030	12-10-2008	Amend	1-1-2009
166-200-0035	12-10-2008	Amend	1-1-2009
166-200-0040	12-10-2008	Amend	1-1-2009
166-200-0045	12-10-2008	Amend	1-1-2009
166-200-0050	12-10-2008	Amend	1-1-2009
166-200-0055	12-10-2008	Amend	1-1-2009
166-200-0060	12-10-2008	Amend	1-1-2009
166-200-0065	12-10-2008	Amend	1-1-2009
166-200-0070	12-10-2008	Amend	1-1-2009
166-200-0075	12-10-2008	Amend	1-1-2009
166-200-0080	12-10-2008	Amend	1-1-2009
166-200-0085	12-10-2008	Amend	1-1-2009
166-200-0090	12-10-2008	Amend	1-1-2009
166-200-0095	12-10-2008	Amend	1-1-2009
166-200-0100	12-10-2008	Amend	1-1-2009
166-200-0105	12-10-2008	Amend	1-1-2009
166-200-0110	12-10-2008	Amend	1-1-2009
166-200-0115	12-10-2008	Amend	1-1-2009
166-200-0120	12-10-2008	Amend	1-1-2009
166-200-0125	12-10-2008	Amend	1-1-2009
166-200-0130	12-10-2008	Amend	1-1-2009
166-200-0135	12-10-2008	Amend	1-1-2009
166-200-0140	12-10-2008	Amend	1-1-2009
166-200-0145	12-10-2008	Amend	1-1-2009
170-040-0090	11-28-2008	Adopt	1-1-2009
170-040-0100	11-28-2008	Adopt	1-1-2009
177-046-0020	11-23-2008	Amend(T)	1-1-2009
177-046-0150	12-1-2008	Repeal	1-1-2009
177-050-0025	12-1-2008	Amend	1-1-2009
177-050-0027	12-1-2008	Amend	1-1-2009
177-050-0100	12-1-2008	Adopt	1-1-2009
177-069-0000	12-1-2008	Adopt	1-1-2009
177-069-0010	12-1-2008	Adopt	1-1-2009
177-069-0020	12-1-2008	Adopt	1-1-2009
177-069-0030	12-1-2008	Adopt	1-1-2009
177-069-0040	12-1-2008	Adopt	1-1-2009
177-069-0050	12-1-2008	Adopt	1-1-2009
177-075-0010	11-23-2008	Amend(T)	1-1-2009
177-081-0020	11-23-2008	Amend(T)	1-1-2009
177-083-0020	11-23-2008	Amend(T)	1-1-2009
177-083-0030	11-23-2008	Amend(T)	1-1-2009
177-083-0040	11-23-2008	Amend(T)	1-1-2009
177-085-0000	1-4-2009	Amend	1-1-2009
177-085-0005	1-4-2009	Amend	1-1-2009
177-085-0010	1-4-2009	Amend	1-1-2009
177-085-0015	11-23-2008	Amend(T)	1-1-2009
177-085-0015	1-4-2009	Amend	1-1-2009
177-085-0020	1-4-2009	Amend	1-1-2009
177-085-0025	1-4-2009	Amend	1-1-2009
177-085-0030	1-4-2009	Amend	1-1-2009
177-085-0035	1-4-2009	Amend	1-1-2009
177-085-0040	1-4-2009	Amend	1-1-2009
177-085-0045	1-4-2009	Amend	1-1-2009
177-085-0050	1-4-2009	Amend	1-1-2009
177-085-0065	1-4-2009	Amend	1-1-2009
177-094-0020	11-23-2008	Amend(T)	1-1-2009
259-008-0010	1-1-2009	Amend	1-1-2009
259-008-0011	1-1-2009	Amend	1-1-2009
259-008-0070	1-1-2009	Amend	1-1-2009
291-022-0115	11-25-2008	Amend(T)	1-1-2009
291-022-0160	11-25-2008	Amend(T)	1-1-2009
291-022-0161	11-25-2008	Adopt(T)	1-1-2009
291-022-0162	11-25-2008	Adopt(T)	1-1-2009

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
330-061-0005	12-5-2008	Amend	1-1-2009
330-061-0025	12-5-2008	Amend	1-1-2009
330-061-0030	12-5-2008	Amend	1-1-2009
331-030-0000	12-1-2008	Amend(T)	1-1-2009
331-030-0005	12-1-2008	Adopt(T)	1-1-2009
331-030-0010	12-1-2008	Amend(T)	1-1-2009
331-810-0038	12-1-2008	Adopt	1-1-2009
339-010-0023	1-1-2009	Amend	1-1-2009
339-010-0035	1-1-2009	Amend	1-1-2009
339-010-0050	1-1-2009	Amend	1-1-2009
339-020-0015	1-1-2009	Adopt	1-1-2009
