OREGON BULLETIN

Supplements the 2004 *Oregon Administrative Rules Compilation*

Volume 43, No. 4
April 1, 2004

For February 17, 2004–March 15, 2004

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 and Opinions of the Attorney General.

Background on Oregon Administrative Rules

The *Oregon Attorney General's Administrative Law Manual* defines "rule" to include "directives, standards, regulations or statements of general applicability that implement, interpret or prescribe law or policy or describe the agency's procedure or practice requirements." ORS 183.310(8) Agencies may adopt, amend, repeal or renumber rules, permanently or temporarily (180 days), using the procedures outlined in the *Oregon Attorney General's Administrative Law Manual*. The Administrative Rules Unit, Archives Division, Secretary of State assists agencies with the notification, filing and publication requirements of the administrative rules 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 the changes to individual rules, and organize the rule filing forms for permanent retention, the Administrative Rules Unit has developed a "history" for each rule which is located at the end of rule text. An Administrative Rule "history" outlines the statutory authority, statutes being implemented and dates of each authorized modification to the rule text. Changes are listed in chronological order and identify the agency, filing number, year, filing date and effective date in an abbreviated format. For example: "OSA 4-1993, f. & cert. ef. 11-10-93; Renumbered from 164-001-0005" documents a rule change made by the Oregon State Archives (OSA). The history notes that 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 rule was renumbered by this rule change and was formerly known as rule 164-001-0005. 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 annual, bound *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 Website 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, Oregon State Archives, 800 Summer Street NE, Salem, OR 97310, (503) 373-0701 - ext. 240, Julie. A.Yamaka@state.or.us

2003–2004 Oregon Bulletin Publication Schedule

The Administrative Rule 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 to set the time and place for a hearing in the Notice of Proposed Rulemaking, and submit their filings early in the month to meet the following publication deadlines.

Submission Deadline	Publishing Date
December 15, 2003	January 1, 2004
January 15, 2004	February 1, 2004
February 13, 2004	March 1, 2004
March 15, 2004	April 1, 2004
April 15, 2004	May 1, 2004
May 14, 2004	June 1, 2004
June 15, 2004	July 1, 2004
July 15, 2004	August 1, 2004
August 13, 2004	September 1, 2004
September 15, 2004	October 1, 2004
October 15, 2004	November 1, 2004
November 15, 2004	December 1, 2004

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 910-1997, 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 915-1997. 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 ARC 910-1997 and ARC 915-1997 are available from the Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310.

Publication Authority

The *Oregon Bulletin* is published pursuant to ORS 183.360(3). Copies of the complete text of permanent and temporary rules may be obtained from the adopting agency or from the Secretary of State, Archives Division, 800 Summer Street, Salem, Oregon, 97310; (503) 373-0701.

TABLE OF CONTENTS

EXECUTIVE ORDER NO. 04-01

DETERMINATION OF A STATE OF DROUGHT EMERGENCY IN KLAMATH COUNTY DUE TO DROUGHT AND LOW WATER CONDITIONS.

Pursuant to ORS 401.055, I find that ongoing drought and low water conditions and weather patterns have the potential to cause an imminent natural and economic disaster in Klamath County (the "Affected County"). Projected weather patterns are not expected to significantly alleviate the current conditions; drought conditions are continuing. These conditions are expected to have profound consequences on the Affected County's agricultural, livestock, and natural resources and are likely to result in stark economic impacts.

Current conditions are being addressed by state agencies including the Department of Agriculture, the Department of Water Resources, and Oregon Emergency Management.

A timely response to this situation being vital to the well being and economic security of the citizens and businesses of the Affected County, I am therefore declaring a "state of drought emergency" in the Affected County and directing the following activities;

IT IS HEREBY ORDERED AND DIRECTED:

I. The Oregon Department of Agriculture is directed to coordinate and provide assistance in seeking federal resources available to mitigate conditions and effect agricultural recovery in the Affected County.

II. The Department of Water Resources is directed to coordinate and provide assistance and regulation for the Affected County as it determines is necessary in accordance with ORS 536.700 to 536.780.

III. The Office of Emergency Management is directed to coordinate and assist as needed with assessment and mitigation activities to address current and projected conditions in the Affected County.

IV. All other departments are directed to coordinate with the above agencies and to provide appropriate state resources as determined essential to assist affected political subdivisions in the Affected County.

V. This Executive Order expires on December 31, 2004

Done at Salem, Oregon this 20th day of February, 2004

/s/ Theodore R. Kulongoski
Theodore R. Kulongoski
GOVERNOR

ATTEST

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

DEQ SEEKS COMMENT ON THE PROPOSED NO FURTHER ACTION FOR THE LAVA LANES II SITE

COMMENTS INVITED: through April 30th, 2004
PROJECT LOCATION: 2978 Crater Lake Highway, Medford
PROPOSAL: The Oregon Department of Environmental Quality is proposing to issue a No Further Action determination for the investigation and cleanup of petroleum contaminated soil at the Lava Lanes II site.
HIGHLIGHTS: The Lava Lanes II site was a former equipment rental and repair shop that operated between 1990 and 1999. At the present time the site is vacant and has had some recent improvements as a result of commercial development in the area. Environmental investigations completed at the site in March 1999 identified releases of petroleum hydrocarbons as a result of the former operations associated with petroleum use and disposal. Between May 1999 and April 2000, additional investigations were completed at Lava Lanes II and approximately 1000 cubic yards of petroleum contaminated soil were excavated. Confirmation soil samples collected confirm removal actions have been successful in eliminating threats to human health and the environment. The soil was transported off-site for treatment and disposal. DEQ has reviewed the details of the investigation and cleanup, and is proposing that given current site conditions and future use of the property, no additional investigation or removals are required at the site unless new or previously undisclosed information becomes available justifying further investigation.
HOW TO COMMENT: Information about the project is available for review at the DEQ Medford office, 201 West Main Street, Suite 2-D, Medford, OR 97501. To schedule an appointment, call the Medford Office at (541) 776-6010. Please send written comments to Nancy Gramlich in the DEQ Salem Office, 750 Front Street, Suite 120, Salem, OR 97301 or by email at gramlich.nancy@deq.state.or.us. For more information, call Nancy Gramlich at 503-378-8240.
FINAL DECISION: DEQ will consider all public comments received before making a final decision regarding the "No Further Action" determination for the site.

PROPOSED APPROVAL OF SOIL CLEANUP AT THE BOISE CASCADE VENEER MILL SITE ST. HELENS, OREGON

COMMENTS DUE: May 3, 2004
PROJECT LOCATION: South First Street, St. Helens, Oregon
PROPOSAL: The Oregon Department of Environmental Quality (DEQ) proposes approval of the cleanup of petroleum-contaminated soil at the site.
HIGHLIGHTS: The Boise Cascade Veneer Mill site covers about 22 acres on the west bank of the Columbia River in downtown St. Helens, Oregon. The current operation produces green veneer from softwood logs, which is shipped off-site for fabrication of plywood and other panel products. Both a sawmill and planing mill operated at the site for about 50 years.

Boise Cascade conducted two independent soil cleanups at the site. In 1995, about 450 cubic yards of petroleum contaminated soil was removed from the former maintenance shop area, and in 1997 about 10 yards of soil was removed from the lathe mill area. Relatively high concentrations of petroleum hydrocarbons as heavy oil over 25,000 milligrams per kilogram (mg/kg) were detected in the lathe mill but could not be removed due to structural integrity concerns.

DEQ evaluated the site in 2002 and concluded the site was a high environmental priority based on the residual contamination and potential impacts to the Columbia River. Results of additional investigation in 2003 showed non-detect to low levels of residual contamination in soil at the maintenance shop and a former UST area, and that relatively high levels of petroleum in the lathe mill area had not adversely impacted groundwater or migrated to the river. Groundwater and deep soil were found to be impacted by heavy oil contamination near the northeast corner of the mill. Due to its limited nature, depth, and relatively low concentrations of polycyclic aromatic hydrocarbons (PAHs), DEQ determined that the residual heavy oil contamination in groundwater does not present a risk to the Columbia River. Because contamination remaining in place beneath the lathe mill area may pose an unacceptable risk if exposed or otherwise disturbed, DEQ has determined that as a condition of the no further action (NFA) determination, the contamination should be fully evaluated if exposed or otherwise uncovered in the future.
HOW TO COMMENT: The staff memorandum and other files will be available for public review beginning Thursday, April 1, 2004. To schedule an appointment to review the site files call Gerald Gamolo at (503) 229-6729. The DEQ project manager is Mark Pugh (503) 229-5587. Written comments should be sent to the project manager at the Department of Environmental Quality, Northwest Region, 2020 SW 4th Ave., Suite 400, Portland, OR 97201 by Monday, May 3, 2004. A public meeting will be held to receive verbal comments if requested by 10 or more people or by a group with a membership of 10 or more.
THE NEXT STEP: DEQ will consider all public comments and DEQ's Northwest Region Cleanup Manager will make the final decision after consideration of these comments.

PROPOSED APPROVAL OF CLEANUP AT THE FRONT AVENUE MP SITE

COMMENTS DUE: April 30, 2004
PROJECT LOCATION: 3445 NW Front Avenue, Portland
PROPOSAL: As required by ORS 465.320, the Department of Environmental Quality (DEQ) invites public comment on the cleanup action completed at the Front Avenue MP site. Soil removal was completed in 2003 and 2004 (27 cubic yards) to address metals and petroleum contamination. The work was completed in 2003/4 under DEQ's Independent Cleanup Pathway. Following the removal, DEQ determined that remaining soil and groundwater contamination at the site does not exceed risk-based concentrations under Oregon Administrative Rule (OAR) 340-122-0205 through 340-122-0360. Therefore, DEQ proposes to find that no further action is required for the site.
HIGHLIGHTS: The 1.44-acre site is located in an area of heavy industrial development in northwest Portland, and has been used for the past 60-70 years as a base for trucking, cargo storage and distribution, crane rigging, and trenching operations. Soil testing identified petroleum and arsenic contamination in near-surface soil. In 2003, 17 cubic yards of petroleum and arsenic-contaminated soil was removed from two areas in the southern portion of the site where heavy surface staining was observed. In 2004, approximately 10 cubic yards of soil was removed from below the site building. Excavated soil was transferred to Hillsboro Landfill for disposal. Remaining soil contaminants are below U.S. Environmental Protection Agency or DEQ risk-based concentrations based on industrial exposure. Groundwater has not been significantly impacted. A closeout memorandum presenting DEQ's recommendation will be available for public review beginning April 1, 2004.
HOW TO COMMENT: To schedule an appointment at DEQ, please contact the file specialist at (503) 229-6729. The DEQ project manager is Dan Hafley (503-229-5417). Written comments should be sent to the project manager at the Department of Environmental Quality, Northwest Region, 2020 SW 4th Avenue, Suite 400, Portland, OR 97201 by April 30, 2004. A public meeting will be held to receive verbal comments if requested by 10 or more people, or by a group with a membership of 10 or more.
THE NEXT STEP: DEQ will consider all comments received and Lower Willamette Section Manager (or designate) will make a final decision after consideration of these comments.

PROPOSED APPROVAL OF CLEANUP AT UPRR ST JOHN'S TANK FARM

COMMENTS DUE: April 30, 2004
PROJECT LOCATION: 11040 N Lombard Street (Port of Portland Terminal 4), Portland, Oregon
PROPOSAL: As required by ORS 465.320 the Department of Environmental Quality (DEQ) invites public comment on the no further action recommendation for the Union Pacific Railroad (UPRR) St. John's Tank Farm site.
HIGHLIGHTS: Bulk petroleum storage and railcar tank loading occurred at the UPRR facility as early as 1924. Bunker C fuel, and later diesel, were the main products handled at the facility with two 55,000-barrel above ground storage tanks and fuel-loading equipment at the railroad tracks. Pipelines ran from the tanks approximately 860 feet east to Terminal 4 Slip 3 where fuel was transferred from ships at former Berth 412. Fuel-loading operations ceased in 1983 and the tanks and 300 cubic yards of petroleum-contaminated soil were removed in 1986. In March 2000, UPRR joined the Voluntary Cleanup Program for DEQ oversight of additional investigation and cleanup at the facility. Following subsequent phases of soil sampling, UPRR conducted soil removal actions in 2001, 2002, and 2003. A total of 187 cubic yards of petroleum-contaminated soil and 64 cubic yards of lead contaminated soil were excavated from the site. Confirmation soil sampling and a site-specific risk evaluation has demonstrated that residual contamination is below levels of concern for potential ecological receptors (primarily birds) and for site workers based on the current intermittent use of the site for maintenance and railyard activities. DEQ is proposing a no further action (NFA) determination for the site with an easement on the property to restrict future site use, ensuring that potential exposure to petroleum and lead remains below levels of concern.
HOW TO COMMENT: The project file is available for public review. To schedule an appointment, contact Gerald Gamolo at 503-229-6729. The DEQ contact for this project is Tom Roick, 503-229-5502. Written comments should be sent to the DEQ contact at the Department of Environmental Quality, Northwest Region, 2020 SW Fourth Avenue, Suite 400, Portland, OR 97201 by April 30, 2004. A public meeting will be held to receive verbal comments if requested by 10 or more people or by a group with a membership of 10 or more. Please notify DEQ if you need copies of written materials in an alternative format (e.g., Braille, large print, etc.). To make these arrangements, contact DEQ Office of Communication and Outreach at 503-229-5317. Additional information is also available at http://www.deq.state.or.us/news/publicnotices/index.asp?program=Land%20Quality.

PROPOSED APPROVAL OF SOIL REMOVAL ACTION FROM PGE PROPETY IN WEST LINN, OREGON

COMMENTS DUE: May 1, 2004
PROJECT LOCATION: Right-of-way near N. 11 Street and Leslie's Way, West Linn, Oregon
PROPOSAL: As required by ORS 465.320, the Department of Environmental Quality (DEQ) invites public comment on the proposed approval of a soil removal at PGE right-of-way property.
HIGHLIGHTS: In January 2002, illegally dumped electrical equipment was discovered in a seasonal wetland area along a utility corridor in West Linn, Oregon. The wetland was within several blocks of the Willamette River. Because the equipment was found on PGE property, PGE disposed of the equipment and removed soil that was impacted by a release of fluids from the equipment. DEQ reviewed information on the soil removal and has determined that no further cleanup actions are required. File information is available for review and describes site conditions and the surface cover.
HOW TO COMMENT: To schedule an appointment at DEQ, contact the file specialist at 229-6729. The DEQ project manager is Alicia C. Voss (229-5011). Written comments should be sent to the project manager at DEQ, Northwest Region, 2020 SW 4th Avenue, Suite 400, Portland, OR 97201 by May 1, 2004. A public meeting will be held to receive verbal comments if requested by 10 or more people or by a group with membership of 10 or more.
THE NEXT STEP: DEQ will consider all public comments and the Regional Administrator will make a final decision after consideration of these public comments.

APPROVAL OF REMEDY AT 2110 N. LEWIS AVENUE, PORTLAND, OREGON

COMMENTS DUE: May 1, 2004
PROJECT LOCATION: 2110 N. Lewis Avenue, Portland, Oregon
PROPOSAL: As required by ORS 465.320, the Department of Environmental Quality (DEQ) invites public comment on the proposed approval of a remedy at 2110 N. Lewis Avenue in Portland, Oregon.
HIGHLIGHTS: The City of Portland redeveloped the property at 2110 N. Lewis Avenue in Portland in 2001/2002 as an on-ramp to N. Interstate Avenue. Historically the property had been the location of an electrical equipment service center and small retail businesses. Most recently the property had been called the Tucker property. During on-ramp construction, contaminants were discovered in the building and in the parking area. The building was demolished and contaminated debris was placed in the basement before being covered by soil and the ramp. The rest of the property is now covered by asphalt pavement. The ramp and pavement adequately cover the property and prevent any exposures to the contamination. The City will insure that the ramp and pavement remain in-place to prevent any future exposures. File information is available for review and describes site conditions and the surface cover.
HOW TO COMMENT: To schedule an appointment at DEQ, contact the file specialist at 229-6729. The DEQ project manager is Alicia C. Voss (229-5011). Written comments should be sent to the project manager at DEQ, Northwest Region, 2020 SW 4th Avenue, Suite 400, Portland, OR 97201 by May 1, 2004. A public meeting will be held to receive verbal comments if requested by 10 or more people or by a group with membership of 10 or more.
THE NEXT STEP: DEQ will consider all public comments and the Regional Administrator will make a final decision after consideration of these public comments.

NOTICE OF SELECTED ENVIRONMENTAL CLEANUP ACTIONS FOR THE FORMER DURHAM QUARRY

PROJECT LOCATION: Former Durham Quarry Northwest of the intersection of SW 72nd Avenue and SW Bridgeport Road, Tigard and Tualatin, Oregon.
CLEANUP DECISION: Pursuant to Oregon Revised Statutes, ORS 465.320 and Oregon Administrative Rules, OAR 340-122-100, the Department of Environmental Quality (DEQ) issues this notice of a final cleanup decision regarding methane gas and other hazardous substances in soil and groundwater at the former Durham Quarry site. The DEQ finalized the selection of the remedial action with the issuance of the Record of Decision on February 25, 2004.
BACKGROUND: Washington County has owned this 29-acre site since 1939, which was operated as a gravel quarry from about 1952 to the early 1970s. The quarry pit was subsequently filled from 1992 through 2002, primarily with inert soil, concrete, and hardened asphalt, although organic land clearing debris, wood debris, and building demolition materials were periodically disposed in the pit. The site is planned for development by Opus Northwest as Bridgeport Village, a commercial and retail complex.

Environmental investigations at the site have found methane gas in the subsurface at the site at concentrations greater than DEQ's regulatory level of 1.25 percent. At those greater concentrations,

methane poses a potential risk to human health and safety. The presence of methane gas is directly attributed to the decomposition of the organic components of the fill material used to backfill the quarry.
SELECTED CLEANUP ACTIONS: DEQ's selected cleanup actions include a combination of active and passive engineering controls, institutional controls, and site monitoring to prevent methane from accumulating in future buildings and other confined spaces on the site, and to prevent methane from migrating to off-site areas. Methane mitigation measures include (1) a perimeter, active gas extraction system with shallow and deep wells; (2) interior, active gas extraction wells in areas of high methane concentrations and/or pressures; (3) impermeable gas barriers and passive venting systems underneath buildings; (4) low-permeable membrane collars or trench plugs in utility corridors; (5) special design and construction of utility vaults, manholes, underground electrical conduits and associated equipment to prevent methane accumulation; (6) long-term methane monitoring of building interiors, building sub-slabs, monitoring wells, gas extraction and venting systems, and confined spaces; (7) institutional controls, such as deeded property-use controls to prevent disturbance of the engineering controls; and (8) contingency measures, such as additional engineering controls, if monitoring results indicate potential methane hazards are not being mitigated.
INFORMATION: A detailed description of DEQ's selected cleanup action is provided in the Record of Decision for the site. The Record of Decision, documents in the administrative record, and other project files are available for public review by appointment at DEQ's Northwest Region Office, 2020 SW Fourth Avenue, Suite 400, Portland, Oregon. Appointments to review these files can be made by calling 503-229-6729, toll free at 1-800-452-4011, or TTY at 503-229-5471. Information is also available on DEQ's web site at http://www.deq.state.or.us/nwr/Durham_Quarry/Durham_Quarry.htm.

Additional information regarding the selected cleanup actions for the site may be obtained by contacting Jill Kiernan, P.E., DEQ Project Engineer, at the above address, by calling 503-229-6900, or by e-mail at kiernan.jill.a@deq.state.or.us.
THE NEXT STEP: DEQ is currently negotiating a Consent Order with Washington County and Opus Northwest to implement the selected remedial actions. Design of the methane mitigation measures has been initiated and is expected to be completed in April 2004.

DEQ REQUESTS COMMENTS ON THE FINAL CLEANUP PROPOSAL FOR THE LAURENCE-DAVID, INC. SITE

COMMENTS INVITED: through April 30, 2004
PROJECT LOCATION: 1400 South Bertelsen Road in Eugene
NOTICE: The Oregon Department of Environmental Quality (DEQ) is proposing to enter a legally binding environmental cleanup agreement with Bertelsen, Inc.. The "Stipulation and Consent Decree" specifies steps that must be taken at the former site of Laurence-David, Inc.(LDI), a specialty paint and putty manufacturer.
BACKGROUND: Environmental investigation and cleanup activities under DEQ oversight have been conducted intermittently since 1982. In August 2002, a study to assess long term alternatives for addressing contamination at the site was completed. Some soil and groundwater at the site contains concentrations of solvents and metals that if left untreated could pose a future risk to workers on the property. Groundwaterwest of the property contains solvents that could pose a risk to people if thegroundwater was used for domestic water supplies. Currently city water is utilized inthis area.
CLEANUP PROPOSAL: The proposed legal agreement with Bertelsen, Inc.details final cleanup requirements for the LDI Site, including: 1) capping an area of soilcontamination with clean soil, 2) worker protection on the site for workers in areas ofknown soil contamination, 3) groundwater use restrictions at the facility to prevent theuse of untreated groundwater, 4) restricting land use to industrial at the site, 5) restrictingactivities at areas of the site where soil contamination remains, 6) reviewinggroundwater use in the adjacent off-site areas to confirm the assumption that off-sitegroundwater is not being used in the future, 7) notification of potentially affected-properties of the possible presence of groundwater contamination, and 8) contingencyplans.
FINAL DECISION: DEQ will consider all public comments. A final decision concerning the Stipulation and Consent Decree will be made after consideration of public comments.
INFORMATION: The Stipulation and Consent Decree is available for public review at DEQ's Salem and Eugene Offices. To schedule an appointment at one of our offices, call the Salem Office at (503) 378-8240 or the Eugene Office at (541) 686-7838. The historical files on the site are also available for public review in Eugene. For questions and comments about the final cleanup proposal, please contact project manager Nancy Gramlich at (503) 378-8240, ext. 259, or by email at gramlich.nancy@deq.state.or.us.

PROPOSED NO FURTHER ACTION DETERMINATION NEW COLUMBIA HOPE VI REDEVELOPMENT PORTLAND, OREGON

COMMENTS DUE: May 3, 2004
PROJECT LOCATION: Portsmouth neighborhood of North Portland (bounded on the north by Columbia Boulevard, on the south by N. Houghton Street, on the west by N. Adriatic Avenue, and on the east by a railroad right of way)
PROPOSAL: The Department of Environmental Quality is proposing to issue a No Further Action determination following removal of lead-contaminated soil from the New Columbia redevelopment site. This determination is based on approval of investigation and remedial measures conducted to date. Public notification is required by ORS 465.320.
HIGHLIGHTS: The Housing Authority of Portland (HAP) is in the process of demolishing and replacing existing structures at this site. In the course of the redevelopment, HAP identified excessive lead contamination in soil around the perimeter of some of the older buildings. This is due to flaking of lead-containing paint and leaching of lead into rainwater dripping off the buildings. The contaminated soil was excavated and disposed of at the Hillsboro Landfill. Subsequent soil sampling indicates that remaining lead in the soil is below acceptable risk levels.