407-001-0000	12-5-2008	Amend	1-1-2009
407-001-0005	12-5-2008	Amend	1-1-2009
407-001-0010	12-5-2008	Amend	1-1-2009
410-120-0000	12-1-2008	Amend	1-1-2009
410-120-1140	12-1-2008	Amend	1-1-2009
410-120-1180	12-1-2008	Amend	1-1-2009
410-120-1195	12-1-2008	Amend	1-1-2009
410-120-1260	12-1-2008	Amend	1-1-2009
410-120-1280	12-1-2008	Amend	1-1-2009
410-120-1340	12-1-2008	Amend	1-1-2009
410-120-1340	1-1-2009	Amend	1-1-2009
410-121-0000	1-1-2009	Amend	1-1-2009
410-121-0030	1-1-2009	Amend	1-1-2009
410-121-0032	1-1-2009	Amend	1-1-2009
410-121-0040	12-1-2008	Amend	1-1-2009
410-121-0060	12-1-2008	Amend	1-1-2009
410-121-0060	1-1-2009	Amend	1-1-2009
410-121-0140	12-1-2008	Amend	1-1-2009
410-121-0140	1-1-2009	Repeal	1-1-2009
410-121-0150	12-1-2008	Amend	1-1-2009
410-121-0157	12-1-2008	Amend	1-1-2009
410-121-0185	1-1-2009	Amend	1-1-2009
410-121-0200	12-1-2008	Amend	1-1-2009
410-121-0300	1-1-2009	Amend	1-1-2009
410-121-0320	12-1-2008	Amend	1-1-2009
410-121-0625	1-1-2009	Amend	1-1-2009
410-122-0040	12-1-2008	Amend	1-1-2009
410-122-0182	1-1-2009	Amend	1-1-2009
410-122-0200	1-1-2009	Amend	1-1-2009
410-122-0203	1-1-2009	Amend	1-1-2009
410-122-0204	1-1-2009	Amend	1-1-2009
410-122-0211	1-1-2009	Adopt	1-1-2009
410-122-0330	1-1-2009	Amend	1-1-2009
410-122-0340	1-1-2009	Amend	1-1-2009
410-122-0365	1-1-2009	Amend	1-1-2009
410-122-0560	1-1-2009	Amend	1-1-2009
410-122-0580	1-1-2009	Amend	1-1-2009
410-122-0630	1-1-2009	Amend	1-1-2009
410-122-0655	1-1-2009	Amend	1-1-2009
410-123-1085	1-1-2009	Amend	1-1-2009
410-123-1160	1-1-2009	Amend	1-1-2009
410-123-1220	1-1-2009	Amend	1-1-2009
410-123-1230	1-1-2009	Amend	1-1-2009
410-123-1240	1-1-2009	Amend	1-1-2009
410-123-1260	1-1-2009	Amend	1-1-2009
410-123-1490	1-1-2009	Amend	1-1-2009
410-123-1620	1-1-2009	Amend	1-1-2009
410-123-1670	1-1-2009	Amend	1-1-2009
410-125-0020	1-1-2009	Amend	1-1-2009
410-125-0041	1-1-2009	Amend	1-1-2009
410-125-0045	1-1-2009	Amend	1-1-2009
410-125-0080	1-1-2009	Amend	1-1-2009
410-125-0085	1-1-2009	Amend	1-1-2009
410-125-0125	12-1-2008	Amend	1-1-2009
410-125-0155	1-1-2009	Amend	1-1-2009
410-125-0181	1-1-2009	Amend	1-1-2009
410-125-0195	1-1-2009	Amend	1-1-2009
410-125-0210	12-1-2008	Amend	1-1-2009
410-125-0220	12-1-2008	Amend	1-1-2009
410-125-0360	12-1-2008	Amend	1-1-2009
410-125-0400	12-1-2008	Amend	1-1-2009
410-125-0600	12-1-2008	Amend	1-1-2009
410-125-0640	12-1-2008	Amend	1-1-2009
410-125-0720	12-1-2008	Amend	1-1-2009
410-125-1020	1-1-2009	Amend	1-1-2009
410-125-1070	12-1-2008	Amend	1-1-2009
410-127-0080	12-1-2008	Amend	1-1-2009
410-129-0080	12-1-2008	Amend	1-1-2009
410-130-0180	12-1-2008	Amend	1-1-2009
410-132-0100	12-1-2008	Amend	1-1-2009
410-136-0240	12-1-2008	Amend	1-1-2009
410-136-0260	12-1-2008	Amend	1-1-2009
410-136-0300	12-1-2008	Amend	1-1-2009
410-141-0000	12-1-2008	Amend	1-1-2009
410-141-0020	12-1-2008	Amend	1-1-2009
410-141-0120	1-1-2009	Amend	1-1-2009
410-141-0220	12-1-2008	Amend	1-1-2009
410-141-0266	1-1-2009	Amend	1-1-2009
410-141-0520	1-1-2009	Amend	1-1-2009
410-141-0520(T)	1-1-2009	Repeal	1-1-2009
410-146-0021	12-1-2008	Amend	1-1-2009
410-146-0040	1-1-2009	Amend	1-1-2009
410-146-0060	12-1-2008	Amend	1-1-2009
410-146-0080	12-1-2008	Amend	1-1-2009
410-146-0085	12-1-2008	Amend	1-1-2009
410-146-0086	12-1-2008	Amend	1-1-2009
410-146-0100	12-1-2008	Amend	1-1-2009
410-146-0120	12-1-2008	Amend	1-1-2009
410-146-0130	12-1-2008	Amend	1-1-2009
410-146-0140	12-1-2008	Amend	1-1-2009
410-146-0340	12-1-2008	Amend	1-1-2009
410-146-0380	12-1-2008	Amend	1-1-2009
410-146-0440	12-1-2008	Amend	1-1-2009
410-147-0020	12-1-2008	Amend	1-1-2009
410-147-0040	1-1-2009	Amend	1-1-2009
410-147-0060	12-1-2008	Amend	1-1-2009
410-147-0120	12-1-2008	Amend	1-1-2009
410-147-0125	12-1-2008	Amend	1-1-2009
410-147-0140	12-1-2008	Amend	1-1-2009
410-147-0160	12-1-2008	Amend	1-1-2009
410-147-0180	12-1-2008	Amend	1-1-2009
410-147-0200	12-1-2008	Amend	1-1-2009
410-147-0220	12-1-2008	Amend	1-1-2009
410-147-0320	12-1-2008	Amend	1-1-2009
410-147-0340	12-1-2008	Amend	1-1-2009

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
410-147-0360	12-1-2008	Amend	1-1-2009
410-147-0460	12-1-2008	Amend	1-1-2009
410-147-0480	12-1-2008	Amend	1-1-2009
410-147-0540	12-1-2008	Amend	1-1-2009
410-147-0560	12-1-2008	Amend	1-1-2009
410-147-0610	12-1-2008	Amend	1-1-2009
410-147-0620	12-1-2008	Amend	1-1-2009
423-001-0006	12-12-2008	Amend(T)	1-1-2009
423-010-0023	12-12-2008	Amend	1-1-2009
436-009-0005	1-1-2009	Amend	1-1-2009
436-009-0008	1-1-2009	Amend	1-1-2009
436-009-0018	1-1-2009	Adopt	1-1-2009
436-009-0020	1-1-2009	Amend	1-1-2009
436-009-0022	1-1-2009	Amend	1-1-2009
436-009-0030	1-1-2009	Amend	1-1-2009
436-009-0035	1-1-2009	Amend	1-1-2009
436-009-0040	1-1-2009	Amend	1-1-2009
436-009-0070	1-1-2009	Amend	1-1-2009
436-009-0080	1-1-2009	Amend	1-1-2009
436-009-0090	1-1-2009	Amend	1-1-2009
436-009-0095	1-1-2009	Adopt	1-1-2009
436-009-0100	1-1-2009	Amend	1-1-2009
436-015-0007	1-1-2009	Adopt	1-1-2009
436-015-0120	1-1-2009	Amend	1-1-2009
436-060-0005	1-1-2009	Amend	1-1-2009
436-060-0009	1-1-2009	Amend	1-1-2009
436-060-0010	1-1-2009	Amend	1-1-2009
436-060-0015	1-1-2009	Amend	1-1-2009
436-060-0017	1-1-2009	Amend	1-1-2009
436-060-0018	1-1-2009	Amend	1-1-2009
436-060-0020	1-1-2009	Amend	1-1-2009
436-060-0025	1-1-2009	Amend	1-1-2009
436-060-0035	1-1-2009	Amend	1-1-2009
436-060-0060	1-1-2009	Amend	1-1-2009
436-060-0105	1-1-2009	Amend	1-1-2009
436-060-0135	1-1-2009	Amend	1-1-2009
436-060-0137	1-1-2009	Amend	1-1-2009
436-060-0147	1-1-2009	Amend	1-1-2009
436-060-0150	1-1-2009	Amend	1-1-2009
436-060-0153	1-1-2009	Adopt	1-1-2009
436-060-0155	1-1-2009	Amend	1-1-2009
436-060-0500	1-1-2009	Amend	1-1-2009
441-865-0025	12-10-2008	Adopt	1-1-2009
459-005-0525	11-26-2008	Amend	1-1-2009
459-005-0535	11-26-2008	Amend	1-1-2009
459-005-0545	11-26-2008	Amend	1-1-2009
459-010-0010	11-26-2008	Amend	1-1-2009
459-013-0260	11-26-2008	Amend	1-1-2009
459-050-0037	11-26-2008	Amend	1-1-2009
459-075-0175	11-26-2008	Adopt	1-1-2009