Based on the information provide, DEQ proposes to issue a No Further Action (NFA) determination for this site. This NFA determination pertains only to lead-contaminated soil. HAP is working with other DEQ Programs to address environmental issues that are beyond the scope of this NFA determination. These include removal of two underground petroleum storage tanks, management of asbestos-containing materials and investigation of drywells.
HOW TO COMMENT: Comments and questions, by phone, fax, mail or email, should be directed to:
Bob Schwarz, Project Manager
Phone: 541-298-7255, ext. 30
Fax: 541-298-7330
Email: Schwarz.bob@deq.state.or.us
To schedule an appointment or to obtain a copy of the staff report, please contact Mr. Schwarz as well. Written comments should be sent by May 3, 2004.
THE NEXT STEP: DEQ will consider all comments received. A final decision concerning the proposed No Further Action determination will be made after consideration of public comments.

PROPOSED NO FURTHER ACTION AT THE ERICKSON AIR CRANE SPILL SITE NEAR GALENA, OREGON

COMMENTS DUE: April 30, 3004
PROJECT LOCATION: milepost 22.5 on County Road 20 near Galena, OR

PROPOSAL: The Department of Environmental Quality (DEQ) is proposing to approve No Further Action at the Erickson Air Crane spill site located at milepost 22.5 on County Road 20 near Galena, Oregon.
HIGHLIGHTS: The DEQ Voluntary Cleanup Program has reviewed the information gathered during the remedial activities performed at the site. On November 10, 1998, a fully loaded tanker truck, transporting Jet A fuel, slid off of County Road 20 at milepost 22.5 and overturned. The majority of the 7,800 gallon fuel load was released as a result of the accident. The site is a hay meadow located within the flood plain of the Middle Fork John Day River. The site is publicly owned and managed by the United States Forest Service (USFS) as part of the Malheur National Forest. Approximately 9,000 cubic yards of contaminated soil were excavated and treated at a near by location. The treated soil was reused to backfill the excavation. Groundwater and surface water sampling performed during and after spill response activities indicate the release did not impact either media. Groundwater sampling has demonstrated the treated soil is not impacting groundwater quality. The site has been re-vegetated to USFS specifications.
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. To schedule an appointment to review the file or to ask questions, please contact Katie Robertson at (541) 278-4620. Written comments should be sent by April 30, 2004 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 determination of No Further Action.

PROPOSED REMEDIAL ACTION AT
THE CHEVRON BULK PLANT (FORMER)
LA GRANDE, OREGON

COMMENTS DUE: April 30, 3004
PROJECT LOCATION: 2219 Island Avenue, La Grande, OR
PROPOSAL: The Department of Environmental Quality (DEQ) is proposing to approve a remedial action and Conditional No Further Action at the Former Chevron Bulk Plant #100-1204 located at 2219 Island Avenue in La Grande, Oregon.
HIGHLIGHTS: The DEQ Voluntary Cleanup Program has reviewed the information gathered during the site investigation and groundwater monitoring activities performed at the site. With the closure of bulk plant operations and the removal of the storage tanks, future releases are unlikely. Extensive groundwater data has been collected since the early 1980s. The groundwater data has shown that the groundwater plume has stabilized and continues to naturally attenuate. Based on the groundwater data, concentrations exceeding occupational risk based concentrations for tap water are limited to the site, the railroad right of way, Island Avenue, and the Skipper's restaurant (formerly County Kitchen). An institutional control (i.e. deed restriction) in the form of an Easement and Equitable Servitude (E&ES) is the proposed remedy for the former Chevron Bulk Plant and the Skippers property to prohibit the installation of water wells without prior DEQ approval. This control will prevent use of shallow groundwater and maintain protective conditions at the site and Skipper' restaurant property. Since the current uses of the railroad right of way and the state highway (Island Avenue) do not anticipate a need for a water source, and the uses are not likely to change in the future, institutional controls are not required on these transportation corridors. If either of these corridors were to change uses, the need for a control may be necessary to maintain protective conditions.

Due to the number of monitoring wells known to have existed at the site, DEQ recommends a well abandonment program be conducted to decommission as many of the previously known monitoring wells associated with the site according to OWRD rules. Upon recordation of the E&ES and completion of the well decommissioning task, a Conditional No Further Action determination would be issued. The site will remain listed on the Confirmed Release List and Inventory of Hazardous Substances.
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. To schedule an appointment to review the file or to ask questions, please contact Katie Robertson at (541) 278-4620. Written comments should be sent by April 30, 2004 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 issuing a record of decision for the site.

PROPOSED REMEDIAL ACTION AT
THE UPRR RIETH ROUNDHOUSE (FORMER)
RIETH, OREGON

COMMENTS DUE: April 30, 3004
PROJECT LOCATION: directly east of Rieth, Umatilla County, OR
PROPOSAL: The Department of Environmental Quality (DEQ) is proposing to approve a remedial action and Conditional No Further Action at the Former Union Pacific Railroad (UPRR) Rieth Roundhouse located directly east of Rieth, in Umatilla County, Oregon.
HIGHLIGHTS: The DEQ Voluntary Cleanup Program has reviewed the information gathered during the site investigation, interim remedial actions, and groundwater monitoring activities performed at the site. Residual petroleum hydrocarbons remain in the shallow soils at the former UPRR Rieth Roundhouse site. The potential sources of the releases were removed from the site over 50 years ago. The residual petroleum hydrocarbons have not migrated significantly from the source areas and are not anticipated in the future. An institutional control (i.e. deed restriction) in the form of an Easement and Equitable Servitude (E&ES) is the proposed remedy for the former Rieth Roundhouse site. The E&ES will restrict property use to industrial use, prevent beneficial use of shallow groundwater, and require appropriate screening, analysis, management, and proper disposal of any soil excavated at the site. The shallow groundwater wells will be abandoned to prevent migration of petroleum hydrocarbons from the shallow soils to the shallow aquifer. Upon recordation of the E&ES and completion of the well decommissioning task, a Conditional No Further Action determination would be issued. The site will remain listed on the Confirmed Release List and Inventory of Hazardous Substances.
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. To schedule an appointment to review the file or to ask questions, please contact Katie Robertson at (541) 278-4620. Written comments should be sent by April 30, 2004 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 issuing a record of decision for the site.

PREFERRED REMEDIAL ACTION
KINGSLEY AIR NATIONAL GUARD
FORMERLY USED DEFENSE SITES 2, 3, 4, 7 AND 8
KLAMATH FALLS, OREGON

COMMENTS DUE: April 30, 2004
PROJECT LOCATION: Three (3) miles south of Klamath Falls, Oregon

PROPOSAL: The Department of Environmental Quality (DEQ) intends to approve selected remedial actions for several Formerly Used Defense Sites (FUDS) located at Kingsley Field in Klamath County, Oregon. Kingsley Field is an airfield approximately three (3) miles south of Klamath Falls, Oregon that is jointly used by the City of Klamath Falls and the Oregon Air National Guard (OANG).
No Action alternatives were recommended for selection at FUDS 2, 4, 7 and 8. The preferred remedy at FUD Site 3 would consist of informational noticing and institutional control. Specifically, FUD Site 3 (former base landfill) remedy implementation would include posting notification signs around the perimeter of the former landfill; preparing an addendum to the airport master plan; memorializing restrictions on and/or protocol for conducting construction/excavation activities; and, recording appropriate provisions on property deed(s).
HOW TO COMMENT: A public comment period will extend from April 1 until April 30, 2004. Please address all comments and/or inquiries to Mr. Cliff Walkey at the following address:

Cliff Walkey
Department of Environmental Quality
2146 NE 4th Street, Suite 104
Bend, Oregon 97701
(541) 388-6146, ext. 224
walkey.cliff@deq.state.or.us

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 selection and implementation of the preferred remedial actions at these FUDS.

CLEANUP ACTION COMPLETED AND DEQ RECOMMENDS NO FURTHER ACTION AT THE MERRY X-RAY COMPANY SITE IN SPRINGFIELD

COMMENTS DUE: April 30, 2004
PROJECT LOCATION: Merry X-Ray Company, 1161 N. 28th Street, Springfield, Oregon.
PROPOSAL: Oregon Department of Environmental Quality (DEQ) invites public comments from April 1, 2004 through April 30, 2004. DEQ will consider all comments before issuing a no further action determination.
HIGHLIGHTS: The staff report will be available for public review at DEQ's Eugene office from April 1, 2004 through April 30, 2004.

The Merry X-Ray Company (MXR) is located at 1161 N. 28th Street in Springfield, Oregon. MXR recycles spent x-ray fixer to recover silver and also distributes x-ray film. In July 2002, the City of Springfield's Public Works Department conducted an inspection of MXR's facility and discovered liquid discharging from an outfall to the Q-Street Floodway. The floor drain in MXR's facility, which lead to the outfall, was plugged to prevent further discharge. In January of 2003, the site was referred to the DEQ for further investigation.

In September of 2003, sampling confirmed the presence of silver in the floodway including the bank soil, channel sediment, and surface water. In order to mitigate the potential impacts of the silver contamination, soil and sediment were removed from the bank and channel in October of 2003. Confirmation soil samples collected after the cleanup activities indicated residual silver concentrations had been reduced to acceptable levels in the soil and sediment, and silver was not detected in surface water above the method reporting limit (non-detect). Ecological habitat is not present in this area or immediately down gradient in the floodway based on the nature and use of the channel. DEQ has concluded that there is no threat to human health and the environment.
HOW TO COMMENT: The staff report, project files, investigation reports, administrative record, etc. are available for public review at DEQ's Eugene office. Please call (800)844-8467 extension 276 to schedule an appointment to view files. Written comments should be sent to Kristy Sewell, 1102 Lincoln Street, Suite 210, Eugene, Oregon 97402 by 5:00 p.m. April 30, 2004. A public meeting will be held to receive verbal 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 and the director will make a decision and publish the final decision after consideration of public comments.

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 listed below.

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 pm on the Last Day for Comment listed below. Written and oral comments may be submitted at the appropriate time during a rulemaking hearing as outlined in OAR 137-001-0030.

ORS 183.335(2)(b)(G) requests 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.

A public rulemaking 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 by the Last Date for Comment as printed in the Notice of Proposed Rulemaking in the Oregon Bulletin. If sufficient hearing requests are received by an agency, the notice of the date and time of the rulemaking hearing must be published in the Oregon Bulletin at least 14 days before the hearing.

• • • • • • • • • •

Board of Architect Examiners
Chapter 806

Date:	Time:	Location:
4-21-04	9 a.m.	Architect Board 750 Front St. NE #260 Salem, OR

Hearing Officer: Kim Arbuckle
Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.020 & 671.025
Proposed Amendments: 806-010-0045
Last Date for Comment: 4-21-04, 11 a.m.
Summary: This rule amendment allows the optional use of a license number on an architect's stamp, identifies the type of stamp authorized by the Board, clarifies the purpose of the stamp and signature, identifies what does not meet the definition of "direct control and supervision" and creates a process that can be used by clients/successor architect in the event of the death or disability of an architect.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Carol Halford
Address: Oregon Board of Architect Examiners, 750 Front St. NE, Suite 260, Salem, OR 97301
Telephone: (503) 763-0662

• • • • • • • • • •

Date:	Time:	Location:
4-21-04	9:30 a.m.	Architect Board 750 Front St. NE #260 Salem, OR

Hearing Officer: Kim Arbuckle
Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.025
Proposed Adoptions: 806-010-0054
Last Date for Comment: 4-21-04, 11:30 a.m.
Summary: In order to protect the public, this rule amendment will require the use of a contract by architects prior to commencing architectural work on projects that begin on and after January 1, 2005. This rule outlines the minimum requirements of what must be included in the contract, along with exceptions to the use of the contracts.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Carol Halford
Address: Oregon Board of Architect Examiners, 750 Front St. NE, Suite 260, Salem, OR 97301
Telephone: (503) 763-0662

• • • • • • • • • •

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.041
Proposed Amendments: 806-010-0080
Last Date for Comment: 4-21-04, 4:30 p.m.
Summary: This is a housekeeping that changes no Board requirements for architectural firms, but clarifies the language of what is required for better understanding.
Rules Coordinator: Carol Halford
Address: Oregon Board of Architect Examiners, 750 Front St. NE, Suite 260, Salem, OR 97301
Telephone: (503) 763-0662

• • • • • • • • • •

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.125 & 671.080
Proposed Amendments: 806-010-0145
Last Date for Comment: 4-21-04, 4:30 p.m.
Summary: This rule adds to the listing in the rule that participation in a teaching program, such as the Architects in Schools (AIS) Program, is allowable CPE for license renewal. This amendment also makes clear to licensees the type of CPE that can be claimed for similar programs.
Rules Coordinator: Carol Halford
Address: Oregon Board of Architect Examiners, 750 Front St. NE, Suite 260, Salem, OR 97301
Telephone: (503) 763-0662

• • • • • • • • • •

Board of Examiners for Speech Pathology and Audiology
Chapter 335

Date:	Time:	Location:
5-21-04	10-11 a.m.	Rm. 445 Portland State Office Bldg. 800 NE Oregon St. Portland, OR

Hearing Officer: Joanna Burk, Chair
Stat. Auth.: ORS 681.205, 681.340, 681.360, 681.370, 681.375, 681.420 & 681.460
Stats. Implemented: 681.250(1), 681.320, 681.330, 681.340, 681.360, 681.370, 681.375, 681.420 & 681.460
Proposed Adoptions: 335-010-0050, 335-010-0060, 335-010-0070, 335-010-0080
Proposed Amendments: 335-005-0015, 335-005-0025, 335-070-0030, 335-070-0060, 335-095-0020, 335-095-0030
Last Date for Comment: 5-21-04
Summary: New Division 10 rules provide an explanation of and requirements for record keeping.

Amended rules in Division 5 add maintenance of clinical records to professional and ethical standards and define the rules for accurate representation of an audiologist who works for a business that dispenses hearing aids. 335-005-0025 (12) (13) also clarifies documentation requirements for speech-language pathologists who supervise others.

Amended rules in Division 70 clarifies that inservices are acceptable at public schools and clarifies the professional development requirements for new licensees.

Amended rules in Division 95 delete a grandparenting qualification that no longer applies and clarifies how a person may qualify outside of grandparenting.

Full text of the proposed rules may be viewed on the Agency website at www.bspa.state.or.us or by contacting the Board office at (503) 731-4050 for a hardcopy.

**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Brenda Felber
Address: Board of Examiners for Speech-Language Pathology and Audiology, 800 NE Oregon St. - Suite 407, Portland, OR 97232-2162
Telephone: (503) 731-4050

• • • • • • • • • •

Board of Optometry
Chapter 852

Stat. Auth.: ORS 683 & 182
Stats. Implemented: ORS 683.155 & 182.466
Proposed Adoptions: 852-060-0060, 852-060-0065, 852-060-0070, 852-060-0075
Proposed Amendments: Rules in 852-001, 852-060-0004
Last Date for Comment: 4-21-04
Summary: 852-010-0005, 0010, 0015 - Deletes language regarding procedures. This language is now in Division 60.
852-060-0004 - References statutory authority for Board processing of complaints.
852-069-0060, 0065, 0070 - Are moved from Division 852-001.
852-060-0075 - Establishes rules for discovery in contested case hearings.
Rules Coordinator: David W. Plunkett
Address: Board of Optometry, 3218 Pringle Rd. SE - Suite 270, Salem, OR 97302
Telephone: (503) 373-7721, ext. 23

• • • • • • • • • •

Board of Pharmacy
Chapter 855

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.205
Proposed Repeals: 855-043-0200, 855-043-0205
Last Date for Comment: 4-21-04
Summary: Remove sections that encompass the purpose, scope and drug delivery and control in student health centers. SB708 eliminated the Board's authority to authorize a Nurse Practitioner to dispense drugs in a college student health center.
Rules Coordinator: Karen Maclean
Address: Board of Pharmacy, 800 NE Oregon St.. - Suite 425, Portland, OR 97232
Telephone: (503) 731-0432, ext. 223

• • • • • • • • • •

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.205
Proposed Adoptions: 855-043-0210
Last Date for Comment: 4-21-04
Summary: This rule adopts a training program jointly with the Board of Nursing for Nurse Practitioners who have applied to the Board of Nursing for special dispensing authority pursuant to OAR 851-050-0162.
Rules Coordinator: Karen Maclean
Address: Board of Pharmacy, 800 NE Oregon St.. - Suite 425, Portland, OR 97232
Telephone: (503) 731-4032, ext. 223

• • • • • • • • • •

Department of Agriculture
Chapter 603

Date:	Time:	Location:
4-29-04	10 a.m.	ODA 635 Capitol St. NE Salem, OR

Hearing Officer: Brent Searle
Stat. Auth.: ORS 561.190, 571 & 632.940
Stats. Implemented: ORS 561.190, 571 & 632.940
Proposed Amendments: 603-051-0855, 603-051-0856, 603-051-0857, 603-051-0858, 603-051-0859
Last Date for Comment: 5-6-04
Summary: The amended rules (Rules for Virus Certification of Oregon Nursery Stock) increase the participation fee for nurseries to $200 per nursery, change the laboratory testing fee structure to $7.00 per sample per virus test requested, and remove references to Oregon State University.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Sherry Kudna
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301-2532
Telephone: (503) 986-4619

• • • • • • • • • •

Date:	Time:	Location:
4-28-04	10 a.m.	Red Lion 304 SE Nye, Yakima Rm. Pendleton, OR (exit #210 off I-84)
4-29-04	10 a.m.	OR Dept. of Agriculture 635 Capitol St. NE Basement Hearings Rm. Salem, OR 97301

Hearing Officer: Claudette Olson
Stat. Auth.: ORS 561.190; Other Auth.: ORS 625.180 & 635.030
Stats. Implemented:
Proposed Amendments: 603-021-0008, 603-021-0709
Last Date for Comment: 4-30-04
Summary: OAR 603-021-0008 and OAR 603-021-0790 establish license fees for bakeries, domestic kitchen bakeries, bakery distributors and non-alcoholic beverage plants. The purpose of the amendment is to increase license fees to compensate for the loss of General Funds and increased costs in the Division. License fees were last raised in 1987.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Sherry Kudna
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301-2532
Telephone: (503) 986-4619

• • • • • • • • • •

Date:	Time:	Location:
4-28-04	10 a.m.	Red Lion 304 SE Nye, Yakima Rm. Pendleton, OR (exit #210 off I-84)
4-29-04	10 a.m.	OR Dept. of Agriculture 636 Capitol St. NE Basement Hearings Rm. Salem, OR 97301

Hearing Officer: Claudette Olson
Stat. Auth.: ORS 561.190; Other Auth.: ORS 621.072
Stats. Implemented:
Proposed Amendments: 603-024-0234, 603-024-0547
Last Date for Comment: 4-30-04
Summary: OAR 603-024-0234(2), 603-024-0547(2) & 603-024-0547(3) establish license fees for dairy products plants, producer-distributors, distributors and non-processing distributors and producers. The purpose of the amendment is to increase license fees to compensate for the loss of General Funds and increased costs in the Division. License fees were last raised in 1987.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Sherry Kudna
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301-2532
Telephone: (503) 986-4619

Date:	Time:	Location:
4-28-04	10 a.m.	Red Lion 302 SE Nye, Yakima Rm. Pendleton, OR (exit #210 off I-84)
4-29-04	10 a.m.	OR Dept. of Agriculture 635 Capitol St. NE Basement Hearings Rm. Salem, OR 97301

Hearing Officer: Claudette Olson
Stat. Auth.: ORS 561.190; Other Auth.: 616.706
Stats. Implemented:
Proposed Amendments: 603-025-0210
Last Date for Comment: 4-30-04
Summary: OAR 603-025-0210(2) establishes license fees for various categories of retail food stores, food warehouses and food processors. The purpose of the amendment is to increase license fees to compensate for the loss of General Funds and increased costs in the Division. License fees were last raised in 1987.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Sherry Kudna
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301-2532
Telephone: (503) 986-4619

• • • • • • • • • •

Date:	Time:	Location:
4-28-04	10 a.m.	Red Lion 304 SE Nye, Yakima Rm. Pendleton, OR (exit #210 off I-84)
4-29-04	10 a.m.	OR Dept. of Agriculture 635 Capitol St. NE Basement Hearings Rm. Salem, OR 97301

Hearing Officer: Claudette Olson
Stat. Auth.: ORS 561.190; Other Auth.: ORS 603.025, 603.085, 619.031 & 619.046
Stats. Implemented:
Proposed Amendments: 603-028-0010
Last Date for Comment: 4-30-04
Summary: OAR 603-028-0010(2) establishes license fees for meat sellers, non-slaughtering processors, slaughterhouses, custom slaughterers, custom processors, animal food slaughterer or processor and poultry & rabbit slaughterer/processors. The purpose of the amendment is to increase license fees to compensate for the loss of General Funds and increased costs in the Division. License fees were last raised in 1987.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Sherry Kudna
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301-2532
Telephone: (503) 986-4619

• • • • • • • • • •

Date:	Time:	Location:
4-15-04	10 a.m.	Hatfield Marine Science Ctr. Guin Library 2030 Marine Science Dr. Newport, OR

Hearing Officer: Brent Searle
Stat. Auth.: ORS 576.620 - 576.650 & Ch. 487 OL 2003, SB 673
Stats. Implemented: ORS 62.845, 646.515, 646.535 & 646.740
Proposed Adoptions: 603-076-0051, 603-076-0052
Last Date for Comment: 4-22-04
Summary: Implements procedures for the Department's supervision and state oversight of price negotiations between seafood harvester cooperatives or bargaining associations and seafood dealers as authorized by Senate Bill 673; and, establishes a process for reimbursement of costs associated with such oversight.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Sherry Kudna
Address: Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301-2532
Telephone: (503) 986-4619

• • • • • • • • • •

Department of Agriculture,
Oregon Processed Vegetable Commission
Chapter 647

Date:	Time:	Location:
4-22-04	7:30 p.m.	3415 Commercial St. SE Salem, OR

Hearing Officer: Mark Lewis
Stat. Auth.: ORS 576.051 - 576.595
Stats. Implemented: ORS 576.051 - 576.595
Proposed Amendments: 647-010-0010
Last Date for Comment: 4-22-04, 7:30 p.m.
Summary: The proposed rule amendments set the assessment rates for the six processed vegetable crops governed by the commission.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: John McCulley
Address: Department of Agriculture, Processed Vegetable Commission, PO Box 2042, Salem, OR 97308-2042
Telephone: (503) 370-7019

• • • • • • • • • •

Department of Community Colleges and
Workforce Development
Chapter 589

Stat. Auth.: ORS 326.051 & 326.550
Stats. Implemented: ORS 192.440 & 326.550
Proposed Amendments: 589-007-0400
Last Date for Comment: 5-22-04
Summary: Proposed amendments to OAR 007-0400 update outdated references and dates referring to the General Educational Development (GED) Program and Certificates of High School Equivalency. The changes are meant to provide clarification on the process of testing requirements and other general housekeeping matters.
Rules Coordinator: Laura J. Roberts
Address: Department of Community Colleges and Workforce Development, 255 Capitol St. NE, Salem, OR 97310
Telephone: (503) 378-8648, ext. 238

• • • • • • • • • •

Department of Consumer and Business Services,
Building Codes Division
Chapter 918

Date:	Time:	Location:
4-20-04	1:30 p.m.	1535 Edgewater NW Salem, OR 97310

Hearing Officer: Mike Ewert
Stat. Auth.: ORS 455.030, 455.110 & 455.020; Other Auth.: ORS 183.310, OAR 918-001-0010 & 918-440-0000
Stats. Implemented: ORS 455.030, 455.110, 455.132 & 455.020
Proposed Amendments: 918-440-0010, 918-440-0040
Last Date for Comment: 4-23-04, 5 p.m.
Summary: ORS 455.020 and ORS 455.110 require the department to promulgate a uniform state building code to govern the construction, reconstruction, alteration and repair of buildings and other structures and the installations of mechanical devices and equipment and to require the correction of unsafe conditions caused by earthquakes in existing buildings. The law further requires the building code to establish uniform performance standards for health, safety, welfare, comfort and security of residents of the State of Oregon, who are occupants and users of buildings and to provide for the use

of modern methods, devices, materials, techniques and practicable maximum energy conservation.