471-010-0025	12-1-2008	Adopt	1-1-2009
471-010-0045	12-1-2008	Adopt	1-1-2009
471-031-0072	12-1-2008	Amend	1-1-2009
471-031-0151	12-1-2008	Amend	1-1-2009
471-031-0190	12-1-2008	Adopt	1-1-2009
471-031-0195	12-1-2008	Adopt	1-1-2009
471-031-0200	12-1-2008	Adopt	1-1-2009
471-031-0205	12-1-2008	Adopt	1-1-2009
471-031-0210	12-1-2008	Adopt	1-1-2009
471-031-0215	12-1-2008	Adopt	1-1-2009
471-031-0220	12-1-2008	Adopt	1-1-2009
471-031-0225	12-1-2008	Adopt	1-1-2009
471-031-0230	12-1-2008	Adopt	1-1-2009
635-004-0014	11-21-2008	Amend	1-1-2009
635-004-0019	12-4-2008	Amend(T)	1-1-2009
635-004-0019(T)	12-4-2008	Suspend	1-1-2009
635-004-0020	11-21-2008	Amend	1-1-2009
635-004-0035	11-21-2008	Amend	1-1-2009
635-004-0048	11-21-2008	Amend	1-1-2009
635-004-0050	11-21-2008	Amend	1-1-2009
635-004-0060	11-21-2008	Amend	1-1-2009
635-004-0135	11-21-2008	Amend	1-1-2009
635-004-0170	11-21-2008	Amend	1-1-2009
635-005-0001	11-21-2008	Amend	1-1-2009
635-005-0005	11-21-2008	Amend	1-1-2009
635-005-0016	11-21-2008	Amend	1-1-2009
635-005-0045	11-21-2008	Amend	1-1-2009
635-005-0047	11-21-2008	Amend	1-1-2009
635-005-0048	11-21-2008	Amend	1-1-2009
635-005-0055	11-21-2008	Amend	1-1-2009
635-005-0055	12-1-2008	Amend(T)	1-1-2009
635-005-0065	11-21-2008	Amend	1-1-2009
635-005-0084	11-21-2008	Amend	1-1-2009
635-005-0090	11-21-2008	Amend	1-1-2009
635-005-0095	11-21-2008	Amend	1-1-2009
635-005-0100	11-21-2008	Amend	1-1-2009
635-005-0135	11-21-2008	Amend	1-1-2009
635-005-0140	11-21-2008	Amend	1-1-2009
635-005-0145	11-21-2008	Amend	1-1-2009
635-005-0180	11-21-2008	Amend	1-1-2009
635-006-0001	11-21-2008	Amend	1-1-2009
635-006-0132	11-21-2008	Amend	1-1-2009
635-006-0133	11-21-2008	Amend	1-1-2009
635-006-0145	11-21-2008	Amend	1-1-2009
635-006-0150	11-21-2008	Amend	1-1-2009
635-006-0165	11-21-2008	Amend	1-1-2009
635-006-0200	11-21-2008	Amend	1-1-2009
635-006-0205	11-21-2008	Amend	1-1-2009
635-006-0207	11-21-2008	Amend	1-1-2009
635-006-0210	11-21-2008	Amend	1-1-2009
635-006-0211	11-21-2008	Amend	1-1-2009
635-006-0213	11-21-2008	Amend	1-1-2009
635-006-0215	11-21-2008	Amend	1-1-2009
635-006-0225	11-21-2008	Amend	1-1-2009
635-006-0230	11-21-2008	Amend	1-1-2009
635-006-0235	11-21-2008	Amend	1-1-2009
635-006-0412	11-21-2008	Amend	1-1-2009
635-006-0425	11-21-2008	Amend	1-1-2009
635-006-0810	11-21-2008	Amend	1-1-2009
635-006-1035	11-21-2008	Amend	1-1-2009
635-006-1075	11-21-2008	Amend	1-1-2009
635-010-0170	12-9-2008	Amend(T)	1-1-2009
635-041-0005	11-21-2008	Amend	1-1-2009
635-041-0010	11-21-2008	Amend	1-1-2009
635-041-0030	11-21-2008	Amend	1-1-2009
635-041-0040	11-21-2008	Amend	1-1-2009

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
635-041-0045	11-21-2008	Amend	1-1-2009
635-041-0060	11-21-2008	Amend	1-1-2009
635-041-0061	11-21-2008	Amend	1-1-2009
635-041-0063	11-21-2008	Amend	1-1-2009
635-041-0065	11-21-2008	Amend	1-1-2009
635-041-0510	11-21-2008	Amend	1-1-2009
635-041-0520	11-21-2008	Amend	1-1-2009
635-041-0600	11-21-2008	Amend	1-1-2009