The current Oregon Mechanical Specialty Code adopted is the 2000 edition of the International Mechanical Code (IMC), with Oregon amendments and is known as the 2002 Oregon Mechanical Specialty Code (OMSC).

The Director of the Department of Consumer and Business Services, with the approval of the Building Codes Structures Board, may amend such codes and regulations provided it conforms to in so far it is practicable to model building code generally acceptable throughout the United States. The proposed rule adopts the 2003 edition of the International Mechanical Code (IMC) with amendments and the appended, International Fuel Gas Code, with proposed amendments, and will be known as the 2004 Oregon Mechanical Specialty Code.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Richard J. Baumann

Address: Department of Consumer and Business Services, Building Codes Division, P.O. Box 14470, Salem, OR 97309-0404

Telephone: (503) 373-7559

• • • • • • • • • •

Date:	Time:	Location:
4-20-04	9:30 a.m.	1535 Edgewater NW Salem, OR 97304

Hearing Officer: Richard Rogers

Stat. Auth.: ORS 447.231, 447.247, 455.020, 455.030, 455.110, 455.447 & 455.610; Other Auth.: ORS 183.310, OAR 918-001-0010 & 918-460-0000

Stats. Implemented: ORS 455.110, 477.247 & 455.020

Proposed Amendments: 918-460-0010, 918-460-0015

Last Date for Comment: 4-23-04, 5 p.m.

Summary: ORS 455.020 and 455.110 require the department to promulgate a uniform state building code to govern the construction, reconstruction, alteration and repair of buildings and other structures and the installations of mechanical devices and equipment and to require the correction of unsafe conditions caused by earthquakes in existing buildings. The law further requires the building code to establish uniform performance standards for health, safety, welfare, comfort and security of residents of the State of Oregon who are occupants and users of buildings and to provide for the use of modern methods, devices, materials, techniques and practicable maximum energy conservation.

The current model building code adopted is the 1997 edition of the Uniform Building Code (UBC), with Oregon amendments and is known as the 1998 Oregon Structural Specialty Code (OSSC).

The Director of Consumer & Business Services, with the approval of the Building Codes Structures Board, may amend such codes and regulations provided it conforms to in so far it is practicable to model building code generally acceptable throughout the United States. The proposed rule adopts the 2003 edition of the International Building Code (IBC) with amendments and will be known as the 2004 Oregon Structural Specialty Code.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Richard J. Baumann

Address: Department of Consumer and Business Services, Building Codes Division, P.O. Box 14470, Salem, OR 97309-0404

Telephone: (503) 373-7559

• • • • • • • • • •

Date:	Time:	Location:
4-21-04	10:30 a.m.	1535 NW Edgewater St. Salem, OR 97310

Hearing Officer: Richard J. Baumann

Stat. Auth.: ORS 447.020, 447.095 & 693.100; Other Auth.: ORS 183.325 & 455.020

Stats. Implemented: ORS 447.020, 447.095 & 693.050

Proposed Amendments: 918-695-0030,918-780-0080

Last Date for Comment: 4-23-04, 5 p.m.

Summary: The division is required to provide a plumbing inspection fee schedule for the installation of plumbing, drainage, potable water supply and drainage in and adjacent to all buildings and structures for inspections made by the division. The current rule lists the division's plumbing permit fees and defines how the fees are calculated. The proposed rules are intended to streamline and simplify the method for calculating the plumbing permit fees charged by the division, without reducing current revenue levels.

Application for a journeyman plumber's license must be accompanied by proof satisfactory to the board that the applicant has had at least four years of general experience and training as an apprentice plumber or equivalent as determined by the board. Division rule defines the qualifications to sit for the journeyman plumber licensing examination. The proposed rules eliminates a provision in rule which allows acceptance of equivalent qualifications without determining how the license was acquired, and if the license is valid based upon legal work experience and training.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Richard J. Baumann

Address: Department of Consumer and Business Services, Building Codes Division, P.O. Box 14470, Salem, OR 97309-0404

Telephone: (503) 373-7559

• • • • • • • • • •

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

Chapter 441

Date:	Time:	Location:
4-27-04	9 a.m.	350 Winter St. NE HR E Salem, OR 97301

Hearing Officer: Pat Locnikar

Stat. Auth.: ORS 59.285

Stats. Implemented: ORS 59.049, 59.065, 59.070, 59.075, 59.175, 59.185 & 59.195

Proposed Adoptions: 441-049-1001, 441-065-0001, 441-175-0002

Proposed Amendments: 441-035-0045, 441-049-1021, 441-049-1031, 441-049-1041, 441-049-1051, 441-065-0015, 441-065-0020, 441-065-0035, 441-065-0170, 441-065-0180, 441-065-0270, 441-075-0020, 441-095-0030, 441-175-0015, 441-175-0060, 441-175-0080, 441-175-0085, 441-175-0100, 441-175-0120, 441-175-0130, 441-175-0160, 441-175-0165, 441-175-0171, 441-195-0010, 441-195-0020, 441-195-0030

Last Date for Comment: 4-27-04

Summary: These Proposals:

1) Streamline the licensing process for those broker-dealers filing through the CRD system by eliminating all paper filing requirements.

2) Revise the broker-dealer books and records rules to make them consistent with the SEC's rules.

3) Permanently adopt, with no changes, the temporary rules as adopted and amended on November 26, 2003 concerning securities fees.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Berri Leslie

Address: Department of Consumer and Business Services, Finance and Corporate Securities, 350 Winter St. NE - Rm. 410, Salem, OR 97301-3881

Telephone: (503) 947-7478

Department of Consumer and Business Services,
Insurance Division
Chapter 836

Date:	Time:	Location:
5-6-04	1:30 p.m.	Conference Rm. F (Basement) 350 Winter St. NE Salem, OR

Hearing Officer: Lewis Littlehales
Stat. Auth.: ORS 731.244 & 746.135
Stats. Implemented: ORS 746.135
Proposed Adoptions: 836-051-0700
Last Date for Comment: 5-13-04
Summary: This rulemaking proposes to adopt a standard authorization form to be used by insurers and other persons that ask applicants for insurance to take a genetic test in connection with the applications. Insurers and other persons that use genetic testing are required by statute to reveal the use of the test to applicants and to obtain their specific authorization. The authorization form requirement primarily applies to life insurance because genetic testing is prohibited in connection with health insurance coverage.
**Auxiliary aids for persons with disabilities are available upon advance request.*
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

• • • • • • • • • •

Date:	Time:	Location:
4-28-04	1:30 p.m.	Conference Rm. F (Basement) 350 Winter St. NE Salem, OR

Hearing Officer: Lewis Littlehales
Stat. Auth.: ORS 731.244 & Sec. 2, Ch. 568, OL 2003 (Enrolled House Bill 3051)
Stats. Implemented: Sec. 2, Ch. 568, OL 2003
Proposed Adoptions: 836-031-0855
Last Date for Comment: 5-7-04
Summary: This rulemaking proposes to permanently adopt temporary rulemaking that implements legislation enacted in 2003 (section 2, chapter 568, Oregon Laws 2003), with changes. This legislation requires that when insurers that belong to the Oregon Insurance Guaranty Association (OIGA) are assessed by the OIGA in order to settle claims against an insolvent insurer, each member insurer must recover the assessment through a recoupment assessment imposed on net direct written premiums.
**Auxiliary aids for persons with disabilities are available upon advance request.*
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

• • • • • • • • • •

Department of Consumer and Business Services,
Oregon Medical Insurance Pool Board
Chapter 443

Date:	Time:	Location:
4-15-04	10 a.m.	250 Church St. SE Ste. 200 Salem, OR 97301

Hearing Officer: Tom Jovick
Stat. Auth.: ORS 735.614
Stats. Implemented:
Proposed Repeals: 443-015-0010
Last Date for Comment: 4-15-04
Summary: Repeal Adm Rule #443-015-0010D which allows carriers to reduce their counts of covered lives by an amount equivalent to 10% of the covered dependents.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Marcy Meink
Address: Department of Consumer and Business Services, Oregon Medical Insurance Pool, 250 Church St. SE, Ste. 200, Salem, OR 97301-3291
Telephone: (503) 373-1656, ext. 22229

• • • • • • • • • •

Department of Consumer and Business Services,
Oregon Occupational Safety and Health Division
Chapter 437

Stat. Auth.: ORS 654.025(2) & 656.726(4)
Stats. Implemented: ORS 654.001 - 654.295
Proposed Amendments: 437-002-0340
Last Date for Comment: 4-30-04
Summary: On February 17, 2004, February OSHA published in the Federal Register (69:7351-7366) final new rules for Commercial Diving, 1910.401(a)(3); 1910.402; 1910.424 and 1910.430.

Oregon OSHA proposes to adopt these rules in Division 2/T, Commercial Diving Operations (CDO). These changes allow employers of recreational diving instructors and diving guides to comply with an alternative set of requirements instead of the decompression-chamber requirements in the current CDO standards. The final rule applies only when these employees engage in recreational diving instruction and diving-guide duties; use an open-circuit, a semi-closed-circuit, or a closed-circuit self-contained underwater-breathing apparatus supplied with a breathing gas that has a high percentage of oxygen mixed with nitrogen; dive to a maximum depth of 130 feet of sea water; and remain within the no-decompression limits specified for the partial pressure of nitrogen in the breathing-gas mixture. These alternate requirements essentially are the same as the terms of a variance granted by Federal OSHA to Dixie Divers, Inc. in 1999.

Please visit OR-OSHA's web site: www.orosha.org
Rules Coordinator: Sue C. Joye
Address: Department of Consumer and Business Services, Oregon Occupational Safety and Health Division, 350 Winter St. NE , Salem, OR 97301-3882
Telephone: (503) 947-7449

• • • • • • • • • •

Department of Consumer and Business Services,
Workers' Compensation Board
Chapter 438

Date:	Time:	Location:
5-28-04	9:30 a.m.	WCB Salem Office 2601 25th St. SE, Ste. 150 Salem, OR 97302

Hearing Officer: Debra L. Young
Stat. Auth.: ORS 654.025(2), 656.278, 656.278(1), 656.307, 656.388 & 656.726(5)
Stats. Implemented: ORS 1.150, 183.341(4), Ch. 656, 656.005(30), 656.054, 656.236, 656.262(4), 656.262(6), 656.262(11), 656.262 (15), 656.268(4), 656.267(1), 656.267(3), 656.278, 656.278(1), 656.278(1)(b), 656.278(2), 656.278(5), 656.278(6), 656.289(4), 656.295(5), 656.307, 656.313(4), 656.325, 656.718 & 656.726(5)
Proposed Adoptions: 438-012-0017, 438-012-0110, 438-015-0011
Proposed Amendments: 438-005-0040, 438-005-0050, 438-005-0055, 438-009-0010, 438-009-0015, 438-012-0018, 438-012-0020, 438-012-00030, 438-012-0032, 438-012-0035, 438-012-0055, 438-012-0060, 438-012-0090, 438-012-0095, 438-012-0100, 438-022-0005, 438-022-0010
Last Date for Comment: 5-28-04

Summary: Permanent amendments to Rules of Practice and Procedures under the Workers' Compensation Law to modify the procedures for submission and approval of DCSs and stipulations to reduce costs, modify rulemaking procedures to comply with statutory changes, and adopt a rule requiring that executed retainer agreements be filed in English. Changes to the Own Motion rules include: adopting a rule setting the requirements for extensions for filing responses/briefs, adopting a rule that provides for consequences for unreasonable failure to comply or untimely compliance with Board's Own Motion rules (including assessment of penalties and attorney fees against carriers for such actions and dismissal of the request for benefits the claimant for such actions), and modifying grounds for unilateral termination of temporary disability benefits to include attainment of medical stationary status.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Vicky Scott
Address: Department of Consumer and Business Services, Workers' Compensation Board, 2601 25th St. SE, Ste. 150, Salem, OR 97302
Telephone: (503) 378-3308

• • • • • • • • • •

Department of Environmental Quality
Chapter 340

Date:	Time:	Location:
4-15-04	3 p.m.	811 S.W. Sixth Ave. Rm. 3a Portland, OR

Hearing Officer: Michelle Butler
Stat. Auth.: ORS 468.065 & 468A.315
Stats. Implemented:
Proposed Amendments: 340-220-0030, 340-220-0040, 340-220-0050
Last Date for Comment: 4-19-04, 5 p.m.
Summary: The proposed rule amendment would increase Title V fees by the 2003 Consumer Price Index, of approximately 2.0%. Base fees currently at $3,116 will increase $66, Emission fees currently at $36.60 per ton, will increase 0.77 per ton, and all Special Activity fees will increase as follows:
Administrative Fee - from $312 to $318
Simple Modification - from $1,257 to $1,273
Moderate Modification - from $9,349 to $9,547
Complex Modification - from $18,699 to $19,095
Ambient Air Monitoring - from $2,493 to $2,546
All fee increases will become effective upon rule adoption which is scheduled for July, 2004, with invoices reflecting the increases to be mailed approximately 30 days thereafter.
To submit comments or request additional information, please contact Kathleen Craig at the Department of Environmental Quality (DEQ), 811 S.W. Sixth Avenue, Portland, OR 97204, toll free in Oregon at 800-452-4011 or 503-229-6833, craig.kathleen//www.deq.state.or.us/news/index.asp
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Rachel Sakata
Address: Department of Environmental Quality, 811 SW Sixth Ave., Portland, OR 97204
Telephone: (503) 229-5659

• • • • • • • • • •

Department of Forestry
Chapter 629

Stat. Auth.: ORS 526.041
Stats. Implemented: ORS 526.610(2)(a)
Proposed Adoptions: 629-065-0210, 629-065-0220, 629-065-0410
Proposed Amendments: 629-065-0005, 629-065-0200, 629-065-0400
Proposed Repeals: 629-065-0100, 629-065-0500
Last Date for Comment: 4-22-04, 5 p.m.
Summary: House Bill 2915 passed by the 2003 Legislature created new provisions for appointment of the Board of Directors for the Oregon Forest Resources Institute (OFRI). The proposed rule changes implement these new provisions by establishing a process for the State Forester to appoint members to the OFRI Board of Directors. Under the rules, the State Forester will solicit nominations and seek recommendations for appointments from producers' organizations, the OFRI Board of Directors, and other interested parties.
Questions specific to the rule may be directed to Ted Lorenson at (503) 945-7206. Written comments may be mailed to Department of Forestry, Attn: Ted Lorenson, 2600 State Street, Salem, OR 97310.
Rules Coordinator: Gayle Birch
Address: Department of Forestry, 2600 State St., Salem, OR 97310
Telephone: (503) 945-7210

• • • • • • • • • •

Department of Human Services,
Child Welfare Programs
Chapter 413

Date:	Time:	Location:
4-22-04	1:30 p.m.	Rm. 257 500 Summer St. NE Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Proposed Amendments: 413-100-0400 - 413-100-0610
Last Date for Comment: 4-30-04
Summary: These Title XIX and GA Medical Eligibility rules are being revised to reflect the changes in Department and/or agency names due to the legislative approval of the integration of all Human Resource agencies. These rules are also being revised to clarify the process of referring relative providers to Self Sufficiency in order to ensure a child placed in the care and custody of Child Welfare (and placed with said relative) receives the necessary Medicaid coverage. These rules also include clarification on the appropriate use of Medicaid coverage for newborn children placed in the care and custody of Child Welfare.
A copy of the draft rules can be accessed at the child welfare policy website: http://www.dhs.state.or.us/policy/childwelfare/drafts/index.htm
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Annette Tesch
Address: Department of Human Services, Child Welfare Programs, 550 Summer St. NE, E48, Salem, OR 97301-1066
Telephone: (503) 945-6067

• • • • • • • • • •

Department of Human Services,
Departmental Administration and
Medical Assistance Programs
Chapter 410

Date:	Time:	Location:
4-16-04	10:30 a.m.-12 p.m.	Rm. 137 B 500 Summer St. NE Salem, OR

Hearing Officer: Darlene Nelson
Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-121-0030
Last Date for Comment: 4-16-04, 5 p.m.
Summary: The Pharmaceutical Services program rules govern Office of Medical Assistance Programs (OMAP) payments for pharmaceutical products and services provided to clients. Rule 410-121-0030 will be amended, effective May 1, 2004 to update Table 121-0030-1 to add a therapeutic drug class Antiotensin-Converting Enzyme Inhibitors (ACE inhibitors) to the Plan drug List.
**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Darlene Nelson
Address: Department of Human Services, Departmental Administration and Medical Assistance Programs, 500 Summer St. NE, E35, Salem, OR 97301-0177
Telephone: (503) 945-6927

. . . . . .

Date:	Time:	Location:
4-16-04	10:30 a.m.-12 p.m.	Rm. 137 B 500 Summer St. NE Salem, OR

Hearing Officer: Darlene Nelson
Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-125-0115, 410-125-0121, 410-125-0181
Proposed Repeals: 410-125-0115(T), 410-125-0121(T), 410-125-0181(T)
Last Date for Comment: 4-16-04, 5 p.m.
Summary: The Hospital Services program rules govern Office of Medical Assistance Programs' payment for services provided to clients. OMAP temporarily amended rules 410-125-0115, 410-125-0121 and 410-125-0181 to revise contiguous and non-contiguous hospital payment methodology to decrease risk of overpayment and to bring into line with in-state hospitals. These rule amendments are retroactively effective for services rendered on or after October 1, 2003. This is the Notice to permanently amend these rules. These rules, permanently amended on October 1, 2003, are being re-filed as permanently amended to assure compliance with HB 3120, 2003 Or Laws 749 section 5. There is no change in the content of the rule as amended, except to clarify that it is retroactive to October 1, 2003. To the extent that rule 410-125-0181, amended on October 1, 2003, has been later amended as of January 1, 2004, those changes are incorporated.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Darlene Nelson
Address: Department of Human Services, Departmental Administration and Medical Assistance Programs, 500 Summer St. NE, E35, Salem, OR 97301-0177
Telephone: (503) 945-6927

. . . . . .

Date:	Time:	Location:
4-16-04	10:30 a.m.-12 p.m.	Rm. 137 B 500 Summer St. NE Salem, OR

Hearing Officer: Darlene Nelson
Stat. Auth.: ORS 409.010 & 409.110
Stats. Implemented: ORS 414.065
Proposed Amendments: 410-141-0520
Last Date for Comment: 4-16-04, 5 p.m.
Summary: The Oregon Health Plan (OHP) Services program rules govern Office of Medical Assistance Programs' payment for services provided to clients. Rule 410-141-0520 incorporates in rule by reference the Oregon Health Services Commission's Prioritized List of Health Services (Prioritized List). Rule 410-141-0520 having been temporarily revised to incorporate the most current updates to the Prioritized List, effective April 1, 2004, is being permanently revised with this filing.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Darlene Nelson
Address: Department of Human Services, Departmental Administration and Medical Assistance Programs, 500 Summer St. NE, E35, Salem, OR 97301-0177
Telephone: (503) 945-6927

Department of Human Services,
Public Health
Chapter 333

Stat. Auth.: ORS 184, 438.605, 438.610, 438.615, 438.620, 448.131, 448.150(1) & 448.280(1)(b) & (2)
Stats. Implemented: ORS 438.605, 438.610, 438.615, 438.620 & 448.280(1)(b) & (2)
Proposed Amendments: 333-064-0025
Last Date for Comment: 4-22-04, 5 p.m.
Summary: Amends rule (for accrediting environmental testing laboratories) to change the standards for accreditation from the National Environmental Laboratory Accreditation Conference (NELAC) 2001 Standards to NELAC 2002 Standards (Chapters 3, 4, 5 and 7) and NELAC Standards 2003 (Chapters 1, 2 and 6) as required to maintain national recognition of the Oregon Environmental Laboratory Accreditation Program by the U.S. Environmental Protection Agency's National Environmental Laboratory Accreditation Program.
Rules Coordinator: Christina Hartman
Address: Department of Human Services, Public Health, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (503) 731-4405

. . . . . .

Stat. Auth.: ORS 441 & 442
Stats. Implemented: ORS 441 & 442
Proposed Adoptions: 333-535-0041
Proposed Repeals: 333-535-0040
Last Date for Comment: 4-22-04
Summary: Retroactively repeals 333-535-0040 and adopts 333-535-0041. These rules changes were previously submitted to the Secretary of State's office and became effective on February 20, 2003. These rules are identical to the rules previously filed with the Secretary of State's office on February 20, 2003.

OAR 333-535-0041 contains major revisions to construction requirements for hospital critical care units. These include care units for intensive care, coronary care patients, pediatric patients, and newborns. The adopted rule combines most requirements for adult units, allowing for better multi-disciplinary use of the same patient rooms. More detailed requirements are proposed for separate pediatric critical care units and newborn intensive care units than in 333-535-0040, with requirements reflective of recent care trends and recommended industry standards.

A public rulemaking hearing was held on January 6, 2003 regarding identical rules.
Rules Coordinator: Christina Hartman
Address: Department of Human Services, Public Health, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (503) 731-4405

. . . . . .

Stat. Auth.: ORS 448.050(2) & 448.131
Stats. Implemented: ORS 438.605, 438.610, 438.615, 438.620, 448.131, 448.150(1) & 448.280(1)(b) and (2)
Proposed Repeals: 333-063-0005 - 333-063-0140
Last Date for Comment: 4-22-04, 5 p.m.
Summary: Repeals rules that govern the Drinking Water Laboratory Certification Program which is obsolete. Drinking water testing laboratories are accredited through the Oregon Environmental Laboratory Accreditation Program (OAR 333-064-0005 to 333-064-0070).
Rules Coordinator: Christina Hartman
Address: Department of Human Services, Public Health, 800 NE Oregon St., Suite 930, Portland, OR 97232
Telephone: (503) 731-4405

Department of Human Services,
Self-Sufficiency Programs
Chapter 461

Date:	Time:	Location:
4-22-04	3 p.m.	Rm. 257 500 Summer St. NE Salem, OR

Hearing Officer: Annette Tesch
Stat. Auth.: ORS 181.537 & 411.060
Stats. Implemented: 181.537, 411.060 & 411.122
Proposed Amendments: 461-165-0180
Last Date for Comment: 4-22-04
Summary: OAR 461-165-0180 is being amended to change the minimum age of a child care provider eligible to receive payment from DHS from 16 to 18. Providers currently listed with DHS under the age of 18 will continue to be eligible for payment.

A copy of the draft rules can be accessed at the self-sufficiency policy website: http://www.dhs.state.or.us/policy/selfsufficiency/ar_proposed.htm
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Annette Tesch
Address: Department of Human Services, Self-Sufficiency Programs, 500 Summer St. NE, E48, Salem, OR 97301-1066
Telephone: (503) 945-6067

• • • • • • • • • •

Department of Human Services,
Seniors and People with Disabilities
Chapter 411

Date:	Time:	Location:
4-15-04	1:30 p.m.	Rm. 166 Human Services Bldg. Salem, OR

Hearing Officer: Lynda Dyer
Stat. Auth.: ORS 410 & 411
Stats. Implemented: ORS 410.060, 410.070 & 414.065
Proposed Amendments: 411-015-0005, 411-015-0010, 411-015-0015, 411-015-0100
Last Date for Comment: 4-22-04
Summary: The Services Priority/Clients served rules are being permanently amended effective April 27, 2004 for the following reasons: A) to clarify language in the rule that has been interpreted by the Administrative Law Judges in a manner that is inconsistent with the actual intent of the rule. B) to tighten the language supporting more consistent application of the assessment process. C) to more clearly define the time frame of reference for case management assessment of client's functional abilities and limitations.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Lynda Dyer
Address: Department of Human Services, Seniors and People with Disabilities, 500 Summer St. NE, E10, Salem, OR 97301-1076
Telephone: (503) 945-6398

• • • • • • • • • •

Department of Transportation
Chapter 731

Date:	Time:	Location:
4-28-04	9 a.m.	ODOT Bldg., Rm. 122 355 Capitol St. NE Salem, OR

Hearing Officer: Alan Kirk
Stat. Auth.: ORS 184.616, 184.619 & 184.631
Stats. Implemented: ORS 184.631
Proposed Adoptions: 731-060-0000 - 731-060-0070
Last Date for Comment: 5-10-04
Summary: ORS 184.631 (Section 18, Chapter 819, Oregon Laws 2003; HB 2661) gives ODOT authority to establish the "Oregon Department of Transportation Commercial Products Research and Development Program." The purpose of which is to enter partnerships with private and other organizations to research or develop commercial products which "reduce the cost of maintenance and preservation, extend the useful life of the state's highways or improve highway safety." These rules establish a process for soliciting and selecting projects to receive funding for research and development of products.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.odot.state.or.us/rules/
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Brenda Trump
Address: Department of Transportation, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

• • • • • • • • • •

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

Date:	Time:	Location:
4-29-04	9 a.m.	ODOT Bldg., Rm. 122 355 Capitol St. NE Salem, OR

Hearing Officer: Liz Woods
Stat. Auth.: ORS 184.616, 184.619, 807.070, 807.350 & Ch. 277, OL 2003
Stats. Implemented: ORS 807.070 & Ch. 277, OL 2003
Proposed Adoptions: 735-062-0300 - 735-062-0380
Proposed Amendments: 735-062-0050
Last Date for Comment: 5-10-04
Summary: Chapter 277, Oregon Laws 2003 allows people who do not meet eligibility standards for a driver's license due to poor visual acuity to qualify for a special restricted license that requires the use of a bioptic telescopic lens if certain criteria are met. The proposed new rule, OAR 735-062-0300 through 735-062-0380, implement the requirements of this law, which becomes effective on July 1, 2004. These proposed rules: establish the requirements for certifying a person as a rehabilitation specialist to provide training to a person with a limited vision condition on the use of bioptic telescopic lens while driving; the requirements of the training program that the certified rehabilitation specialists must provide; establish the skills the limited vision condition applicant must exhibit in order for the rehabilitation specialist to certify the person's competency to apply for driving privileges; and the process and criteria for issuance of a special limited vision condition learner's permit or a driver license or instruction permit to a person with a limited vision condition. OAR 735-062-0050 establishes the vision standards that a person must meet to qualify for a driver's license. The rule is being amended to clarify that persons issued driving privileges pursuant to the proposed rules implementing Oregon Laws 2003, Chapter 2777, are exempt from these eyesight check standards. DMV also proposes to amend section (2) of this rule to clarify the information necessary to add or remove a daylight only driving restriction on a person's driving privileges.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.odot.state.or.us/rules/
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Brenda Trump
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

• • • • • • • • • •

Stat. Auth.: ORS 184.616, 814.619, 805.205 & 805.206
Stats. Implemented: ORS 805.205 & 805.206
Proposed Amendments: 735-040-0050, 735-040-0055, 735-040-0061, 735-040-0080, 735-040-0095, 735-040-0097, 735-040-0100
Last Date for Comment: 5-10-04

Summary: These rules are needed to implement 2003 Or. Laws Chapter 409, sections 3 and 4 (SB 508) that amended ORS 805.205 and ORS 805.206. The amendments change statutory provisions that pertain to the procedures and requirements for issuance of special registration plates for certain groups. Special group registration plates are issued to benefit qualified veterans organizations, institutions of higher education and non-profit organizations. More specifically, the statutory amendments require a $10,000 application fee when a group applies for a special registration plate. The application fee will be refunded if the group sells at least 1,000 sets of plates within the first 12 months of issuance. Further, the legislative amendments require DMV to stop production of a group's plates if the group fails to sell or renew at least 500 sets of plates within a 12 consecutive month period. The previous group plate sales threshold was 50 sets of plates within a 12-month period. Other revisions to these rules have been made to clarify eligibility and the application process. Because the legislative changes went into effect January 1, 2004, DMV temporarily amended OAR 735-040-0050 through 735-040-0100 to coincide with the effective date of amendments to ORS 803.205 and 803.206. DMV now proposes to permanently amend these rules.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.odot.state.or.us/rules/
Rules Coordinator: Brenda Trump
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

• • • • • • • • • •

Stat. Auth.: ORS 184.616, 184.619, 802.012, 803.112 & 803.113
Stats. Implemented: ORS 802.012, 803.112, 803.113 & 803.117
Proposed Adoptions: 735-018-0120, 735-020-0080
Last Date for Comment: 5-10-04
Summary: These rules are needed to implement amendments to ORS 803.112, 803.113 and 803.117 made by Chapter 121, Oregon Laws 2003 (HB 2542). Specifically, HB 2542 amends ORS 803.112 by repealing vehicle transferor notice requirements formerly codified at ORS 803.112(1). This amendment authorizes DMV to specify by rule what information is to be submitted to DMV from a transferor (seller) who transfers an interest in a vehicle covered by an Oregon title. The legislative change also deleted language in ORS 803.117 that defined "notice to DMV" for purposes of relieving the seller from ongoing liability for the vehicle when title is not transferred. DMV is adopting these rules to specify what information is to be submitted to DMV from a transferor (seller) who transfers an interest in a vehicle covered by an Oregon title. As proposed, OAR 735-020-0080 specifies the form and content of the notice required to be submitted to DMV by a transferor (seller) of an interest in a vehicle pursuant to ORS 803.112 and 803.117. In addition to written notice, the rule authorizes notice by electronic means and gives DMV discretion to accept seller notice information by telephone or facsimile machine. The adoption of OAR 735-018-0120 authorizes electronic submission of a notice under ORS 803.112 and 803.117 through DMV's website. Because HB 2542 went into effect January 1, 2004, DMV temporarily adopted OAR 735-018-0120 and 735-020-0080 to coincide with the act. DMV now proposes to permanently adopt these rules.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.odot.state.or.us/rules/
Rules Coordinator: Brenda Trump
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

• • • • • • • • • •

Stat. Auth.: ORS 184.616, 184.619, 802.012, 803.015, 819.016 & 821.060
Stats. Implemented: ORS 803.015, 803.113, 803.117 & 821.060
Proposed Adoptions: 735-024-0045
Proposed Amendments: 735-024-0010, 735-024-0020
Last Date for Comment: 5-10-04
Summary: These rules are necessary to implement amendments to ORS 803.015 made by Chapter 330, Oregon Laws 2003 (SB 588). Prior to the amendment of ORS 803.015, all title brands except "reconstructed," "replica," and "totaled" were determined by DMV by rule. The provisions for these brands were determined by statute. A title brand is printed on a certificate of title to indicate the condition or history of a vehicle. Amended ORS 803.015 authorizes DMV to determine by rule all title brands that may be printed on a certificate of title including "reconstructed," "replica," and "totaled." Accordingly, DMV proposes to adopt OAR 735-024-0045 to specify when DMV will issue a title with or remove from a title the "reconstructed," "replica," and "totaled" brand. This rule only applies to an application for title submitted to DMV with an Oregon title or salvage title. The rule does not apply to vehicles from other jurisdictions as described under OAR 735-024-0020. OAR 735-024-0010 is amended to clarify Division 24 definitions. OAR 735-024-0020 is amended to include a reference to OAR 735-024-0045. Because the legislative change went into effect January 1, 2004, DMV temporarily amended OAR 735-024-0010 and 735-024-0020 and temporarily adopted OAR 735-024-0045 to coincide with the effective date of amended ORS 803.015. DMV now proposes to permanently adopt these rules.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.odot.state.or.us/rules/
Rules Coordinator: Brenda Trump
Address: Department of Transportation, Driver and Motor Vehicle Services Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

• • • • • • • • • •

Department of Transportation,
Motor Carrier Transportation Division
Chapter 740

Date:	**Time:**	**Location:**
5-5-04	9 a.m.	ODOT Bldg. Rm. 122 355 Capitol St. NE Salem, OR

Hearing Officer: Craig Bonney
Stat. Auth.: ORS 823.011, 825.232, 825.245, 825.246 & 825.247
Stats. Implemented: ORS 823.101, 823.103, 825.100, 825.202, 825.245, 825.246, 825.247 & 825.950
Proposed Adoptions: 740-060-0055, 740-300-0035
Proposed Amendments: 740-060-0030, 740-060-0050
Last Date for Comment: 5-10-04
Summary: These proposed rules implement Chapter 754, Oregon Laws 2003 (Senate Bill 471), which became effective January 1, 2004. Chapter 754, Oregon Laws 2003 requires a person in the business of providing a pack or load service to register with ODOT. Pack or load service, defined in Chapter 754, Oregon Laws 2003, offers the public an alternative to using a moving company when relocating. Chapter 754, Oregon Laws 2003 directs the Department to adopt rules that establish fees, set minimum levels of insurance and provide registration and renewal standards for persons who provide a pack or load service. The rules also establish the fee amount to be collected from existing household goods carriers and establish civil monetary penalties for persons who provide an unregistered pack or load service or an unauthorized household goods moving service. OAR 740-060-0030 is amended to decrease the time a customer of a household goods carrier has to file a damage claim, from nine months to three months, in compliance with section 12 of SB 471. These proposed permanent rules would replace temporary rules effective January 1, 2004. In response to comment received since the adoption of the temporary rule related to insurance coverage, the proposed permanent rules provide registrants an option of obtaining a bond in lieu of insurance to indemnify customers' household goods.

Text of proposed and recently adopted ODOT rules can be found at web site http://www.odot.state.or.us/rules/
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Brenda Trump
Address: Department of Transportation, Motor Carrier Transportation Division, 1905 Lana Ave. NE, Salem, OR 97314
Telephone: (503) 945-5278

• • • • • • • • • •

Health Licensing Office
Chapter 331

Date:	Time:	Location:
4-19-04	9 a.m.	700 Summer St. Suite 320 Salem, OR 97302

Hearing Officer: Bert Krages
Stat. Auth.: ORS 676.605, 676.615, 668.830 & 2003 OL Ch. 547; Other Auth.: ORS 183
Stats. Implemented: OL 2003, Ch. 547
Proposed Amendments: 331-705-0050, 331-705-0060, 331-710-0000, 331-710-0010, 331-710-0020, 331-710-0030, 331-715-0000, 331-715-0010, 331-715-0030, 331-720-0000, 331-720-0010, 331-720-0020, 331-725-0020
Proposed Repeals: 331-700-0000, 331-700-0010, 331-705-0000, 331-705-0010, 331-705-0020, 331-705-0030, 331-705-0040, 331-715-0020, 331-715-0040, 331-715-0050, 331-725-0000, 331-725-0010, 331-730-0000, 331-730-0010, 331-730-0020, 331-730-0030, 331-730-0040.
Last Date for Comment: 4-19-04
Summary: Passage of HB 2325 by the 2003 Legislature completed the process of reorganizing oversight and centralizing service for 15 health and related professions, including the practice of respiratory therapy. Rules are being amended to eliminate duplicative provisions in each of the programs rules — procedural rules, general administration, regulatory operations and licensing requirements. General amendments focus on adding provisions to link requirements between agency and program rules, improve readability of provisions, conform continuing education audit and sanction requirements with HLO business practices, and revises specific rule titles for uniformity with all programs under the agency's administration.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Date:	Time:	Location:
4-19-04	9 a.m.	Rhoades Conf. Rm. Salem, OR

Hearing Officer: Bert Krages
Stat. Auth.: ORS 676.605, 676.615, 694.155 & OL 2003, Ch. 547; Other Auth.: ORS 183
Stats. Implemented: OL 2003, Ch. 547
Proposed Adoptions: 331-630-0010, 331-650-0000
Proposed Repeals: 333-025-0018, 333-025-0030, 333-025-0080, 333-025-0090, 333-025-0095
Proposed Ren. & Amends: 333-025-0000 to 331-601-0000, 333-025-0005 to 331-601-0010, 333-025-0002(5)-(9) to 331-610-0000, 333-025-0008 to 331-610-0010, 333-025-0007(5)-(10) to 331-610-0020, 333-025-0007 to 331-610-0030, 333-025-0004(1)-(10) to 331-610-0040, 333-025-0004(11)-(13) to 331-610-0050, 333-025-0002 to 331-620-0000, 333-025-0006 to 331-620-0010, 333-025-0009 to 331-620-0020, 333-025-0040 to 331-630-0000, 333-025-0050 to 331-640-0000, 333-025-0014 to 331-640-0010, 333-025-0027 to 331-640-0020, 333-025-0065 to 331-640-0030, 333-025-0029 to 331-640-0040, 333-025-0012 to 331-640-0050, 333-025-0070 to 331-650-0000, 333-025-0075 to 331-650-0010
Last Date for Comment: 4-19-04
Summary: Passage of HB 2325 by the 2003 Legislature completed the process of reorganizing oversight and centralizing service for 15 health and related professions, including the practice of dealing in hearing aids. Rules are being amended to eliminate duplicative provisions in each of the programs rules — procedural rules, general administration, regulatory operations and licensing requirements. General amendments focus on adding provisions to link requirements between agency and program rules, improve readability of provisions, conform continuing education audit and sanction requirements with HLO business practices, and revises specific rule titles for uniformity with all programs under the agency's administration.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Stat. Auth.: ORS 676.612 & OL 1999, Ch. 736, Sec. 11; Other Auth.: ORS 183
Stats. Implemented: ORS 676.612 & OL 1999, Ch. 736, Sec. 11
Proposed Amendments: 331-135-0000
Last Date for Comment: 4-19-04
Summary: The above referenced rule is being re-filed to correct an error on a previous Notice of Rulemaking Hearing filed 02-13-04 and published in the Oregon Bulletin 03-01-04. This rule number was inadvertently listed in the 02-13-04 filing under the **Repeal** section, and was intended to be **Amended** to clarify and link the agency's investigative authority under ORS 676.612 and OAR Chapter 331, Division 20, in the rules regulating the practice of athletic training.
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Stat. Auth.: ORS 676.612 & 690.515; Other Auth.: ORS 183
Stats. Implemented: ORS 676.612 & 690.515
Proposed Amendments: 331-225-0000
Last Date for Comment: 4-19-04
Summary: The above referenced rule is being re-filed to correct an error on a previous Notice of Rulemaking Hearing filed 02-13-04 and published in the Oregon Bulletin 03-01-04. This rule number was inadvertently listed in the 02-13-04 filing under the **Repeal** section, and was intended to be **Amended** to clarify and link the agency's investigative authority under ORS 676.612 and OAR Chapter 331, Division 20, in the rules regulating the practice of body piercing.
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Stat. Auth.: ORS 676.612 & 680.535; Other Auth.: ORS 183
Stats. Implemented: ORS 676.612 & 680.535
Proposed Amendments: 331-425-0010
Last Date for Comment: 4-19-04
Summary: The above referenced rule is being re-filed to correct an error on a previous Notice of Rulemaking Hearing filed 02-13-04 and published in the Oregon Bulletin 03-01-04. This rule number was inadvertently listed in the 02-13-04 filing under the **Repeal** section, and was intended to be **Amended** to clarify and link the agency's investigative authority under ORS 676.612 and OAR Chapter 331, Division 20, in the rules regulating the practice of denture technology.
Rules Coordinator: Patricia C. Allbritton

Address: Health Licensing Office, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Health Licensing Office,
Board of Cosmetology
Chapter 817

Stat. Auth.: ORS 676.612 & 690.167; Other Auth.: ORS 183
Stats. Implemented: ORS 676.612 & 690.167
Proposed Amendments: 817-080-0005
Last Date for Comment: 4-19-04
Summary: The above referenced rule is being re-filed to correct an error on a previous Notice of Rulemaking Hearing filed 02-13-04 and published in the Oregon Bulletin 03-01-04. This rule number was inadvertently listed in the 02-13-04 filing under the **Repeal** section, and was intended to be **Amended** to clarify and link the agency's investigative authority under ORS 676.612 and OAR Chapter 331, Division 20, in the rules regulating the practice of cosmetology.
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, Board of Cosmotology, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Health Licensing Office,
Board of Licensed Direct Entry Midwifery
Chapter 332

Date:	**Time:**	**Location:**
4-19-04	9 a.m.	700 Summer St. Suite 320 Salem, OR 97302

Hearing Officer: Bert Krages
Stat. Auth.: ORS 676.605, 676.615, 687.485 & OL 2003, Ch. 547; Other Auth.: ORS 183
Stats. Implemented: OL 2003, Ch. 547
Proposed Amendments: 332-015-0000, 332-015-0010, 332-015-0030, 332-015-0040, 332-015-0050, 332-015-0060, 332-015-0065, 332-015-0070, 332-020-0000, 332-020-0010, 332-020-0015, 332-020-0020, 332-025-0021, 332-025-0020, 332-025-0022, 332-025-0030, 332-025-0040, 332-025-0050, 332-030-0000
Proposed Repeals: 332-001-0000, 332-001-0005, 332-001-0010, 332-001-0020, 332-001-0030, 332-001-0040, 332-025-0000, 332-025-0010, 332-030-0010, 332-030-0020, 332-030-0030
Last Date for Comment: 4-19-04
Summary: Passage of HB 2325 by the 2003 Legislature completed the process of reorganizing oversight and centralizing service for 15 health and related professions, including the practice of direct entry midwifery. Rules are being amended to eliminate duplicative provisions in each of the programs rules — procedural rules, general administration, regulatory operations and licensing requirements. General amendments focus on adding provisions to link requirements between agency and program rules, improve readability of provisions, conform continuing education audit and sanction requirements with HLO business practices, and revises specific rule titles for uniformity with all programs under the agency's administration.

Fee reduction proposed to the licensing fee for initial, renewal and reactivation from $2000 to $1800. Program definitions, practice standards, including provisions for risk assessment criteria, standards of care and legend drugs and devices are being amended.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, Board of Licensed Direct Entry Midwifery, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

Health Licensing Office,
Sanitarians Registration Board
Chapter 338

Stat. Auth.: ORS 676.612 & 700.111; Other Auth.: ORS 183
Stats. Implemented: ORS 676.612 & 700.111
Proposed Amendments: 338-030-0020
Last Date for Comment: 4-19-04
Summary: The above referenced rule is being re-filed to correct an error on a previous Notice of Rulemaking Hearing filed 02-13-04 and published in the Oregon Bulletin 03-01-04. This rule number was inadvertently listed in the 02-13-04 filing under the **Repeal** section, and was intended to be **Amended** to clarify and link the agency's investigative authority under ORS 676.612 and OAR Chapter 331, Division 20, in the rules regulating the practice of environmental sanitation and waste water sanitation.
Rules Coordinator: Patricia C. Allbritton
Address: Health Licensing Office, Sanitarians Registration Board, 700 Summer St. NE, Ste. 320, Salem, OR 97301-1287
Telephone: (503) 378-8667, ext. 4322

• • • • • • • • • •

Oregon Board of Dentistry
Chapter 818

Date:	**Time:**	**Location:**
5-13-04	7 p.m.	OHSU School of Dentistry 611 SW Campus Dr. Rms. 220 & 225 Portland, OR

Hearing Officer: Board President or Designee
Stat. Auth.: ORS 679 & 680
Stats. Implemented: ORS 679.010, 679.020, 679.025, 679.040, 679.050, 679.060, 679.065, 679.070, 679.080, 679.090, 679.140, 679.250, 679.500, 680.040, 680.050, 680.060, 680.070, 680.072 & 680.200
Proposed Adoptions: 818-012-0110
Proposed Amendments: 818-012-0040, 818-012-0075, 818-021-0010, 818-021-0011, 818-021-0020, 818-021-0025, 818-035-0030, 818-035-0080, 818-042-0010, 818-042-0020, 818-042-0070, 818-042-0080
Last Date for Comment: 5-13-04
Summary: With the passage of Senate Bill 390, the Board is adopting 818-012-0110 Extension of Authority to Operate a Dental Practice to comply with Oregon Law.

The Board is amending 818-012-0040 Infection Control Guidelines as a result of the issuance by the United States Department of Health and Human Services Centers for Disease Control and Prevention "Guideline for Infection Control in Dental Health-Care Settings - 2003" to bring the Board's rules into conformity with these guidelines.

With the passage of Senate Bill 606, the Board is amending rule 818-012-0075 Administration of Local Anesthesia - Lip Color Procedures to bring the rules into compliance with Oregon Law.