635-042-0001	11-21-2008	Amend	1-1-2009
635-042-0007	11-21-2008	Amend	1-1-2009
635-042-0022	11-21-2008	Amend	1-1-2009
635-042-0110	11-21-2008	Amend	1-1-2009
635-049-0205	11-24-2008	Amend	1-1-2009
635-195-0000	11-24-2008	Adopt	1-1-2009
635-195-0010	11-24-2008	Adopt	1-1-2009
734-071-0010	12-15-2008	Amend	1-1-2009
734-073-0110	12-15-2008	Amend	1-1-2009
734-073-0120	12-15-2008	Repeal	1-1-2009
735-010-0130	1-1-2009	Amend	1-1-2009
735-010-0130(T)	1-1-2009	Repeal	1-1-2009
735-062-0005	1-1-2009	Amend	1-1-2009
735-062-0014	1-1-2009	Adopt	1-1-2009
735-062-0014(T)	1-1-2009	Repeal	1-1-2009
735-062-0015	1-1-2009	Amend	1-1-2009
735-062-0015(T)	1-1-2009	Repeal	1-1-2009
735-062-0020	1-1-2009	Amend	1-1-2009
735-062-0020(T)	1-1-2009	Repeal	1-1-2009
735-064-0110	12-15-2008	Amend	1-1-2009
736-004-0062	12-15-2008	Amend	1-1-2009
736-010-0040	12-15-2008	Amend	1-1-2009
736-010-0055	12-15-2008	Amend	1-1-2009
736-146-0010	12-15-2008	Amend	1-1-2009
736-146-0012	12-15-2008	Amend	1-1-2009
736-146-0015	12-15-2008	Amend	1-1-2009
736-146-0020	12-15-2008	Amend	1-1-2009
736-146-0025	12-15-2008	Repeal	1-1-2009
736-146-0030	12-15-2008	Repeal	1-1-2009
736-146-0040	12-15-2008	Repeal	1-1-2009
736-146-0050	12-15-2008	Amend	1-1-2009
736-146-0060	12-15-2008	Amend	1-1-2009
736-146-0070	12-15-2008	Amend	1-1-2009
736-146-0080	12-15-2008	Amend	1-1-2009
736-146-0090	12-15-2008	Amend	1-1-2009
736-146-0100	12-15-2008	Amend	1-1-2009
736-146-0110	12-15-2008	Amend	1-1-2009
736-146-0120	12-15-2008	Amend	1-1-2009
736-146-0130	12-15-2008	Amend	1-1-2009
736-146-0140	12-15-2008	Amend	1-1-2009
736-147-0010	12-15-2008	Amend	1-1-2009
736-147-0020	12-15-2008	Repeal	1-1-2009
736-147-0030	12-15-2008	Amend	1-1-2009
736-147-0040	12-15-2008	Adopt	1-1-2009
736-147-0050	12-15-2008	Amend	1-1-2009
736-147-0060	12-15-2008	Amend	1-1-2009
736-147-0070	12-15-2008	Adopt	1-1-2009
736-148-0010	12-15-2008	Amend	1-1-2009
736-148-0020	12-15-2008	Amend	1-1-2009
736-149-0010	12-15-2008	Amend	1-1-2009
740-015-0020	12-15-2008	Amend	1-1-2009
740-015-0040	12-15-2008	Amend	1-1-2009
812-002-0060	11-20-2008	Amend	1-1-2009
812-002-0420	11-20-2008	Amend	1-1-2009
812-003-0450	11-20-2008	Repeal	1-1-2009
812-005-0280	11-20-2008	Amend	1-1-2009
812-005-0800	11-20-2008	Amend	1-1-2009
812-006-0100	11-20-2008	Amend	1-1-2009
812-006-0200	11-20-2008	Amend	1-1-2009
812-020-0050	11-20-2008	Adopt	1-1-2009
812-020-0055	11-20-2008	Adopt	1-1-2009
812-020-0060	11-20-2008	Adopt	1-1-2009
812-020-0062	11-20-2008	Adopt	1-1-2009
812-020-0065	11-20-2008	Adopt	1-1-2009
812-020-0070	11-20-2008	Adopt	1-1-2009
812-020-0072	11-20-2008	Adopt	1-1-2009
812-020-0080	11-20-2008	Adopt	1-1-2009
812-020-0082	11-20-2008	Adopt	1-1-2009
812-020-0085	11-20-2008	Adopt	1-1-2009
812-020-0087	11-20-2008	Adopt	1-1-2009
812-020-0090	11-20-2008	Adopt	1-1-2009
817-030-0005	12-1-2008	Amend(T)	1-1-2009
817-030-0015	12-1-2008	Amend(T)	1-1-2009
817-030-0020	12-1-2008	Amend(T)	1-1-2009
817-030-0040	12-1-2008	Amend(T)	1-1-2009