The Board is amending 818-021-0010 Application for License to Practice Dentistry and 818-021-0020 Application for License to Practice Dental Hygiene to include the Canadian National Dental Examining Board Examination and the Canadian National Dental Hygiene Certificate Examination.

The Board is amending 818-021-0011 Application for License to Practice Dentistry Without Further Examination to allow an applicant who has completed a post doctoral General Residency Program to be eligible for a license.

The Board is amending 818-035-0030 Additional Functions of Dental Hygienists to eliminate a conflict in the Dental Hygiene rules regarding the administration of intravenous medication.

With the passage of House Bill 3157, the Board is amending rule 818-035-0080 Continuing Education to bring the rules into compliance with Oregon Law.

With the passage of House Bill 2240, the Board is amending rules 818-042-0010 Definitions, 818-042-0020 Dentist Responsibility, 818-021-0010 Application for License to Practice Dentistry, 818-021-0011 Application for License to Practice Dentistry Without Further Examination, 818-021-0020 Application for License to Practice Dental Hygiene, and 818-021-0025 Application for License to Practice Dental Hygiene Without Further Examination to bring the rules into compliance with Oregon Law.

The Board is amending 818-042-0080 Certification-Expanded Function Dental Assistant to add the words "or composite" to reflect the change in materials used in Dentistry today.

The Board is amending 818-042-0070 Expanded Functions Dental Assistants (EFDA) to expand what EFDAs would be allowed to do under the direction of a supervising dentist.

Copies of the full text of proposed changes can be found on the Board's website (www.oregondentistry.org) under *What's New* or by calling the Board of Dentistry at 503-229-5520.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Sharon Ingram
Address: Oregon Board of Dentistry, 1515 SW 5th Ave, Ste. 602, Portland, OR 97201
Telephone: (503) 229-5520

• • • • • • • • • •

Oregon Department of Education
Chapter 581

Date:	Time:	Location:
4-20-04	3 p.m.	Public Service Bldg. 255 Capitol St. NE Rm. 251-A Salem, OR

Hearing Officer: Mike Reed
Stat. Auth.: ORS 326.051
Stats. Implemented: ORS 326.051
Proposed Adoptions: 581-001-0120
Last Date for Comment: 4-20-04
Summary: This rule was developed to clearly outline and codify the process by which the Oregon Department of Education will solicit and award intergovernmental agreements to school districts, Education Service Districts, and community colleges.

If you have questions regarding this rule, please contact Bret West at (503) 378-3600, ext. 4446 or e-mail bret.west@state.or.us. For a copy of this rule, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Debby Ryan
Address: Oregon Department of Education, Public Service Bldg., 255 Capitol St. NE, Salem, OR 97310-0203
Telephone: (503) 378-3600, ext. 2348

• • • • • • • • • •

Date:	Time:	Location:
4-20-04	3 p.m.	Public Service Bldg. 255 Capitol St. NE Rm. 251-A Salem, OR

Hearing Officer: Mike Reed
Stat. Auth.: ORS 326.051
Stats. Implemented: ORS 326.051
Proposed Adoptions: 581-021-0110
Last Date for Comment: 4-20-04
Summary: The proposed rule would extend the requirement for districts to have policies establishing "zero-tolerance" for tobacco and tobacco products to include students, staff and visitors. The proposed rule would reduce student exposure to environmental tobacco smoke as well as reinforce a clear no use message to students by eliminating images of adults using tobacco on school grounds.

If you have questions regarding this rule, please contact Randy Harnisch at (503) 378-3600, ext. 2350 or e-mail randy.harnisch@state.or.us. For a copy of this rule, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Debby Ryan
Address: Oregon Department of Education, Public Service Bldg., 255 Capitol St. NE, Salem, OR 97310-0203
Telephone: (503) 378-3600, ext. 2348

• • • • • • • • • •

Date:	Time:	Location:
4-20-04	3 p.m.	Public Service Bldg. 255 Capitol St. NE Rm. 251-A Salem, OR

Hearing Officer: Mike Reed
Stat. Auth.: ORS 326.051 & 339.430
Stats. Implemented: ORS 339.430
Proposed Amendments: 581-021-0035
Last Date for Comment: 4-20-04
Summary: The language in the current rule is unclear as to the ability of the State Board of Education to hear appeals of decisions regarding eligibility from local school district boards. The amendments proposed here would make clear that the State Board's authority is limited to appeals of decisions of interscholastic activity organizations and does not extend to decisions of local school district boards.

For questions regarding this rule, please contact Randy Harnisch at (503) 378-3600, ext. 2350 or e-mail randy.harnisch@ state.or.us. For a copy of this rule, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Debby Ryan
Address: Oregon Department of Education, Public Service Bldg., 255 Capitol St. NE, Salem, OR 97310-0203
Telephone: (503) 378-3600, ext. 2348

• • • • • • • • • •

Oregon Forest Resources Institute
Chapter 628

Date:	Time:	Location:
4-23-04	9:15 a.m.	3rd Floor Conf. Rm. 625 SW Stark Portland, OR

Hearing Officer: Dennis Creel
Stat. Auth.: ORS 526.645(6)
Stats. Implemented: ORS 526.675
Proposed Adoptions: 628-010-0020
Last Date for Comment: 6-1-04
Summary: These rules implement legislation adopted in 2003 in response to recent federal court decisions involving mandatory assessments by agricultural commodity commissions. In some of these cases the courts have held that commodity commissions may not require growers to contribute to advertising, product promotion, and similar forms of speech. It is not clear that these cases apply to the Oregon Forest Resources Institute (OFRI), nor the information which it produces and distributes. Nevertheless, in order to reduce the likelihood of legal challenge, these rules permit tax payers who might disagree with OFRI's activities the opportunity to seek a refund of that portion of the Forest Products Harvest tax which supports OFRI's informational programs.

**Auxiliary aids for persons with disabilities are available upon advance request.*

Rules Coordinator: Kathy Robbins
Address: Oregon Forest Resources Institute, 317 SW Sixth Ave, Ste. 400, Portland, OR 97204
Telephone: (503) 229-6718, ext. 22

Oregon Liquor Control Commission
Chapter 845

Date:	Time:	Location:
4-27-04	10 a.m.-12 p.m.	9079 SE McLoughlin Blvd. Portland, OR 97222

Hearing Officer: Katie Hilton
Stat. Auth.: ORS 471, 471.030, 471.730(1)&(5)
Stats. Implemented: ORS 471.750(1)
Proposed Amendments: 845-015-0155
Last Date for Comment: 5-11-04
Summary: OAR 845-015-0155 currently prohibits consumption of alcoholic beverages in a retail liquor store. The Commission has received a request to amend the rule to allow tastings of distilled spirits in retail liquor stores. The proposed amendments would allow limited tastings (limited in size and number, hours). The proposed amendments are modeled on long-standing OLCC rules which allow tastings of malt beverages and wine in grocery-type stores.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Katie Hilton
Address: Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222-7355
Telephone: (503) 872-5004

. . . . . .

Oregon State Lottery
Chapter 177

Stat. Auth.: Oregon Constitution, Article XV, § 4(4), ORS 461
Stats. Implemented: ORS 461.200
Proposed Amendments: 177-099-0050
Last Date for Comment: 4-27-04
Summary: Effective February 23rd, 2004, the proposed amendment revises the Keno drawing interval from five to four minutes.
Rules Coordinator: Mark W. Hohlt
Address: Oregon State Lottery, 500 Airport Rd. SE, Salem, OR 97301
Telephone: (503) 540-1417

. . . . . .

Oregon Student Assistance Commission,
Office of Degree Authorization
Chapter 583

Date:	Time:	Location:
5-7-04	11 a.m.	1500 Valley River Dr. Suite 100 Eugene, OR 97401

Hearing Officer: Brian Clem, Commission Chair
Stat. Auth.: ORS 348.609
Stats. Implemented: 348.609
Proposed Amendments: 583-050-0031
Last Date for Comment: 5-7-04
Summary: Revises method and standards used to determine validity of unaccredited degrees.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Susan Taylor
Address: Student Assistance Commission, Office of Degree Authorization, 1500 Valley River Dr. #100, Eugene, OR 97401
Telephone: (541) 687-7443

. . . . . .

Oregon University System
Chapter 580

Date:	Time:	Location:
5-11-04	10-11 a.m.	Rm. 358 SCH 1431 Johnson Ln. Eugene, OR

Hearing Officer: Nancy Heiligman, AVC, BAM
Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070
Proposed Amendments: 580-040-0040
Last Date for Comment: 5-12-04
Summary: To establish tuition and fees for the 2004-05 Academic Year, including room and board rates.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Marcia M. Stuart
Address: Oregon University System, PO Box 3175, Eugene, OR 97403-0175
Telephone: (541) 346-5795

. . . . . .

Oregon University System,
University of Oregon
Chapter 571

Date:	Time:	Location:
4-20-04	3:30 p.m.	Rogue Rm. Erb Memorial Union, UO Eugene, OR
4-23-04	12 p.m.	Walnut Rm. Erb Memorial Union, UO Eugene, OR

Hearing Officer: Deb Eldredge
Stat. Auth.: ORS 351.070 & 352; Other Auth.: OAR 581-013-0005 et. seq
Stats. Implemented: 351.070
Proposed Amendments: 571-020-0120, 571-020-0180
Last Date for Comment: 4-23-04, 5 p.m.
Summary: Amends current rule to include protocol for law enforcement subpoenas which requires review by General Counsel's Office prior to release of student records.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Deb Eldredge
Address: Oregon University System, University of Oregon, 1226 President's Office, Eugene, OR 97403-1226
Telephone: (541) 346-3082

. . . . . .

Date:	Time:	Location:
4-23-04	2:30 p.m.	Alsea/Coquille Rms. Erb Memorial Union, UO Eugene, OR
4-29-04	12 p.m.	Alsea/Coquille Rooms Erb Memorial Union, UO Eugene, OR

Hearing Officer: Deb Eldredge
Stat. Auth.: ORS 351.070 & 325.010; Other Auth.: OAR 580-012-0010 State Board of Higher Education Internal Management Directive 1.130
Stats. Implemented: ORS 351.070 & 352.010
Proposed Amendments: 571-021-0005, 571-021-0015, 571-021-0019
Last Date for Comment: 4-29-04, 5 p.m.
Summary: 571-021-0005 - establishes the educational nature of the Student Conduct Code and its goal to create an environment conducive to learning.

571-021-0015 - describes when and where the Student Conduct Code will be applied.

571-021-0019 - establishes authority of Student Conduct Committee and authority to sub-delegate hearing authority.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Deb Eldredge
Address: Oregon University System, University of Oregon, 1226 President's Office, Eugene, OR 97403-1226
Telephone: (541) 346-3082

Oregon Youth Authority
Chapter 416

Stat. Auth.: ORS 420A.025
Stats. Implemented:
Proposed Repeals: 416-030-0000, 416-030-0010, 416-030-0020, 416-030-0030, 416-030-0040, 416-030-0050, 416-030-0060, 416-030-0070, 416-030-0080, 416-030-0090, 416-030-0100, 416-030-0110
Last Date for Comment: 5-3-04
Summary: This rule is being repealed because it is no longer relevant and the Agency uses other avenues to receive input from local partners and community members. Interested persons may request a copy of the current rule from Kimberly Walker, OYA Rules/Policy Coordinator, 530 Center Street, Suite 200, Salem, OR 97301; 503-378-3864.
Rules Coordinator: Kimberly Walker
Address: Oregon Youth Authority, 530 Center St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 378-3864

• • • • • • • • • •

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS Ch. 192 & 419A.255
Proposed Adoptions: 416-105-0000, 416-105-0010, 416-105-0020, 416-105-0030, 416-105-0040
Last Date for Comment: 5-3-04
Summary: This is an amended notice incorporating language as required in ORS 183.335. The intent of adopting this rule remains the same as that set out in the Notice of December 19, 2003 and published in the Oregon Bulletin in February 2004. Interested persons may request a copy of the proposed rule from Kimberly Walker, OYA Rules/Policy Coordinator, 530 Center Street, Suite 200, Salem, OR 97301; 503-378-3864.
Rules Coordinator: Kimberly Walker
Address: Oregon Youth Authority, 530 Center St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 378-3864

• • • • • • • • • •

Stat. Auth.: ORS 420A.025
Stats. Implemented:
Proposed Repeals: 416-110-0000, 416-110-0010, 416-110-0020, 416-110-0030
Last Date for Comment: 5-3-04
Summary: This is an amended notice. The intent of repealing this rule as noticed on December 19, 2003 remains the same. The language required in ORS 183.335 has been added to this notice. This rule is being repealed in its entirety. The language will be adopted in a new division number. The OYA is aligning its rules to more closely follow its policies and procedures. Interested persons may request a copy of the current rule from Kimberly Walker, OYA Rules/Policy Coordinator, 530 Center Street, Suite 200, Salem, OR 97301; 503-378-3864.
Rules Coordinator: Kimberly Walker
Address: Oregon Youth Authority, 530 Center St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 378-3864

• • • • • • • • • •

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 131.040, 420.014 & 420A.010
Proposed Adoptions: 416-150-0040, 416-150-0050
Proposed Amendments: 416-150-0000, 416-150-0010, 416-150-0020, 416-150-0030
Last Date for Comment: 5-3-04
Summary: This rule is being amended to re-name the title of the rule, address law enforcement interrogation or polygraph, incorporate and amend OAR 416-440-0010 and OAR 416-440-0030 which are concurrently being repealed at this time. Interested persons may request a copy of the current rule from Kimberly Walker, OYA Rules/Policy Coordinator, 530 Center Street, Suite 200, Salem, OR 97301; 503-378-3864
Rules Coordinator: Kimberly Walker
Address: Oregon Youth Authority, 530 Center St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 378-3864

• • • • • • • • • •

Stat. Auth.: ORS 420A.025
Stats. Implemented: ORS 420A.223
Proposed Amendments: 416-180-0000, 416-180-0010, 416-180-0020, 416-180-0030, 416-180-0040, 416-180-0050
Last Date for Comment: 5-3-04
Summary: This Division is being amended to revise the project vision, refine the steering committee participants' list, delineate the JJIS policy review process, and clarify personal use of JJIS. Interested persons may request a copy of the current rule from Kimberly Walker, OYA Rules/Policy Coordinator, 530 Center Street, Suite 200, Salem, OR 97301; 503-378-3864.
Rules Coordinator: Kimberly Walker
Address: Oregon Youth Authority, 530 Center St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 378-3864

• • • • • • • • • •

Stat. Auth.: ORS 420A.025
Stats. Implemented:
Proposed Repeals: 416-440-0010, 416-440-0030
Last Date for Comment: 5-3-04
Summary: These rules are being repealed and will be incorporated in an amended Division 150. Division 150 is being concurrently amended at this time. Interested persons may request a copy of the current rule from Kimberly Walker, OYA Rules/Policy Coordinator, 530 Center Street, Suite 200, Salem, OR 97301; 503-378-3864.
Rules Coordinator: Kimberly Walker
Address: Oregon Youth Authority, 530 Center St. NE, Suite 200, Salem, OR 97301
Telephone: (503) 378-3864

• • • • • • • • • •

Parks and Recreation Department
Chapter 736

Stat. Auth.: ORS 390.121 & 390.117
Stats. Implemented:
Proposed Adoptions: 736-019-0000, 736-019-0020, 736-019-0040, 736-019-0060, 736-019-0080, 736-019-0100, 736-019-0120
Last Date for Comment: 4-30-04
Summary: The proposed rule will set forth the scope and purpose, definitions, policy, criteria for acquisition, sources of funding, acquisition practices and use of third parties in connection with the Department's land acquisition and land exchange transactions.
Rules Coordinator: Angie Springer
Address: Parks and Recreation Department, 725 Summer St. NE, Ste. C, Salem, OR 97301-1002
Telephone: (503) 986-0719

• • • • • • • • • •

Stat. Auth.: ORS 390.124
Stats. Implemented: ORS 390.010 & 390.117
Proposed Amendments: 736-100-0010, 736-100-0020, 736-100-0030, 736-100-0040, 736-100-0050, 736-100-0060, 736-100-0070, 736-100-0080
Last Date for Comment: 4-22-04
Summary: These eight rules set the Department's overall goals and guiding principles, covering recreation, heritage resources, natural resource management and financial principles.
Rules Coordinator: Angie Springer

Address: Parks and Recreation Department, 725 Summer St. NE, Ste. C, Salem, OR 97301-1002
Telephone: (503) 986-0719

• • • • • • • • • •

Real Estate Agency
Chapter 863

Stat. Auth.: ORS 185.335 & 696.385
Stats. Implemented: ORS 696.020, 696.022, 696.026, 696.174, 696.255, 696.265, 696.301, 696.527, 696.445(4)
Proposed Amendments: 863-001-0007, 863-015-0015, 863-015-0020, 863-015-0025, 863-015-0050, 863-015-0055, 863-015-0065, 863-015-0080, 863-015-0085, 863-015-0180, 863-015-0200
Proposed Repeals: 863-015-0270
Last Date for Comment: 4-22-04
Summary: OAR 863-015-0015, 863-015-0055 and 863-015-0200 were previously amended by temporary rule. This notice includes the permanent amendment of those rules. The proposed changes to the remaining rules are required to fix inconsistencies within the rules promulgated subsequent to the passage of Senate Bill 206 and are necessary to further implement the policies and procedures contemplated by the legislation.
Rules Coordinator: Brian DeMarco
Address: Real Estate Agency, 1177 Center St. NE, Salem, OR 97301-2505
Telephone: (503) 378-4170, ext. 237

• • • • • • • • • •

Stat. Auth.: ORS 185.335, 696.385, 696.578, 696.541 & 696.581
Stats. Implemented: ORS 696.527, 696.535(1), 696.581, OL 2003 Ch. 427, Sec. 3 & 696.527 (2003 OL Ch. 427, Sec. 8, (4)(b))
Proposed Adoptions: 863-050-0035
Proposed Amendments: 863-050-0020, 863-050-0115
Last Date for Comment: 4-22-04
Summary: OAR 863-050-0035 was previously adopted by temporary rule effective January 14, 2004. This notice includes the permanent adoption of that rule. OAR 863-050-0020 and 863-050-0115 are being amended to fix inconsistencies within those rules, which were promulgated subsequent to the passage of Senate Bill 207 and the amendments are necessary to further implement the policies and procedures contemplated by the legislation.
Rules Coordinator: Brian DeMarco
Address: Real Estate Agency, 1177 Center St. NE, Salem, OR 97301-2505
Telephone: (503) 378-4170, ext. 237

• • • • • • • • • •

Secretary of State,
Corporation Division
Chapter 160

Stat. Auth.: ORS 56, 58, 60, 62, 63, 65, 68, 70, 128, 183, 554, 647 & 183
Stats. Implemented: ORS 183.335 & 183.341
Proposed Amendments: 160-001-0000, 160-001-0005
Last Date for Comment: 4-22-04
Summary: The amendment to OAR 160-001-0000 directs the Secretary of State to give Notice of Intent to Adopt, Amend or Repeal any permanent rules 21 days prior to the effective date.

The amendment to 160-001-0005 states the Corporate Division of the Secretary of State will adopt the January 1, 2004 version of the Model Rules of Procedure as the Division's rules of procedure.
Rules Coordinator: Thomas E. Wrosch
Address: Secretary of State, Corporation Division, 136 State Capitol, Salem, OR 97301
Telephone: (503) 986-1522

Teacher Standards and Practices Commission
Chapter 584

Date:	Time:	Location:
5-6-04	3 p.m.	George Fox University 12753 SW 68th Ave. Portland, OR 97223

Hearing Officer: Cathy Gwinn, TSPC Chair
Stat. Auth.: ORS 342.165
Stats. Implemented: ORS 181.525, 342.120 - 342.200, 342.223 - 342.232, 342.400 & 342.985
Proposed Amendments: 584-017-0185, 584-036-0062, 584-060-0171, 584-070-0011
Last Date for Comment: 5-6-04
Summary: 1. Amends teacher work sample requirements to include differentiation of instruction.

2. Clarifies fingerprint check requirement as part of criminal background check.

3. Removes requirement of passing the Basic Skills Test for renewal of the Limited Teaching License.

4. Allows alternative route to obtain Initial School Counselor License.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Victoria Chamberlain
Address: Teacher Standards and Practices Commission, 465 Commercial St. NE, Salem, OR 97301
Telephone: (503) 378-6813

• • • • • • • • • •

Date:	Time:	Location:
5-6-04	3 p.m.	George Fox University 12753 SW 68th Ave. Portland, OR 97223
7-28-04	9 a.m.	Southern Oregon University 1250 Siskiyou Blvd. Ashland, OR 97520

Hearing Officer: Cathy Gwinn, TSPC Chair
Stat. Auth.: ORS 342.165
Stats. Implemented: ORS 342.120 - 342.143, 342.147, 342.165 & 342.223 - 342.232
Proposed Adoptions: 584-065-0060
Proposed Amendments: 584-010-0020
Last Date for Comment: 7-28-04
Summary: 1. Establish teacher competencies for Middle-Level and High School Mathematics License Endorsements.

2. Allows the participation of Commissioners on site visit review teams so long as the Commissioner only vote during final approval of any site visit report in which the Commissioner participated.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Victoria Chamberlain
Address: Teacher Standards and Practices Commission, 465 Commercial St. NE, Salem, OR 97301
Telephone: (503) 378-6813

• • • • • • • • • •

Water Resources Department
Chapter 690

Date:	Time:	Location:
4-20-04	12-1 p.m. & 6-7 p.m.	Dept. of Water Resources Conference Rm. 124 725 Summer St. NE, Ste. A Salem, OR 97301

Hearing Officer: Gerry Clark
Stat. Auth.: ORS 536.027
Stats. Implemented: ORS 537.797 & 537.799
Proposed Amendments: 690-014-0005, 690-014-0020, 690-014-0030, 690-014-0050, 690-014-0080, 690-014-0100, 690-014-0170, 690-014-0190, 690-014-0220

Proposed Ren. & Amends: 690-014-0150 to 690-014-0090, 690-014-0200 to 690-014-0110
Last Date for Comment: 4-23-04
Summary: The Water Resources Department is initiating a public rulemaking proposing to amend rules under OAR Chapter 690, Division 14 regarding the certification of Water Right Examiners and the criteria and standards for conducting surveys to describe the extent of beneficial use under a water appropriation. Final proposed rules must be adopted by the Water Resources Commission. The Commission's current Division 14 rules were adopted in 1988 and have not been updated since that time.