817-030-0045	12-1-2008	Amend(T)	1-1-2009
817-030-0065	12-1-2008	Amend(T)	1-1-2009
817-030-0100	12-1-2008	Suspend	1-1-2009
817-035-0030	12-1-2008	Amend(T)	1-1-2009
820-010-0215	12-12-2008	Amend	1-1-2009
836-043-0005	1-1-2009	Amend	1-1-2009
836-043-0009	1-1-2009	Amend	1-1-2009
836-043-0017	1-1-2009	Amend	1-1-2009
836-043-0021	1-1-2009	Amend	1-1-2009
836-043-0024	1-1-2009	Amend	1-1-2009
836-043-0028	1-1-2009	Amend	1-1-2009
836-043-0032	1-1-2009	Amend	1-1-2009
836-043-0034	1-1-2009	Adopt	1-1-2009
836-043-0036	1-1-2009	Repeal	1-1-2009
836-043-0037	1-1-2009	Repeal	1-1-2009
836-043-0041	1-1-2009	Amend	1-1-2009
836-043-0044	1-1-2009	Amend	1-1-2009
836-043-0046	1-1-2009	Amend	1-1-2009
836-043-0048	1-1-2009	Amend	1-1-2009
836-043-0050	1-1-2009	Amend	1-1-2009
836-043-0053	1-1-2009	Amend	1-1-2009
836-043-0060	1-1-2009	Amend	1-1-2009
836-043-0062	1-1-2009	Amend	1-1-2009
836-043-0064	1-1-2009	Amend	1-1-2009
836-043-0066	1-1-2009	Amend	1-1-2009
836-043-0068	1-1-2009	Amend	1-1-2009
836-043-0070	1-1-2009	Repeal	1-1-2009
836-043-0071	1-1-2009	Adopt	1-1-2009
836-043-0076	1-1-2009	Amend	1-1-2009
836-043-0079	1-1-2009	Amend	1-1-2009
836-043-0082	1-1-2009	Amend	1-1-2009
836-043-0086	1-1-2009	Repeal	1-1-2009
836-043-0087	1-1-2009	Adopt	1-1-2009

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
836-043-0089	1-1-2009	Amend	1-1-2009
836-051-0106	12-9-2008	Amend	1-1-2009
836-051-0750	12-9-2008	Adopt	1-1-2009
836-051-0755	12-9-2008	Adopt	1-1-2009
836-051-0760	12-9-2008	Adopt	1-1-2009
836-051-0765	12-9-2008	Adopt	1-1-2009
836-051-0770	12-9-2008	Adopt	1-1-2009
836-051-0775	12-9-2008	Adopt	1-1-2009
836-072-0001	12-10-2008	Adopt	1-1-2009
836-072-0005	12-10-2008	Adopt	1-1-2009
836-072-0010	12-10-2008	Adopt	1-1-2009
836-072-0015	12-10-2008	Adopt	1-1-2009
836-072-0020	12-10-2008	Adopt	1-1-2009
836-072-0025	12-10-2008	Adopt	1-1-2009
836-072-0030	12-10-2008	Adopt	1-1-2009
836-072-0035	12-10-2008	Adopt	1-1-2009
836-072-0040	12-10-2008	Adopt	1-1-2009
836-072-0045	12-10-2008	Adopt	1-1-2009
839-003-0005	12-5-2008	Amend	1-1-2009
839-003-0010	12-5-2008	Amend	1-1-2009
839-003-0020	12-5-2008	Amend	1-1-2009
839-003-0025	12-5-2008	Amend	1-1-2009
839-003-0040	12-5-2008	Amend	1-1-2009
839-003-0045	12-5-2008	Amend	1-1-2009
839-003-0050	12-5-2008	Amend	1-1-2009
839-003-0055	12-5-2008	Amend	1-1-2009
839-003-0060	12-5-2008	Amend	1-1-2009
839-003-0065	12-5-2008	Amend	1-1-2009
839-003-0070	12-5-2008	Amend	1-1-2009
839-003-0080	12-5-2008	Amend	1-1-2009
839-003-0085	12-5-2008	Amend	1-1-2009
839-003-0090	12-5-2008	Amend	1-1-2009
839-003-0095	12-5-2008	Amend	1-1-2009
839-003-0100	12-5-2008	Amend	1-1-2009
839-003-0200	12-5-2008	Amend	1-1-2009
839-003-0205	12-5-2008	Amend	1-1-2009
839-003-0210	12-5-2008	Amend	1-1-2009
839-003-0215	12-5-2008	Amend	1-1-2009
839-003-0220	12-5-2008	Amend	1-1-2009
839-003-0225	12-5-2008	Amend	1-1-2009
839-003-0230	12-5-2008	Amend	1-1-2009
839-003-0235	12-5-2008	Amend	1-1-2009
839-003-0240	12-5-2008	Amend	1-1-2009