The proposed modifications seek to update and clarify the current rules and address a number of general housekeeping issues. Some of the specific proposed amendments are as follows: update statutory and rule references; add registered geologists to the list of individuals qualified to become a Certified Water Right Examiner as provided for in ORS 537.797; modify various definitions; clarify the information required in the Claim of Beneficial Use report; require additional information in the Claim of Beneficial Use report for certain reservoirs; establish a provision for waivers of reporting and mapping standards; establish a requirement that the Claim of Beneficial Use map indicate the location of fish screens, by-pass devices, and meters if required; establish a mapping standard for municipal Claim of Beneficial Use maps; and correct various clerical errors.
**Auxiliary aids for persons with disabilities are available upon advance request.*
Rules Coordinator: Adam Sussman
Address: Water Resources Department, 725 Summer St. NE, Ste. A, Salem, OR 97301
Telephone: (503) 986-0877

Board of Accountancy
Chapter 801

Adm. Order No.: BOA 1-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04 thru 7-1-04
Notice Publication Date:
Rules Amended: 801-010-0050
Subject: The amendment permits the Board of Accountancy to allow candidates who apply for the computer-based Uniform CPA Exam an opportunity to voluntarily disclose their social security number to the Board, and for the Board to transfer the number to the Examination Contractor for candidate identification. The temporary rule does not REQUIRE candidates to provide a social security number.
Rules Coordinator: Kimberly Bennett—(503) 378-4181, ext. 24

801-010-0050
Application for Uniform CPA Examination

(1) Definitions

(a) **Authorization to Test (ATT)**: Issued by the Board of Accountancy to eligible exam candidates to authorize the candidate to test for specified sections of the CPA exam. The ATT may be issued for one or more CPA exam sections. Each ATT authorizes the candidate to take each CPA exam section designated in the ATT one time only. The ATT may become expired as to one exam section named in the ATT, and remain valid as to other specified exam sections. The candidate must submit a Re-examination Application and re-examination fee to the Board of Accountancy for any exam section that is expired under the ATT or to retake any section of the CPA Exam not passed.

(b) **Notice to Schedule (NTS)**: Issued by NASBA and enables the candidate to schedule testing at an examination test center. The NTS shall remain open until the candidate schedules testing or until six months have elapsed since the NTS was issued, whichever occurs first.

(c) **Testing Center**: Computer testing facilities, approved by the Board and listed on the Board website, at which candidates may take the CPA examination. Testing centers are located throughout the United States, Guam, Puerto Rico and the Virgin Islands.

(d) **Testing Opportunity**: Each testing window is considered a testing opportunity. There are four testing opportunities per year. A candidate may test for a particular section only once per testing window. A candidate may not retake a failed test section(s) in the same testing window.

(e) **Testing Windows**: A three-month period in which candidates have an opportunity to take the CPA exam. The testing window is comprised of two months in which the examination is available to be taken and one month in which the examination will not be offered so that maintenance may be performed.

(2) **Applications**.

(a) Applications for the CPA exam shall be submitted on a form provided by the Board and shall be accompanied by the appropriate fee. The act of filing an application for the CPA exam constitutes an agreement by the candidate to observe and comply with the CPA Exam rules adopted by the Board.

(b) An application will not be reviewed until the application fee and all required supporting documents have been received, including proof of identity (as determined by the Board and specified on the application form), official transcripts and evidence that the candidate has met eligibility requirements.

(c) All foreign academic credentials submitted as evidence of eligibility for the CPA exam are required to be evaluated by a credentialing agency that is a member of the National Association of Credential Evaluation Services, Inc. (NACES);

(d) Candidates shall file an initial application when applying to take the CPA exam for the first time in Oregon. Thereafter candidates shall file a re-examination application. Each application filed shall specify the exam sections to be taken under that application.

(e) Candidates shall pay the CPA exam application fee designated in OAR 801-010-0010 to the Board. All other fees associated with the CPA exam are required to be paid to NASBA. All CPA exam fees are non-refundable. If a candidate fails to appear for a scheduled testing at an approved test center, all fees paid will be forfeited for the examinations scheduled on that day,

(f) At the time of application and during the time any ATT issued by the Oregon Board of Accountancy is open, the candidate shall not have an open ATT for the same section in any other state or jurisdiction.

(g) The candidate shall certify at the time of application that he or she is in compliance with subsection (f) of this rule. Falsifying this certification or including any false, fraudulent, or materially misleading statements on the application for the examination, or including any material omission on the application for the examination shall be cause for disciplinary action under ORS 673.170.

(h) When an application is approved, the Board or its designee will forward authorization to test (ATT) for the computer-based CPA exam to the candidate and to the NASBA National Candidate Database.

(i) The Board will offer a candidate the opportunity to voluntarily disclose the candidate's social security number to the Board so that the Board may provide the social security number to NASBA for identification purposes.

(3) **Eligibility under education requirements**. Candidates for admission to the CPA exam after January 1, 2000 who are applying under the educational requirements of ORS 673.050(1)(a) shall demonstrate eligibility as follows:

(a) **150 Hour rule**: Candidates shall present satisfactory evidence that the candidate has successfully completed 150 semester hours or 225 quarter hours, including:

(A) A baccalaureate or higher degree from an accredited college or university as described in ORS 673.050(1)(a);

(B) A minimum of 24 semester hours or 36 quarter hours, or the equivalent thereof, in the study of accounting; and

(C) A minimum of 24 semester hours or 36 quarter hours in accounting or related subjects. Related subjects are defined as business, finance, economics, and written and oral communication.

(D) The required number of hours in accounting or related subjects may be obtained by satisfactory completion of such hours taken from divisions of continuing education extended by an accredited four-year college or university, or from a community college, providing the community college courses are transferable as equivalent courses to an accredited four-year college or university.

(E) Credit for community college courses. Applicants who have earned a baccalaureate or higher degree from an accredited college or university may obtain additional hours from a community college, if such hours would be transferable to an accredited college or university. However, completion of 150 hours consisting entirely of courses taken from a community college or divisions of continuing education shall not be considered equivalent to a baccalaureate or higher degree from a four-year accredited college or university under the requirements of ORS 673.050.

(b) **Candidates who applied before January 1, 2000**: Returning candidates after January 1, 2000 who do not meet the educational requirement under ORS 673.050(1)(a) are required to sit for at least one section of the CPA exam in any two testing windows per year in order to maintain eligibility under the requirements of ORS 673.050 that were in effect prior to January 1, 2000. Returning candidates shall provide satisfactory evidence that:

(A) The candidate met CPA exam eligibility requirements that were in effect in Oregon at the time the candidate sat for the CPA exam for the first time in any jurisdiction; and

(B) The candidate sat for and received grades for at least one of the Uniform CPA Examinations in any jurisdiction in 1998 or 1999.

(c) **Evidence of eligibility**. Candidates must meet all requirements under this rule at the time of application. Satisfactory evidence of the educational requirement may be provided in the following manner:

(A) Candidates who have completed all course requirements and been awarded a baccalaureate or higher degree shall provide an official transcript(s) demonstrating successful completion of all courses required under these rules, and that a degree was awarded.

(B) Candidates who have completed all course requirements at the time of application, but for whom a baccalaureate degree has not yet been awarded shall provide an official transcript(s) showing successful completion of all courses required under these rules, together with a letter from the Registrar's Office of the college or university stating that the candidate has met the degree requirements and the date that the degree will be awarded.

(C) Only official transcripts that are forwarded directly to the Board office by the issuing college or university will be accepted. All transcripts must be received in the Board office 14 days prior to the date of the CPA exam.

(D) Only colleges or universities accredited by one of the six regional accrediting associations and listed as accredited in the Directory of Post secondary Institutions published by the National Center for Education Statistics, shall be recognized by the Board.

(4) **Eligibility under experience standards**. Candidates for the CPA exam who are applying under the experience requirements of ORS 673.050(2) to be licensed as a Public Accountant shall submit satisfactory evidence that:

(a) The candidate graduated from a high school with a four-year program, or the equivalent; and

(b) The candidate completed two years of experience in public accountancy or the equivalent satisfactory to the Board.

(c) Returning candidates after January 1, 2002 who were eligible to take two sections of the CPA Exam under provisions of ORS 673.100 in effect prior to January 1, 2002, are required to sit for at least one exam section in any two testing windows each year in order to maintain eligibility under those requirements.

(5) **Authorization to Test and Notice to Schedule**.

(a) An ATT authorizes the candidate to test one time for those sections of the CPA Exam that are specified in the ATT. An ATT is effective for six months from the date on which the corresponding NTS is issued or until the NTS expires, whichever occurs first; however, the ATT will expire ninety (90) days after it is issued if the candidate has not requested an NTS and paid the appropriate fees to NASBA.

(b) **Expiration of the ATT**. Authorization to take a specified exam section will expire on any of the following events:

(A) When the candidate schedules and takes a designated exam section;

(B) If the candidate schedules a testing date for a designated exam section but fails to appear and take the section at the scheduled time;

(C) If the candidate fails to schedule a designated exam section within the six-month period defined by the NTS; or

(D) If the candidate fails to request an NTS and pay the appropriate fees to NASBA within 90 days of the date the ATT is issued.

(c) **Suspension of the ATT**. An ATT may be suspended by the Board of Accountancy based on a report from NASBA that a problem related to the candidate is identified on the National Candidate Database, or for other good cause as determined by the Board.

(d) Payment of CPA Exam testing fees. To obtain a Notice to Schedule (NTS), the candidate must remit the CPA Exam testing fees required for the CPA exam sections specified in the ATT to NASBA within ninety (90) days from the date the ATT is issued. Failure to remit the required fees and obtain the NTS will cause the ATT to expire, and the candidate must submit a re-examination application to the Board, with the appropriate CPA Exam Fee, to receive another ATT.

(e) **NTS**. When the candidate receives an ATT from the Board, the candidate is required to:

(A) Contact NASBA to request the NTS;

(B) Submit to NASBA payment of all fees related to testing of the CPA Exam sections authorized by the ATT;

(C) Upon receipt of the NTS, contact an approved test center to schedule the time and place for testing of the exam sections authorized by the ATT. CPA Exam sections do not have to be scheduled on the same date.

(D) The NTS remains valid for each exam section until the candidate schedules testing for that specific section, or for six months from the date the NTS was issued, whichever occurs first.

(E) The NTS expires as to each individual exam section when the candidate schedules testing for that section, whether or not the candidate appears at the scheduled testing appointment.

(f) **Testing**.

(A) A candidate may schedule testing at an approved testing center in Oregon or in another jurisdiction. A list of approved testing centers is on the Board of Accountancy website.

(B) Candidates must comply with the procedures and rules of the test center.

(g) **Re-examination**. A Re-examination Application and payment of the appropriate fee to the Board of Accountancy is required:

(A) To retake any exam section that the candidate does not pass;

(B) To obtain an NTS for any exam section that the candidate failed to schedule during the six month period for which a previous NTS was issued;

(C) To obtain an NTS for any exam section for which the candidate failed to obtain an NTS during the ninety (90) day period after the date the ATT was issued.

Stat. Auth.: ORS 670.310, ORS 673.050, ORS 673.100

Stat. Implemented: ORS 673.050, ORS 673.100, ORS 673.410

Hist.: 1AB 10, f. 2-7-63; 1AB 14, f. 8-15-68; 1AB 20, f. 10-22-71, ef. 11-15-71; 1AB 34, f. 1-29-74, ef. 2-25-74; 1AB 41, f. & ef. 12-2-76; 1AB 44, f. & ef. 3-31-77; 1AB 48, f. & ef. 7-21-77; 1AB 6-1978, f. & ef. 6-22-78; 1AB 7-1981, f. & ef. 7-27-81; 1AB 2-1983, f. & ef. 9-20-83; AB 3-1988, f. & cert. ef. 6-9-88; AB 2-1989, f. & cert. ef. 1-25-89; AB 4-1991, f. & cert. ef. 7-1-91; AB 4-1994, f. & cert. ef. 9-27-94; AB 1-1995, f. & cert. ef. 1-25-95; AB 5-1995, f. & cert. ef. 8-22-95; AB 1-1996, f. & cert. ef. 1-29-96; AB 1-1997, f. & cert. ef. 1-28-97; BOA 5-1998, f. & cert. ef. 7-9-98; BOA 6-1998, f. & cert. ef. 7-29-98; BOA 7-1998(Temp), f. & cert. 7-29-98 thru 1-25-99; BOA 8-1998, f. & cert. ef. 10-22-98; BOA 4-1999, f. & cert. ef. 7-23-99; BOA 6-1999, f. 12-21-99, cert. ef. 1-1-00; BOA 4-2001, f. 12-28-01, cert. ef. 1-1-02; BOA 3-2002, f. 12-27-02, cert. ef. 1-1-03; BOA 4-2003, f. 12-23-03 cert. ef. 1-1-04; BOA 1-2004(Temp), f. & cert. ef. 3-15-04 thru 7-1-04

• • • • • • • • • •

Board of Architect Examiners
Chapter 806

Adm. Order No.: BAE 2-2004
Filed with Sec. of State: 3-2-2004
Certified to be Effective: 3-2-04
Notice Publication Date: 1-1-04
Rules Adopted: 806-010-0037
Rules Amended: 806-010-0035, 806-010-0060
Subject: This simplifies the requirements for reinstatement to active status by those who have remained in an inactive status for over five years. This amendment also reduces the fees associated with reinstatement for this same group. In addition, passage of SB934 during the 2003 Legislative Assembly session made housekeeping changes to the Board's laws which are reflected in these rule changes, including the use of two new titles as part of those housekeeping changes.
Rules Coordinator: Carol Halford—(503) 763-0662

806-010-0035
Reciprocal Transfer

(1) Any registered or certified architect from another state or a territory, or Canadian Province who desires registration to practice in Oregon, must furnish, with an Oregon Board application, a National Council of Architectural Registration Boards' (NCARB) Blue Cover to aid the Board in determining the applicant's qualifications. In addition, the applicant must provide all of the following:

(a) If an architect has not been examined for seismic and lateral forces knowledge through successful completion of an NCARB examination in 1965 or later, the architect must then provide evidence of successfully completing the NCARB Division LF Lateral Forces examination.

(b) Verification of two years of practice in architecture after initial registration or proof of completion of the NCARB/IDP training requirements.

(c) The reciprocal application fee (See Schedule of Actual Fees, OAR 806-010-0105).

(2) **Jurisprudence Examination**: After the candidate has completed the application process, the candidate shall sit for and pass the Oregon Board of Architect Examiners examination based on the Oregon Statues and the Oregon Administrative rules governing the practice of architecture prior to appearing before the Board for Oral Interview.

(a) The examination shall be administered in the same city and on the same day as the Board Meeting, successful candidates will appear before the Board for their Oral Interview that same day.

(b) Unsuccessful candidates will not be allowed any opportunity to review or challenge test results and will be required to reschedule the examination no sooner than the next regularly scheduled board meeting.

(c) The examination will be scheduled for 60 minutes in length, a passing score of 84 percent is minimum acceptable and candidates are allowed to have copies of the Statutes and Rules during the examination.

(3) Oral Interview: Prior to registration, each applicant for registration by examination shall appear before the Board for an Oral Interview. The Oral Interview will be held after the applicant has successfully completed the Architectural Registration Examination (A.R.E.) and the Jurisprudence Examination.

(4) **Registration**: Upon successful completion of the requirements of this section and upon payment of the registration fee, the Board may grant a certificate of registration by reciprocity.

(5)(a) Reciprocity applicants may use the "Architect" title only under the conditions outlined in OAR 806-010-0037 and ORS 671.065.

(b) Reciprocity candidates may not practice architecture in Oregon until such time as Oregon registration is granted by the Oregon Board.

Stat. Auth.: ORS 671.125

Stats. Implemented: ORS 671.050 & 671.065

Hist.: AE 5, f. 12-22-64; AE 11, f. 2-15-74, ef. 3-11-74; AE 1-1978, f. & ef. 1-23-78; AE 1-1979, f. 5-31-79, ef. 6-1-79; AE 2-1980, f. & ef. 10-3-80; AE 1-1984, f. & ef. 8-22-84; AE 1-1987, f. & ef. 3-30-87; AE 1-1988, f. & cert. ef. 3-14-88; AE 1-1992, f. 1-9-92, cert. ef. 1-10-92; AE 3-1992, f. & cert. ef. 6-30-92; AE 1-1996, f. 1-23-96, cert. ef. 2-1-96; AE 2-1997, f. & cert. ef. 9-24-97; BAE 2-1998, f. & cert. ef. 6-22-98; BAE 1-1999, f. & cert. ef. 3-25-99; BAE 3-2000, f. & cert. ef. 7-24-00; BAE 5-2002, f. 8-14-02 cert. ef. 8-15-02; BAE 4-2003, f. 8-13-03, cert. ef. 8-14-03; BAE 2-2004, f. & cert. ef. 3-2-04

805-010-0037
Architect Title

The title of "Architect" is a protected title and may be used only by certain qualified individuals and businesses, as follows:

(1) Those individuals who have been notified by the Board that they have qualified as an Oregon architect and have received a certificate of registration by the Board.

(2) Individuals may use the title of "Consulting Architect" only as prescribed by ORS 671.010 and 671.020(2).

(3) Individuals may use the title of "Foreign Architect" only as prescribed by ORS 671.010 and 671.020(2).

(4) Those individuals who have submitted an application to the Oregon Board for consideration as Oregon architects by reciprocity under OAR 806-010-0035 (applicants) are entitled to use the title "Architect" under certain conditions. Applicants may not practice architecture until such time as an active Oregon architect registration is granted. Applicants may use the title "Architect", along with the name of the state in which the individual holds an active architect license (for example; "John Smith, CA Architect"), but only after all of the following have been completed:

(a) The Board receives a completed reciprocity application;

(b) The Board receives all the required fees from the applicant;

(c) The Board receives a written notice from the applicant of the applicant's intent to offer architectural services in Oregon; and

(d) The prospective client(s) has been advised, in writing, by the applicant that the applicant may not commence the project until Oregon registration is granted.

(5) Firms registered with the Board under OAR 806-010-0080 and 806-010-0110 as providing architectural services in Oregon must use a derivative of the architect title within the firm name to identify the firm appropriately, according to OAR 806-010-0110.

(6) Except as provided in this rule, no title, sign, cards, or device may be used to indicate or tend to indicate that the person or firm or business using the title is practicing architecture or is an architect, or represents in any manner that the person or firm or business is an architect or architectural practice.

(7) For purposes of this rule and OAR 806-010-0035(5), the phrase "offering to render architectural services" includes to solicit for an architectural project in Oregon.

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.050, 671.065, 671.080, 671.085
Hist.: BAE 2-2004, f. & cert. ef. 3-2-04

806-010-0060
Abandonment and Reinstatement of Practice

(1) **Inactive Status**. Unless otherwise provided by the Board, a licensee's certificate becomes inactive on the 61st day following the certification expiration date if registrant fails to meet renewal requirements as designated by statute or rule (including, but not limited to, failure to comply with the continuing professional education (CPE) program or failure to pay renewal fees or accrued penalties). A registrant may also request inactive status prior to the 61st day following the certification expiration date. An inactive Oregon certificate prohibits an architect from practicing architecture in Oregon, as defined by statute and rule. An inactive Oregon certificate also prohibits use of the architect title in Oregon, as defined by statute and rule.

(2) The Board may reinstate an inactive licensee's certificate to practice architecture to active status from inactive status as provided in this rule.

(a) **Inactive for less than or equal to five years**. An inactive licensee whose certificate has been inactive in Oregon for less than, or equal to, five years may gain reinstatement to active status only after:

(A) Filing an application for reinstatement,

(B) Demonstrating current professional proficiency, as outlined under subsection (3) of this rule, and

(C) Paying the reinstatement fee (See Schedule of Actual Fees, OAR 806-010-0105).

(b) Inactive over five years. An individual who held a previously active license in Oregon whose license has been inactive for greater than five years, may gain reinstatement to active status only after:

(A) Filing a current reinstatement application,

(B) Payment of the reinstatement fee and the registration fee (See Schedule of Actual Fees, OAR 806-010-0105),

(C) Demonstration of current professional proficiency, as outlined under subsection (3) of this rule,

(D) Providing verification of meeting the National Council of Architect Registration Board (NCARB)'s seismic requirements, or the equivalent, as determined by this Board; and

(E) Passing a jurisprudence examination and oral interview by the Board.

(c) "**Architect Emeritus**". An Architect Emeritus seeking reinstatement of his or her Oregon registration that became inactive as an "Architect Emeritus" may gain reinstatement as follows:

(A) An Architect Emeritus in that status **for equal to or less than five years** may gain reinstatement to active status, at the discretion of the Board, only upon:

(i) Filing a reinstatement application;

(ii) Demonstration of current professional proficiency, as outlined in subsection (3) of this rule; and

(iii) Payment of the reinstatement fee.

(B) An Architect Emeritus in that status for **greater than five years** may gain reinstatement to active status only upon meeting the requirements listed in OAR 806-010-0060(2)(b).

(3) "**Current Professional Proficiency**". For purposes of this rule, current professional proficiency may be established by any one of the following:

(a) Submitting to the Board verifiable evidence of compliance with the aggregate continuing professional education (CPE) requirements for the reporting periods that the certificate was inactive in Oregon,

(b) Residents of another jurisdiction recognized by this Board that have a mandatory CPE requirement may submit a copy of the certificate of architect registration, or equivalent documentation, covering the inactive period that demonstrates substantial compliance with Oregon's CPE requirements,

(c) Satisfying the requirements of OAR 806-010-0020 or 806-010-0035.

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.080
Hist.: AE 5, f. 12-22-64; AE 2-1978, f. & ef. 3-6-78; AE 1-1979, f. 5-31-79, ef. 6-1-79; AE 2-1980, f. & ef. 10-3-80; AE 1-1987, f. & ef. 3-30-87; AE 1-1996, f. 1-23-96, cert. ef. 2-1-96; AE 2-1997, f. & cert. ef. 9-24-97; BAE 1-1999, f. & cert. ef. 3-25-99; BAE 3-2000, f. & cert. ef. 7-24-00; BAE 4-2002, f. & cert. ef. 8-7-02; BAE 2-2004, f. & cert. ef. 3-2-04

• • • • • • • • • •

Board of Massage Therapists
Chapter 334

Adm. Order No.: BMT 1-2004
Filed with Sec. of State: 2-23-2004
Certified to be Effective: 2-23-04
Notice Publication Date: 12-1-03
Rules Amended: 334-010-0005, 334-010-0010, 334-010-0015, 334-010-0017, 334-010-0025, 334-010-0050
Subject: 334-010-0005: Deletes the verbiage concerning application deadlines.

334-010-0010: further defines the timeline of the application process as well as allowing more time for an applicant to forward or get a refund of fees.

334-010-0015: Would allow a different method of obtaining CE hours.

334-010-0017: Would allow a different method of obtaining CE hours.

334-010-0025: The current sentence is unintelligible. This is rewritten for clarification purposes.

334-010-0050: Some housekeeping changes were made as well as redefining the continuing education requirements.
Rules Coordinator: Michelle Sherman—(503) 365-8657

334-010-0005
Applications

(1) All applications for examinations, licensure, inactive status, renewal, or temporary permit shall be made on forms provided by the Board. Only applications that are completed and on Board approved forms, without alterations, will be accepted for filing and review by the Board.

(2) All applications made to the Board shall be accompanied by the required fee.

(3) Applicants for examination shall submit the following with their application:

(a) A copy of a legal picture identification. This identification could be a valid driver's license, a current U.S. passport, immigration/naturalization papers, or a current, valid state identification card;

(b) An official certificate or transcript from the administering institutions, instructors, or programs showing successful completion of study and practice in the required subject matter and hours required by the Board; or,

for reciprocity applicants, verification from original licensing state of successful completion of a written examination and an active license in that state; or, for indorsement applicants, verification of current license from the state of licensing.

(A) Official copies of transcripts or certificates presented to the Board in an envelope sealed by the program or institution or instructor and verified as sealed may be accepted directly from the applicant.

(B) If a program or institution granting credit is no longer in business, the Board will accept for review a copy of a certificate of completion or transcript or diploma in the required subject matter and hours. The Board may require additional information to verify the authenticity of such documents; or verification of licensure as a Licensed Massage Therapist.

(c) Proof of current certification in cardiopulmonary resuscitation;

(d) A current photograph of the applicant;

(4) Transcripts must include a minimum of 500 hours of certified classes. The 500 hours must include the knowledge and skills identified in the Entry Level Competency Document and shall be comprised of:

(a) A minimum of 200 hours of health sciences to include Anatomy & Physiology, Pathology, and Kinesiology;

(b) A minimum of 300 hours of Massage Theory and Practical Application, Clinical Practice, Business Development, Communication and Ethics, Sanitation, and Hydrotherapy; and

(c) Content that incorporates the Entry Level Competencies established by the Board (334-010-0047).

(5) If for any reason an applicant does not appear to be qualified for admission to take the examination, the applicant shall be so notified and invited to submit additional evidence that he/she is entitled to have his/her case considered or to be admitted to examination.

(6) Documents in a Foreign Language All application documents for examination and licensure submitted in a language other than English shall be accompanied by:

(a) An accurate translation of those documents into English;

(b) A notarized affidavit certifying that the translator is competent in both the language of the document and the English language;

(c) A notarized affidavit certifying that the translation is a true and complete translation of the foreign language original.

(7) Any costs of translation of all documents required by the Board shall be at the expense of the applicant.

Stat. Auth.: ORS 183, 687.121 & SB 1127

Stats. Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121

Hist.: HB 88, f. 3-16-56; Renumbered from 333-035-0002; MTB 1-1979, f. & ef. 5-22-79; MTB 2-1985, f. & ef. 1-23-85; MB 3-1985(Temp), f. & ef. 9-20-85; MTB 1-1986, f. & ef. 1-29-86; MTB 1-1990, f. & cert. ef. 4-20-90; MTB 1-1992, f. & cert. ef. 7-28-92; Section (7)(d) Renumbered from 334-010-0036; BMT 2-1998, f. & cert. ef. 7-22-98; BMT 2-2002, f. & cert. ef. 5-8-02; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2004, f. & cert. ef. 2-23-04

334-010-0010
Examination

(1) The L.M.T. examination shall be held at least twice annually.

(2) The applicant shall be notified by mail, postmarked at least two weeks before the scheduled exam, unless otherwise waived by the applicant, of the time and place.

(3) Applicants who request an extension in writing to the Board postmarked 7 days in advance for the practical examination may have their examination fees apply to a subsequent examination so long as the applicant sits for the examination within a year of the date of the extension. Only one extension shall be permitted. Exceptions will be reviewed on a case-by-case basis by the Board. Refund of the examination fee will be granted should the applicant request a refund in writing postmarked at least 7 days prior to the exam.

(4) Applicants are required to take and pass both the NCBTMB's certifying exam in massage and bodywork and the Oregon practical examination which includes a written test on Oregon statutes and administrative rules.

(5) **Failure to Pass** An applicant must pass the practical examination within 24 months of the initial examination with a maximum of three attempts. If the applicant fails to pass in three attempts, he/she must re-establish eligibility to apply and sit for the massage therapist licensing examinations by undertaking and satisfactorily completing a Board approved program of remedial study from a certified school and/or instructor(s).

(6) Applicants for reciprocity or indorsement who are sitting only for the practical examination shall take the examination during the regularly scheduled examination dates.

(7) The Board may elect to administer examinations at other than regularly scheduled times if such administration

(a) does not interfere with the normal workload and work duties of the Board and its staff and

(b) additional costs associated with administering an unscheduled examination are paid by the applicant.

(8) **Examinee Conduct** An examinee, whose conduct interferes with the testing process or whose behavior violates ethical practices or jeopardizes the safety of a volunteer subject, may be dismissed and disqualified from examination. Such conduct includes but is not limited to the following behaviors:

(a) Giving or receiving examination data, either directly or indirectly, during the examination process;

(b) Failure to follow written or oral instructions relative to conducting the examination, including termination times and procedures;

(c) Endangering the life or health of a model, other examinees, or examination staff;

(d) Introducing unauthorized materials during any portion of the examination;

(e) Attempting to remove examination materials or notations from the testing site; or

(9) Violating the credentialing process such as falsifying or misrepresenting educational credentials or other information required for admission to the examination, impersonating an examinee, or having an impersonator take the licensing examination on one's behalf.

(10) Test questions, scoring keys, and other examination data used to administer the qualifying examination are exempt from disclosure under ORS 192.410 to 192.505 as amended.

(11) The Board may release statistical information regarding examination pass/fail rates by group, type of examination, school, year, and subject area to any interested party.

(12) All examinations are given in the English language. An applicant is presumed to possess sufficient sensory, visual, hearing and psychomotor skills to independently perform massage and bodywork skills.

(13) **Applicants with Special Needs** An applicant with special needs may apply to the Board for the provision of special conditions to complete the examination:

(a) The Board may require proof, provided by a qualified professional on letterhead, of the nature of the special need and type of special conditions recommended to complete the exam.

(b) A request for special conditions must be made to the Board in writing no later than three weeks prior to the date of the examination.

Stat. Auth.: ORS 183, 687.121 & SB 1127

Stats. Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086, 687.121

Hist.: HB 88, f. 3-16-56; Renumbered from 333-035-0004; MTB 1-1979, f. & ef. 5-22-79; MTB 2-1982, f. & ef. 7-21-82; MTB 2-1985, f. & ef. 1-23-85; MTB 1-1992, f. & cert. ef. 7-28-92; BMT 2-1998, f. & cert. ef. 7-22-98, Renumbered from 334-010-0021 [Hist.: MTB 1-1990, f. & cert. ef. 4-20-90; MTB 1-1992, f. & cert. ef. 7-28-92; Sections (6) - (20)(h) Renumbered from 334-030-0020]; BMT 1-1999(Temp), f. 6-14-99, cert. ef. 7-4-99 thru 12-31-99; BMT 1-2000, f. & cert. ef. 1-12-00; BMT 2-2000, f. & cert. ef. 8-3-00; BMT 1-2001(Temp), f. & cert. ef. 1-9-02 thru 7-5-02; BMT 2-2002, f. & cert. ef. 5-8-02; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2004, f. & cert. ef. 2-23-04

334-010-0015
Licensure

(1) An applicant for a renewal or initial massage therapist license shall complete, without alterations, an application furnished by the Board.

(2) Application for a massage therapist license shall contain information stating whether the applicant has ever been arrested or convicted of a misdemeanor or crime and if so, stating the nature of the offense, the location of the arrest or conviction and the date(s) of occurrence(s).

(3) Applicants for renewal of licensure shall sign a statement of completion of a minimum of 25 hours of continuing education.

(4) Applicants for initial licensure must apply within one year of the successful completion of the license examination.

(a) If an applicant does not apply within one year, then re-examination shall be required.

(b) At the time of re-examination, the applicant must meet all current licensing requirements and submit original documents as required by the Board.

(5) All applicants for initial, renewal, or reinstated license must sign a statement verifying that they have read all current Oregon Statutes (ORS 687), Rules (OAR 334), and policy statements of the Board.

(6) Licenses issued by the Board shall not be transferable.

Stat. Auth.: ORS 687.121 & 687.051

Stats. Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121

Hist.: HB 88, f. 3-16-56; Renumbered from 333-035-0006; MTB 1-1979, f. & ef. 5-22-79; MTB 1-1990, f. & cert. ef. 4-20-90; MTB 1-1992, f. & cert. ef. 7-28-92; BMT 2-1998, f. & cert. ef. 7-22-98; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2004, f. & cert. ef. 2-23-04

334-010-0017
Lapsed License

(1) The massage therapist license shall be considered lapsed if an individual fails to pay the licensing fee when due or fails to meet continuing education requirements.

(2) During the lapsed status, no such person shall practice massage in the State of Oregon.

(3) A license in lapsed status shall not be placed in an inactive status.

(4) If the lapsed license is activated within the first two years of lapsed status, the following must be included with the completed application:

(a) Late fee;

(b) Current licensing fee;

(c) Proof of 25 hours of continuing education.

(5) An applicant whose license has been lapsed for more than two years but less than three years may reinstate by including the following with the completed application:

(a) Payment of the licensing fee applicable for the two years of the lapsed license;

(b) Payment of the current fee for activation of the license;

(c) late fee payment;

(d) Proof of 25 hours continuing education for the two year lapsed period; and

(e) Proof of 25 hours continuing education for the current licensing period.

(6) All information required for restoring a lapsed license after the first two years of lapsed status must be received by December 31 of the third year of lapsed status. After December 31, the license is expired. To become licensed, one must apply as a new applicant.

(7) Inactive License Prior to Lapsed Status If the license was in an inactive status prior to the current lapsed status, the applicant shall provide the following with the completed application:

(a) Payment of the current licensing fee for activation of the license;

(b) If the license is in the third year of lapsed status but still eligible for reactivation, payment of the licensing fee applicable for the two years of the lapsed license and payment of the current licensing fee are both required;

(c) Late payment fee;

(d) Proof of 25 hours of continuing education for the two year inactive period; and

(e) Proof of 25 hours of continuing education to activate the license; or

(f) If in the third year of lapsed status, proof of an additional 25 hours of continuing education for the two years of lapsed status.

Stat. Auth.: ORS 183, ORS 687.121 & SB 1127
Stats. Implemented: ORS 687.011, ORS 687.051, ORS 687.057, ORS 687.061, ORS 687.081, ORS 687.086 & ORS 687.121
Hist.: BMT 2-1998, f. & cert. ef. 7-22-98; BMT 2-2002, f. & cert. ef. 5-8-02; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2004, f. & cert. ef. 2-23-04

334-010-0025
Practice of Massage

(1) The practice of massage shall consist of applying pressure on, friction against, stroking, and kneading the body by manual or mechanical means, and gymnastics, with or without appliances such as vibrators, infrared heat, sun lamps, and external baths such as steam, tub, or shower baths for the purpose of maintaining good health and establishing and maintaining good physical condition as stated in ORS 687.011.

(a) Gymnastics is defined as: Exercise intended to stretch and strengthen soft tissues in a general fashion.

(b) Massage is defined in part as treatment of soft tissue by means of manual techniques which include:

(A) Applying pressure, holding, or causing movement to the body with hand, elbow, knee, or foot;

(B) Passive, active, and resisted movement within the normal range of a client's physical capabilities;

(C) External use of hot, cold, or topical preparations such as lubricants and other preparations available to the general public;

(D) Application of any tool or device in common use which mimics or enhances the actions possible by the hands.

(2) Massage treatment does not include:

(a) The application of high velocity/low amplitude force further defined as thrust techniques directed toward joint surfaces;

(b) The application of ultrasound, diathermy, and electrical neuromuscular stimulation or substantially similar modalities;

(c) Colonic irrigation;

(d) Making a medical diagnosis.

(3) A person represents himself or herself as a massage therapist when the person adopts or uses any word(s) that implies a skill or application as defined by statute 687.011.

(4) Any person who holds a license as a massage therapist in this state may use the abbreviation "L.M.T." No other person(s) may assume such title or such abbreviation or any other word, letters, signs, or figures to indicate that the person using the title is a licensed massage therapist.

(5) No licensed massage therapist shall perform or offer to perform any services for customers other than those incidental to or connected with the giving of massage treatments or rendered pursuant to a state issued license.

(6) All licensed massage therapists must notify the Board office in writing of any change of residence, business or mailing address within 30 days of change of address.

(7) For purposes of ORS 687.031(1) the Board deems "direction" to mean massage performed on the written order of the licensee. The Board does not recognize any such "direction" unless it is under the specific sanction of a rule of the licensing agency defining the scope of the licensee's authority to delegate and the extent of supervision required of the licensee.

(8) All licensed massage therapists must clearly display their license at their place of business.

(9) All licensed massage therapists are required to include their license number in all advertisements, including but not limited to: written, electronic, televised and audio.

Stat. Auth.: ORS 183, 687.121 & SB 1127
Stats. Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121
Hist.: HB 88, f. 3-16-56; Renumbered from 333-035-0010; MTB 1-1979, f. & ef. 5-22-79; MTB 2-1985, f. & ef. 1-23-85; MTB 3-1985(Temp), f. & ef. 9-20-85; MTB 1-1986, f. & ef. 1-29-86; MTB 1-1990, f. & cert. ef. 4-20-90; MTB 1-1992, f. & cert. ef. 7-28-92; BMT 2-1998, f. & cert. ef. 7-22-98; BMT 3-2002, f. 5-8-02, cert. ef. 1-1-03; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2004, f. & cert. ef. 2-23-04

334-010-0050
Continuing Education

(1) At the biennial renewal time, each licensee shall sign a statement and provide proof that they have completed 25 hours of continuing education.

(2) All continuing education must be completed within the 24 months preceding the date renewal is due. Hours in excess of the total number required may not be carried over for credit toward future renewals.

(3) The continuing education requirement shall not apply to a massage therapist's first license renewal, but will apply every biennium thereafter.

(4) Each licensee must provide records of all continuing education hours at the time of renewal in the manner prescribed below:

(a) Official abstract of research conducted;

(b) Copy of official certificate or letter of attendance at seminars, workshops, institutes, classes;

(c) Official transcripts from a university, college, or technical school demonstrating successful completion of a course;

(d) Official letter from a designated agent of a Board or national or state agency or organization verifying participation as a Board member, test item writer, or examiner;

(e) official letter from designated agent of agency for whom students are precepted or supervised with information stating number of students and dates of supervision or precepting;

(f) Type, name and dates of production of media materials;

(g) Dates and hours of mentoring contact;

(h) Names, author(s), and date of publication of reading material used for self study;

(i) Name, producer, date of telecommunication conferences or videotaped presentations;

(j) Certificate of completion from agency or program providing self-study credits;

(k) Name, topic, date and hours of presentation for classes, workshops, seminars, institutes taught by licensee.

(5) Continuing education records shall be maintained by each licensee for no less than three years.

(6) Falsification of continuing education records will result in disciplinary action.

(7) Failure to complete continuing education hours by the time of renewal will result in non-issuance of a license.

(8) If the Board determines that the licensee does not meet continuing education requirements, licensee has thirty days from date of notification of non-compliance to come into compliance. Failure to be in compliance within thirty days shall result in suspension of license to practice massage.

(9) If the Board finds indications of fraud, investigative action shall be instituted. Findings of fraud may result in loss of license.

(10) Topic Areas: Continuing education must be in areas related to the practice of massage or bodywork including theory, research, technique or practice. Topic areas may include, but are not limited to:

(a) Sciences related to massage or bodywork;

(b) Movement modalities related to massage or bodywork;

(c) Psychosocial sciences;

(d) Somatics;

(e) Medicinal substances (allopathic, herbal, homeopathic, naturopathic);

(f) Devices related to massage or bodywork practice;

(g) Communication principles & techniques including group, interpersonal, and documentary;

(h) Ethics;

(i) Health care contexts related to massage or bodywork such as business practices, insurance, standards, politics;

(j) Specialized forms or modalities of massage and bodywork;

(k) Communicable disease principles and prevention;

(l) Sanitation practices related to massage or bodywork practice;

(m) Regulatory and legal requirements related to massage or bodywork;

(n) Theories of massage & bodywork paradigms, principles & practice; and

(o) Interventions and techniques;

(11) Categories. The required 25 hours of continuing education per biennium shall be selected from one of the following categories however, 12 of the continuing education hours must be in activities that involve attendance at organized events involving other massage and bodywork practitioners unless otherwise specified in the rules. The Board accepts any CE class that is approved by a national credentialing program and any class presented by a school that has Oregon Department of Education approval.

(a) Attendance at an accredited university, college or technical course — may claim 3 hours per credit hour earned;

(b) Attendance at Board approved seminars, workshops, or institutes — may claim 1 hour per direct hour of contact up to a total of 25 hours for the biennium;

(c) Attendance at Board approved telecommunication presentations of educational courses, seminars, workshops — may claim 1 hour per direct hour up to a total of 12 hours for the biennium;

(d) Completion of a Board approved self-study course — may claim one hour of credit per unit.

(e) Attendance at educational sessions at state and national conferences related to massage or bodywork — may claim 1 hour per hour of attendance (up to 25 hours);

(f) Professional presentation (as presenter) for a class, seminar, or workshop — may claim two hours of credit for every hour of actual presentation up to 25 hours of credit. No additional hours may be claimed for subsequent presentation.

(g) Author or co-author of a publication related to massage or bodywork may claim 25 hours of credit one time only per publication.

(h) Research related to massage or bodywork as a principal investigator or co-investigator or as an associate investigator in an established research project — may claim:

(A) 25 hours of credit if principal or co-investigator;

(B) 12 hours of credit if associate investigator;

(i) Participation as an item writer for a state or national licensing or certifying examination — may claim up to 12 hours of credit;

(j) Supervision of massage or mentoring of massage or bodywork students in a formal program of study-may claim 2 hours of credit for each student supervised during the course up to a total of 12 hours of credit

(k) Participation as an examiner for a state or national practical examination for licensure or certification — may claim 6 hours of credit for every year up to 12 hours of credit for the biennium;

(l) Serving as a Board member on a state licensing board for massage or bodywork or on a state or national professional organization for massage or bodywork — may claim 6 hours of credit for every year served up to a total of 12 hours of credit for the biennium.

(m) Serving as a Committee member for the Oregon Board — may claim 6 hours of credit for every year served up to a total of 12 hours of credit for the biennium;

(n) Volunteer work at an organized event — may claim 2 hours of credit for every year up to a total of 4 hours of credit for the biennium; and,

(o) Attendance at a Board approved CPR class — may claim 4 hours of CE per biennium.

(12) A continuing education class, seminar, workshop or institute that is not approved by an outside professional accrediting agency or the Oregon Department of Education, must meet the following. Providers must submit the documents listed below and receive written verification of approval from the Board:

(a) Resume and qualifications or licenses in subject area;

(b) Course applicability to massage and bodywork;

(c) Course syllabus and content outline;

(d) Course objectives;

(e) Methods of evaluation; and,

(f) Sample of certificate or proof of credit.

Stat Auth: ORS 687.081, 687.121 & 687.122

Stats. Implemented: ORS 687.011, 687.051, 687.057, 687.061, 687.081, 687.086 & 687.121

Hist.: BMT 1-1998(Temp), f. & cert. ef. 2-3-98 thru 7-31-98; BMT 2-1998, f. & cert. ef. 7-22-98; BMT 1-2003, f. & cert. ef. 1-24-03; BMT 1-2004, f. & cert. ef. 2-23-04

• • • • • • • • • •

Board of Nursing
Chapter 851

Adm. Order No.: BN 4-2004
Filed with Sec. of State: 2-20-2004
Certified to be Effective: 2-20-04
Notice Publication Date: 1-1-04
Rules Amended: 851-062-0010, 851-062-0070
Subject: These rules clarify the definition of "reactivation" and set forth the criteria under which an individual may reactivate an expired certificate.
Rules Coordinator: KC Cotton—(503) 731-4754

851-062-0010
Definitions

(1) "Application" means a request for certification including all information identified on a form supplied by the Board and payment of required fee.

(2) "Approved Nursing Program" means a pre-licensure educational program approved by the Board for registered or practical nurse scope of practice, or an educational program in another state or jurisdiction approved by the licensing board for nurses or other appropriate accrediting agency for that state.

(3) "Certificate of Completion" means a document meeting the standards set in OAR 851-061-0100(3)(a-i) and awarded upon successfully meeting all requirements of a nursing assistant or medication aide training program.

(4) "Certified Medication Aide (CMA)" means a Certified Nursing Assistant who has had additional training in administration of noninjectable medication and holds a current unencumbered Oregon CMA Certificate.

(5) "Certified Nursing Assistant (CNA)" means a person who holds a current Oregon CNA certificate by meeting the requirements specified in these rules; whose name is listed on the CNA Registry; and who assists licensed nursing personnel in the provision of nursing care. The phrase Certified Nursing Assistant and the acronym CNA are generic and may refer to CNA 1, CNA 2 or all CNAs.

(6) "Certified Nursing Assistant 1 (CNA1)" means a person who holds a current Oregon CNA 1 certificate and who assists licensed nursing personnel in the provision of nursing care.

(7) "Certified Nursing Assistant 2 (CNA 2)" means a CNA 1 who has met requirements specified in these rules for one or more of the CNA 2 categories.

(8) "Client" means the individual who is provided care by the CNA or CMA including a person who may be referred to as "patient" or "resident" in some settings.

(9) "CNA Registry" means the listing of Oregon Certified Nursing Assistants maintained by the Board.

(10) "Competency evaluation" means the Board-approved process for determining competency.

(11) "Completed Application" means a signed application, paid application fee and submission of all supporting documents related to certification requirements.

(12) "Completed Application Process" means a completed application, a Law Enforcement Data System (LEDS) check including any subsequent investigation; successful competency examination, if required; and final review for issue or denial.

(13) "Endorsement" means the process of certification for an applicant who is trained and certified as a CNA in another state or jurisdiction.

(14) "Enrolled" means making progress toward completion of a RN or LPN nursing program, whether or not registered in the current quarter or semester, as verified by the director or dean of the program.

(15) Examinations:

(a) "Competency Examination" means the Board-approved examination administered to determine minimum competency for CNA 1 authorized duties. The competency examination consists of a written examination and a manual skills examination. The examination is administered in English.

(b) "Medication Aide Examination" means the Board-approved examination administered to determine minimum competency for CMA authorized duties. The examination is administered in English.

(16) "Full-time" means at least 32 hours of regularly scheduled work each week.

(17) "Licensed Nursing Facility" means a licensed nursing home or a Medicare or Medicaid certified long term care facility.

(18) "Monitoring" means that a Registered Nurse assesses and plans for care of the client, delegates duties to the nursing assistant according to OAR 851-040-0000 through 851-047-0040 and monitors client outcomes as an indicator of CNA/CMA competency.

(19) "Nurse Aide Registry" means the listing of Certified Nursing Assistants maintained by the appropriate state agency in another state or jurisdiction of the United States.