839-003-0245	12-5-2008	Amend	1-1-2009
839-005-0000	12-5-2008	Amend	1-1-2009
839-005-0003	12-5-2008	Amend	1-1-2009
839-005-0010	12-5-2008	Amend	1-1-2009
839-005-0016	12-5-2008	Amend	1-1-2009
839-005-0026	12-5-2008	Amend	1-1-2009
839-005-0195	12-5-2008	Amend	1-1-2009
839-005-0200	12-5-2008	Amend	1-1-2009
839-005-0205	12-5-2008	Amend	1-1-2009
839-005-0220	12-5-2008	Amend	1-1-2009
839-025-0700	12-1-2008	Amend	1-1-2009
850-060-0225	12-8-2008	Amend	1-1-2009
850-060-0226	12-8-2008	Amend	1-1-2009
851-050-0138	11-26-2008	Amend	1-1-2009
851-056-0006	11-26-2008	Amend	1-1-2009
851-056-0022	11-26-2008	Amend	1-1-2009
851-062-0020	11-26-2008	Amend	1-1-2009
863-014-0000	1-1-2009	Adopt	1-1-2009
863-014-0003	1-1-2009	Adopt	1-1-2009
863-014-0038	1-1-2009	Adopt	1-1-2009
863-014-0042	1-1-2009	Adopt	1-1-2009
863-015-0000	1-1-2009	Adopt	1-1-2009
863-015-0005	1-1-2009	Am. & Ren.	1-1-2009
863-015-0010	1-1-2009	Am. & Ren.	1-1-2009
863-015-0015	1-1-2009	Am. & Ren.	1-1-2009
863-015-0020	1-1-2009	Am. & Ren.	1-1-2009
863-015-0025	1-1-2009	Repeal	1-1-2009
863-015-0030	1-1-2009	Am. & Ren.	1-1-2009
863-015-0035	1-1-2009	Am. & Ren.	1-1-2009
863-015-0040	1-1-2009	Am. & Ren.	1-1-2009
863-015-0045	1-1-2009	Am. & Ren.	1-1-2009
863-015-0050	1-1-2009	Am. & Ren.	1-1-2009
863-015-0055	1-1-2009	Am. & Ren.	1-1-2009
863-015-0060	1-1-2009	Am. & Ren.	1-1-2009
863-015-0061	1-1-2009	Am. & Ren.	1-1-2009
863-015-0062	1-1-2009	Am. & Ren.	1-1-2009
863-015-0063	1-1-2009	Am. & Ren.	1-1-2009
863-015-0065	1-1-2009	Am. & Ren.	1-1-2009
863-015-0070	1-1-2009	Am. & Ren.	1-1-2009
863-015-0075	1-1-2009	Am. & Ren.	1-1-2009
863-015-0076	1-1-2009	Am. & Ren.	1-1-2009
863-015-0080	1-1-2009	Am. & Ren.	1-1-2009
863-015-0085	1-1-2009	Am. & Ren.	1-1-2009
863-015-0095	1-1-2009	Am. & Ren.	1-1-2009
863-015-0100	1-1-2009	Am. & Ren.	1-1-2009
863-015-0120	1-1-2009	Am. & Ren.	1-1-2009
863-015-0130	1-1-2009	Amend	1-1-2009
863-015-0135	1-1-2009	Amend	1-1-2009
863-015-0140	1-1-2009	Amend	1-1-2009
863-015-0145	1-1-2009	Amend	1-1-2009
863-015-0150	1-1-2009	Amend	1-1-2009
863-015-0155	1-1-2009	Amend	1-1-2009
863-015-0160	1-1-2009	Am. & Ren.	1-1-2009
863-015-0165	1-1-2009	Repeal	1-1-2009
863-015-0175	1-1-2009	Amend	1-1-2009
863-015-0180	1-1-2009	Repeal	1-1-2009
863-015-0185	1-1-2009	Repeal	1-1-2009
863-015-0186	1-1-2009	Amend	1-1-2009
863-015-0188	1-1-2009	Adopt	1-1-2009
863-015-0190	1-1-2009	Amend	1-1-2009
863-015-0195	1-1-2009	Repeal	1-1-2009
863-015-0200	1-1-2009	Amend	1-1-2009
863-015-0205	1-1-2009	Amend	1-1-2009
863-015-0210	1-1-2009	Amend	1-1-2009
863-015-0215	1-1-2009	Amend	1-1-2009
863-015-0220	1-1-2009	Repeal	1-1-2009
863-015-0225	1-1-2009	Am. & Ren.	1-1-2009
863-015-0230	1-1-2009	Am. & Ren.	1-1-2009
863-015-0250	1-1-2009	Amend	1-1-2009
863-015-0255	1-1-2009	Amend	1-1-2009
863-015-0260	1-1-2009	Amend	1-1-2009
863-015-0265	1-1-2009	Amend	1-1-2009
863-015-0275	1-1-2009	Amend	1-1-2009

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
863-024-0000	1-1-2009	Adopt	1-1-2009
863-024-0003	1-1-2009	Adopt	1-1-2009
863-024-0005	1-1-2009	Adopt	1-1-2009
863-024-0010	1-1-2009	Adopt	1-1-2009
863-024-0015	1-1-2009	Adopt	1-1-2009
863-024-0020	1-1-2009	Adopt	1-1-2009
863-024-0030	1-1-2009	Adopt	1-1-2009
863-024-0050	1-1-2009	Adopt	1-1-2009
863-024-0055	1-1-2009	Adopt	1-1-2009
863-024-0060	1-1-2009	Adopt	1-1-2009
863-024-0061	1-1-2009	Adopt	1-1-2009
863-024-0062	1-1-2009	Adopt	1-1-2009
863-024-0063	1-1-2009	Adopt	1-1-2009
863-024-0065	1-1-2009	Adopt	1-1-2009
863-024-0070	1-1-2009	Adopt	1-1-2009
863-024-0075	1-1-2009	Adopt	1-1-2009
863-024-0076	1-1-2009	Adopt	1-1-2009
863-024-0085	1-1-2009	Adopt	1-1-2009
863-024-0095	1-1-2009	Adopt	1-1-2009
863-024-0100	1-1-2009	Adopt	1-1-2009
863-025-0005	1-1-2009	Amend	1-1-2009
863-025-0010	1-1-2009	Amend	1-1-2009
863-025-0015	1-1-2009	Amend	1-1-2009
863-025-0020	1-1-2009	Amend	1-1-2009
863-025-0025	1-1-2009	Amend	1-1-2009
863-025-0030	1-1-2009	Amend	1-1-2009
863-025-0035	1-1-2009	Amend	1-1-2009
863-025-0040	1-1-2009	Amend	1-1-2009
863-025-0045	1-1-2009	Amend	1-1-2009
863-025-0050	1-1-2009	Amend	1-1-2009
863-025-0055	1-1-2009	Amend	1-1-2009
863-025-0060	1-1-2009	Amend	1-1-2009
863-025-0065	1-1-2009	Amend	1-1-2009
863-025-0070	1-1-2009	Amend	1-1-2009
863-025-0080	1-1-2009	Amend	1-1-2009
863-027-0000	1-1-2009	Adopt	1-1-2009
863-027-0005	1-1-2009	Adopt	1-1-2009
863-050-0000	1-1-2009	Amend	1-1-2009
863-050-0015	1-1-2009	Amend	1-1-2009
863-050-0020	1-1-2009	Amend	1-1-2009
863-050-0025	1-1-2009	Amend	1-1-2009
863-050-0030	1-1-2009	Amend	1-1-2009
863-050-0033	1-1-2009	Amend	1-1-2009
863-050-0035	1-1-2009	Amend	1-1-2009
863-050-0040	1-1-2009	Repeal	1-1-2009
863-050-0050	1-1-2009	Amend	1-1-2009
863-050-0052	1-1-2009	Adopt	1-1-2009
863-050-0055	1-1-2009	Amend	1-1-2009
863-050-0060	1-1-2009	Amend	1-1-2009
863-050-0065	1-1-2009	Amend	1-1-2009
863-050-0066	1-1-2009	Amend	1-1-2009
863-050-0100	1-1-2009	Amend	1-1-2009
863-050-0105	1-1-2009	Amend	1-1-2009
863-050-0115	1-1-2009	Amend	1-1-2009
863-050-0150	1-1-2009	Amend	1-1-2009
863-050-0151	1-1-2009	Repeal	1-1-2009
863-050-0205	1-1-2009	Repeal	1-1-2009
863-050-0210	1-1-2009	Repeal	1-1-2009
863-050-0215	1-1-2009	Repeal	1-1-2009
863-050-0220	1-1-2009	Repeal	1-1-2009
863-050-0225	1-1-2009	Repeal	1-1-2009
863-050-0230	1-1-2009	Repeal	1-1-2009
863-050-0235	1-1-2009	Repeal	1-1-2009
863-050-0240	1-1-2009	Amend	1-1-2009
875-010-0090	12-15-2008	Amend	1-1-2009
875-020-0005	12-15-2008	Amend	1-1-2009
875-030-0010	12-15-2008	Amend	1-1-2009
875-030-0050	12-15-2008	Amend	1-1-2009
918-050-0000	1-1-2009	Amend	1-1-2009
918-050-0010	1-1-2009	Amend	1-1-2009
918-050-0020	1-1-2009	Amend	1-1-2009
918-050-0030	1-1-2009	Amend	1-1-2009
918-050-0100	1-1-2009	Amend	1-1-2009
918-050-0110	1-1-2009	Amend	1-1-2009
918-050-0120	1-1-2009	Amend	1-1-2009
918-050-0130	1-1-2009	Amend	1-1-2009
918-050-0140	1-1-2009	Amend	1-1-2009
918-050-0150	1-1-2009	Amend	1-1-2009
918-050-0160	1-1-2009	Amend	1-1-2009
918-050-0170	1-1-2009	Amend	1-1-2009