(20) "OBRA" means the Omnibus Budget Reconciliation Act of 1987, successor legislation and written directives from the Center for Medicare and Medicaid Services (CMS).

(21) "Qualifying Disability" means a diagnosed physical or mental impairment which substantially limits one or more major life activities, and is subject to the protection of the Americans with Disabilities Act (ADA).

(22) "Reactivation" is the process of renewing certification after the certificate is expired.

(23) "Reinstatement" is the process of activating a certificate after it has been subject to disciplinary sanction by the Board.

(24) "Supervision" means that the licensed nurse periodically observes and evaluates the skills and abilities of the CNA/CMA to perform authorized duties.

(25) "Unlicensed Persons" means individuals who are not necessarily licensed or certified by this Board or another Oregon health regulatory agency but who are engaged in the care of clients.

Stat. Auth.: ORS 678.442
Stats. Implemented: ORS 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 4-2004, f. & cert. ef. 2-20-04

851-062-0070
Renewal of Certification

(1) The expiration date of a CNA certificate occurs biennially the midnight before the individual's birthdate:

(a) For individuals born in odd numbered years the certificate expires in odd numbered years.

(b) For individuals born in even numbered years the certificate expires in even numbered years.

(c) Persons whose birthdate falls on February 29 shall be treated as if the birthdate were March 1 for purpose of establishing the expiration date.

(2) The certificate shall automatically expire if the CNA fails to renew by the expiration date.

(a) A CNA may not work as a CNA with an expired certificate.

(b) Failure to receive the application for renewal shall not relieve the CNA of the responsibility of renewing the certificate by the expiration date.

(3) To renew certification a CNA shall, prior to the certificate expiration date:

(a) Submit a completed application using forms and instructions provided by the Board;

(b) Pay renewal fees established by the Board;

(c) Document paid employment:

(A) Document at least 400 hours of paid employment as a CNA within the CNA or CMA authorized duties, under supervision or monitoring by a nurse, in the two years immediately preceding the certificate expiration date.

(B) A CNA who has been certified for less than two years is exempt from the requirement in OAR 851-062-0070(3)(c)(A).

(d) A nursing assistant who cannot meet all the practice requirements for renewal in OAR 851-062-0070(3)(c)(A) may renew certification upon passing the competency examination.

(A) A nursing assistant has three attempts within two years of the expiration date on the certificate to pass the competency examination.

(B) A nursing assistant who fails to pass the competency examination in three attempts or within two years of the expiration date on the certificate may become certified by completing a Board-approved nursing assistant training program and then passing the competency examination.

(4) To reactivate certification, within two years after the certificate expiration date:

(a) Submit a completed application using forms and instructions provided by the Board;

(b) Pay the fees established by the Board; and

(c) Document at least 400 hours of paid employment as a CNA under supervision or monitoring by a nurse, or the successful completion of the competency exam, within two years immediately preceding receipt of application.

(d) A nursing assistant who cannot meet all the requirements for reactivation in OAR 851-062-0070(4)(c) must apply for and pass the competency examination within three attempts and within two years of the expiration date on the certificate.

(e) A nursing assistant who fails to pass the competency examination in three attempts or within two years of the expiration date on the certificate may become certified by completing a Board-approved training program and then passing the competency examination.

(5) Individuals whose CNA certificate has been expired for more than two years are required to take a Board-approved nursing assistant training program and pass the competency examination according to OAR 851-062-0050(1) to reactivate certification.

(6) An enrolled nursing student may renew without documentation of paid employment.

(7) A former nursing student may use clinical practice hours in the nursing program within the last two years as part or all of the required 400 hours in lieu of paid employment.

(8) Information provided to the Board to establish eligibility for renewal is subject to audit. Falsification of an application is grounds for disciplinary action.

(9) An applicant for renewal must answer all mandatory questions on the application form, including those about employment and education.

Stat. Auth.: ORS 678.150, 678.442
Stats. Implemented: ORS 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 4-2004, f. & cert. ef. 2-20-04

• • • • • • • • • •

Adm. Order No.: BN 5-2004
Filed with Sec. of State: 2-26-2004
Certified to be Effective: 2-26-04
Notice Publication Date: 1-1-04
Rules Amended: 851-047-0000, 851-047-0010, 851-047-0020, 851-047-0030, 851-047-0040
Subject: These amendments are proposed as a result of periodic rule review of Division 47 (Standards for Registered Nurse Delegation of Nursing Care Tasks to Unlicensed Persons). The conceptual changes include removal of the term "assignment" when referring to basic tasks of care, inclusion of the terms used in statute related to noninjectable medications and nursing care, specifically "initial direction," "procedural guidance" and "periodic inspection," and extending the upper limit for periodic review of the caregiver's skills from 120-days to 180-days.
Rules Coordinator: KC Cotton—(503) 731-4754

851-047-0000
Rule Summary, Statement of Purpose and Intent

These rules provide standards and guidance for nurses to delegate specific tasks of nursing care and teach administration of noninjectable medications to unlicensed persons. Registered Nurses have a broad scope of practice in teaching and delegating tasks of nursing care to unlicensed persons and providing periodic supervision. Licensed Practical Nurses' scope of practice includes teaching and supervision of unlicensed persons at the discretion and under the direction of the Registered Nurse. It is the responsibility of the Registered Nurse to decide when, how and if it is appropriate for unlicensed persons to be delegated tasks of nursing care. The Registered Nurse, when delegating to an unlicensed person, is authorizing that person to perform a task of nursing care normally within the Registered Nurse's scope of practice. Prior to agreeing to delegate tasks of nursing care, the Registered Nurse has the responsibility to understand

these rules for delegating tasks of nursing care and achieve the competence to delegate and supervise. This may be accomplished by attending a class on delegation, obtaining one to one instruction or using other methods to understand delegation. These rules describe the type of settings in which delegation may occur, define delegation of tasks of nursing care, who may delegate, describe the process for delegation and describe the process for teaching the administration of noninjectable medications.

(1) These rules apply only in settings where a Registered Nurse is not regularly scheduled and not available to provide direct supervision. These are home and community-based settings as described in OAR 851-047-0010(6) and local corrections, lockups, juvenile detention, youth corrections, detoxification facilities, adult foster care and residential care, training and treatment facilities as described in ORS 678.150(9).

(2) These rules have no application in acute care or long-term care facilities or any setting where the regularly scheduled presence of a registered nurse is required by statute or administrative rule.

(3) The purpose of these rules is to govern nurses (Registered Nurses, Licensed Practical Nurses, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Nurse Practitioners) who practice in settings where delegation may occur. These rules are not intended to govern the setting itself. The Board recognizes that some settings do not provide nursing services. The Board believes that settings which provide nursing services or advertise that they provide nursing services should have consistent nursing practice standards in place that the public may rely on, including the delegation of nursing care tasks consistent with the provisions of these administrative rules.

(4) Pursuant to ORS 678.036, a Registered Nurse who delegates tasks of nursing care to an unlicensed person shall not be held responsible for civil damages for the actions of the unlicensed person in performing a task of nursing care unless:

(a) The unlicensed person is acting on specific instructions from the nurse; or

(b) The nurse fails to leave instructions when the nurse should have done so.

(5) The Registered Nurse is responsible for:

(a) Assessing a client situation to determine whether or not delegation of a task of nursing care could be safely done;

(b) Safely implementing the delegation process;

(c) Following the Board's process for delegation as described in these rules; and

(d) Reporting unsafe practices to the facility owner, administrator and/or the appropriate state agency(ies).

(6) Failure to follow the provisions of these rules may subject the nurse to disciplinary sanctions by the Board.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 2-1999, f. & cert. ef. 3-16-99; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0010
Definitions

For the purpose of rules in this division, the following definitions apply:

(1) "Activities of Daily Living" means those self-care activities which a person performs independently, when able, to sustain personal needs and/or to participate in society. Activities of daily living include activities such as bathing, dressing, eating, drinking, ambulating, and toileting.

(2) "Administration of Medications" means removal of an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's or nurse practitioner's order, giving the individual dose to the proper client at the proper time by the proper route and promptly recording the time and dose given.

(3) "Assisting with Administration of Medications" means helping the client with one or more steps in the process of taking medications, but does not mean "administration of medications" as defined in these rules. Examples of "assisting" include, but are not limited to, opening the medication container, reminding the client of the proper time to take the medication, helping the client to self-administer their own medication, assisting the client with one or more steps of medication administration at the client's direction and setting up medications for future administration by another person.

(4) "Certified Nursing Assistant (CNA)" means a person who holds a current Oregon CNA certificate by meeting the requirements specified in Division 61; whose name is listed on the CNA Registry; and who assists licensed nursing personnel in the provision of nursing care. The phrase Certified Nursing Assistant and the acronym CNA are generic and may refer to CNA 1, CNA 2 or all CNAs.

(5) "Client-Directed Care" means that a person requiring care fully self-directs or manages his/her own care even though he/she is not physically able to perform the care. The care that may be client directed includes activities of daily living, administration of noninjectable medications and tasks of nursing care.

(6) "Community Based Care" means a setting that does not exist primarily for the purpose of providing nursing/medical care, but where nursing care is incidental to the setting. These settings include adult foster homes, assisted living facilities, child foster homes, private homes, public schools and twenty-four hour residential care facilities.

(7) "Delegation" means that a registered nurse authorizes an unlicensed person to perform tasks of nursing care in selected situations and indicates that authorization in writing. The delegation process includes nursing assessment of a client in a specific situation, evaluation of the ability of the unlicensed persons, teaching the task, ensuring supervision of the unlicensed persons and re-evaluating the task at regular intervals. For the purpose of these rules, the unlicensed person, caregiver or certified nursing assistant performs tasks of nursing care under the Registered Nurse's delegated authority.

(8) "Initial Direction for Administration of Noninjectable Medications" means giving explicit instructions regarding administration of noninjectable medications.

(9) "Initial Direction for a Task of Nursing Care" means that the Registered Nurse gives explicit instructions regarding the provision of the task of nursing care.

(10) "Injectable Medications," for the purpose of Division 47, means any medication administered by intravenous or subcutaneous routes.

(11) "Noninjectable Medication" means any medication, including controlled substances, which is not administered by the arterial, intradermal, subcutaneous, intramuscular, intraosseous, epidural, intrathecal or intravenous route.

(12) "Nursing Assessment" means the systematic collection of data about an individual client for the purpose of judging that person's health/illness status and actual or potential health care needs. Nursing assessment involves collecting information about the whole person including the physical, psychological, social, cultural and spiritual aspects of the person. Nursing assessment includes taking a nursing history and an appraisal of the person's health/illness through interview, physical examination and information from family/significant others and pertinent information from the person's past health/medical record. The data collected during the nursing assessment process provides the basis for a diagnosis(es), plan for intervention and evaluation.

(13) "Nursing Process" means a systematic problem-solving method licensed nurses use when they provide nursing care. The nursing process includes the steps of assessing, making a nursing diagnosis, establishing a plan of care, carrying out the plan of care by completing client/nursing care procedures and evaluating the effectiveness of the plan of care.

(14) "Periodic Inspection, Supervision and Evaluation of the Administration of Noninjectable Medications" means that either a physician or Registered Nurse determines the frequency at which review of medication administration practices should occur within a setting in accordance with the rules and policies of that setting.

(15) "Periodic Inspection, Supervision and Evaluation of a Task of Nursing Care" means that the Registered Nurse, at regular intervals, assesses and evaluates the condition of the client for whom a task of nursing care has been delegated, reviews the procedures and directions established for the provision of the nursing care and reviews the competence of the caregiver(s).

(16) "Rescind" means to cancel or take back.

(17) "P.R.N. (pro re nata) medications and treatments" means those medications and treatments which have been ordered to be given as needed.

(18) "Procedural Guidance" means written instructions that the Registered Nurse leaves as a specific outline of how the task of nursing care or administration of medications is to be performed.

(19) "Regularly Scheduled" means that the presence of a licensed nurse is required by statute and administrative rule 24 hours each day in a setting where client care is being continuously delivered.

(20) "Stable/Predictable Condition" means a situation where the client's clinical and behavioral state is known, not characterized by rapid changes, and does not require frequent reassessment and evaluation. This includes clients whose deteriorating condition is predictable.

(21) "Supervision of Unlicensed Persons" means that the Registered Nurse periodically monitors by direct observation on-site or by use of technology that enables the Registered Nurse to visualize the unlicensed person's skill and ability to perform a task, reassesses the client and assesses the need for continued supervision.

(22) "Tasks of Nursing Care" means procedures that require nursing education and a license as a Registered Nurse or Licensed Practical Nurse to perform.

(23) "Teaching," for the purpose of Division 47, means providing instructions for the proper way to administer noninjectable medications and/or perform a task of nursing care. Teaching may include presentation of information in a classroom setting or informally to a group, discussion of written material and/or demonstration of a technique/procedure.

(24) "Unlicensed Person," for the purpose of Division 47, means an individual who is not licensed to practice nursing, medicine, or any other health occupation requiring a license in Oregon, but who provides tasks of nursing care or is taught to administer noninjectable medications. A certified nursing assistant, as defined by these rules, is an unlicensed person. For the purpose of these delegation rules, unlicensed persons do not include members of the client's immediate family. Family members may perform tasks of nursing care without specific delegation from a Registered Nurse. The terms "unlicensed person" and "caregiver" may be used interchangeably.

(25) "Unstable Condition" means a situation where the client's clinical and behavioral status is of a serious nature, critical, fluctuating, expected to rapidly change, and in need of the continuous reassessment and evaluation of a licensed nurse.

(26) "Written Parameters" means directions that are so specific that the unlicensed caregivers use no discretion in administering p.r.n. medications or treatments.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0020
Assignment of Basic Tasks of Nursing Care, Including Noninjectable Medications

These rules for teaching administration of noninjectable medications apply only when a Registered Nurse is designated by the facility or client to provide training and consultation. Unlicensed persons administer noninjectable medications in community-based care settings. Many of these settings are regulated and the unlicensed persons who function in them are regulated from the standpoint of training requirements for them to be caregivers. Training to administer noninjectable medications may or may not be part of the caregiver's orientation program and the training is not required to be done by a Registered Nurse. Community-based care settings may or may not require nurse consultation or the involvement of a licensed nurse. In these settings, the nurse is encouraged to review the facility license requirements that reference the duties of a licensed nurse.

(1) A physician may provide the initial direction for administration of noninjectable medications.

(2) A Registered Nurse, or Licensed Practical Nurse at the direction of a Registered Nurse, may provide the initial direction for administration of noninjectable medications. When a Registered Nurse provides initial direction for the administration of noninjectable medications, the Registered Nurse must ensure that procedural guidance for administration of noninjectable medications is available to caregivers who administer medications. Initial direction shall include the following:

(a) The proper methods for administration of noninjectable medications;

(b) The reasons for the medications;

(c) The potential side-effects of the medications;

(d) Observation of the client's response;

(e) Expected actions if side-effects are observed;

(f) Documentation of the administration of the medications; and

(g) Verification of the physician's or nurse practitioner's order and accurately transcribing the order onto the medication administration record.

(3) Administration of noninjectable medication may or may not be periodically inspected, at the discretion of the Registered Nurse, and must be in accordance with the regulations for the setting in which the medications are administered. Individual clients within the setting may require more frequent review as determined by the judgment of the Registered Nurse. Factors to consider in determining more frequent review include:

(a) The client's condition and medical diagnoses;

(b) The number of medications prescribed and their potential for interaction;

(c) The type and amount of medication administered;

(d) The potential side-effects of the medications; and

(e) The client's history of medication side-effects.

(4) Assisting with the administration of medications does not include administration of noninjectable medications and is not subject to the requirements of OAR 851-047-0020.

(5) Administration of noninjectable p.r.n. medications and treatments may be taught to unlicensed caregivers by a Registered Nurse or a Licensed Practical Nurse at the direction of a Registered Nurse and in accordance with the regulations of the setting in which medications are administered, provided:

(a) Initial direction for administration of noninjectable medications as described in OAR 851-047-0020(2) is provided for the p.r.n. medications;

(b) The Registered Nurse writes parameters to clarify the physician's or nurse practitioner's p.r.n. order;

(c) The Registered Nurse or Licensed Practical Nurse leaves written parameters for the unlicensed caregiver(s) who administer medications; and

(d) The Registered Nurse or Licensed Practical Nurse leaves information for the caregivers who administer medications about the medications/treatments to be administered, including the purpose of the medications/treatments, their side effects and instructions for action if side effects are observed.

(6) The Registered Nurse and Licensed Practical Nurse have the responsibility to report unsafe practices that come to their attention related to administration of noninjectable medications to the proper person or agency even though the nurse may not have the primary responsibility for review of medication administration practices or supervision of the caregivers who administer noninjectable medications.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0030
Delegation of Special Tasks of Client/Nursing Care

These rules for delegation of tasks of nursing care, in particular the process for initial direction described in OAR 851-047-0030(3)(g), the first supervisory visit within at least 60 days described in OAR 851-047-0030(4)(d) and the documentation requirements described in OAR 851-047-0030(3)(k), apply only to those tasks of nursing care delegated after the date these rules are adopted and in effect. Any new delegation of a task of nursing care undertaken after the effective date of these rules shall be in accordance with OAR 851-047-0030(2) and (3). After the effective date of these rules, the next scheduled periodic inspection, supervision and re-evaluation shall be in accordance with OAR 851-047-0030(4).

(1) The Registered Nurse may delegate tasks of nursing care, including the administration of subcutaneous injectable medications.

(a) Under no circumstance may the Registered Nurse delegate the nursing process in its entirety to an unlicensed person.

(b) The responsibility, accountability and authority for teaching and delegation of tasks of nursing care to unlicensed persons shall remain with the Registered Nurse.

(c) The Registered Nurse may delegate a task of nursing care only to the number of unlicensed persons who will remain competent in performing the task and can be safely supervised by the Registered Nurse.

(d) The decision whether or not to delegate a task of nursing care, to transfer delegation and/or to rescind delegation is the sole responsibility of the Registered Nurse based on professional judgment.

(e) The Registered Nurse has the right to refuse to delegate tasks of nursing care to unlicensed person if the Registered Nurse believes it would be unsafe to delegate or is unable to provide adequate supervision.

(2) The Registered Nurse may delegate a task of nursing care to unlicensed persons, specific to one client, under the following conditions:

(a) The client's condition is stable and predictable.

(b) The client's situation or living environment is such that delegation of a task of nursing care could be safely done.

(c) The selected caregiver(s) have been taught the task of nursing care and are capable of and willing to safely perform the task of nursing care.

(3) The Registered Nurse shall use the following process to delegate a task of nursing care:

(a) Perform a nursing assessment of the client's condition;

(b) Determine that the client's condition is stable and predictable prior to deciding to delegate;

(c) Consider the nature of the task, its complexity, the risks involved and the skills necessary to safely perform the task;

(d) Determine whether or not an unlicensed person can perform the task safely without the direct supervision of a Registered Nurse;

(e) Determine how often the client's condition needs to be reassessed to determine the appropriateness of continued delegation of the task to the unlicensed persons; and

(f) Evaluate the skills, ability and willingness of the unlicensed persons.

(g) Provide initial direction by teaching the task of nursing care, including:

(A) The proper procedure/technique;

(B) Why the task of nursing care is necessary;

(C) The risks associated with;

(D) Anticipated side effects;

(E) The appropriate response to untoward or side effects;

(F) Observation of the client's response; and

(G) Documentation of the task of nursing care.

(h) Observe the unlicensed persons performing the task to ensure that they perform the task safely and accurately.

(i) Leave procedural guidance for performance of the task for the unlicensed persons to use as a reference. These written instructions shall be appropriate to the level of care, based on the previous training of the unlicensed persons and shall include:

(A) A specific outline of how the task of nursing care is to be performed, step by step;

(B) Signs and symptoms to be observed; and

(C) Guidelines for what to do if signs and symptoms occur.

(j) Instruct the unlicensed persons that the task being taught and delegated is specific to this client only and is not transferable to other clients or taught to other care providers.

(k) Document the following:

(A) The nursing assessment and condition of the client;

(B) Rationale for deciding that this task of nursing care can be safely delegated to unlicensed persons;

(C) The skills, ability and willingness of the unlicensed persons;

(D) That the task of nursing care was taught to the unlicensed persons and that they are competent to safely perform the task of nursing care;

(E) The written instructions left for the unlicensed persons, including risks, side effects, the appropriate response and that the unlicensed persons are knowledgeable of the risk factors/side effects and know to whom they are to report the same;

(F) Evidence that the unlicensed person(s) were instructed that the task is client specific and not transferable to other clients or providers;

(G) How frequently the client should be reassessed by the registered nurse regarding continued delegation of the task to the unlicensed persons, including rationale for the frequency based on the client's needs;

(H) How frequently the unlicensed persons should be supervised and reevaluated, including rationale for the frequency based on the competency of the caregiver(s); and

(I) That the Registered Nurse takes responsibility for delegating the task to the unlicensed persons, and ensures that supervision will occur for as long as the Registered Nurse is supervising the performance of the delegated task.

(4) The Registered Nurse shall provide periodic inspection, supervision and re-evaluation of a delegated task of nursing care by using the following process and under the following conditions:

(a) Assess the condition of the client and determine that it remains stable and predictable; and

(b) Observe the competence of the caregiver(s) and determine that they remain capable and willing to safely perform the delegated task of nursing care.

(c) Assessment and observation may be on-site or by use of technology that enables the Registered Nurse to visualize both the client and the caregiver.

(d) Evaluate whether or not to continue delegation of the task of nursing care based on the Registered Nurse's assessment of the caregiver and the condition of the client within at least 60 days from the initial date of delegation.

(e) The Registered Nurse may elect to re-evaluate at a more frequent interval until satisfied with the skill of the caregiver and condition of the client.

(f) The subsequent intervals for assessing the client and observing the competence of the caregiver(s) shall be based on the following factors:

(A) The task of nursing care being performed;

(B) Whether the Registered Nurse has taught the same task to the caregiver for a previous client;

(C) The length of time the Registered Nurse has worked with each caregiver;

(D) The stability of the client's condition and assessment for potential to change;

(E) The skill of the caregiver(s) and their individual demonstration of competence in performing the task;

(F) The Registered Nurse's experience regarding the ability of the caregiver(s) to recognize and report change in client condition; and

(G) The presence of other health care professionals who can provide support and backup to the delegated caregiver(s).

(g) The less likely the client's condition will change and/or the greater the skill of the caregiver(s), the greater the interval between assessment/supervisory visits may be. In any case, the interval between assessment/supervisory visits may be no greater than every 180 days.

(5) It is expected that the Registered Nurse who delegates tasks of nursing care to unlicensed persons will also supervise the unlicensed person(s). However, supervision may also be provided by another Registered Nurse who was not the delegator provided the supervising nurse is familiar with the client, the skills of the unlicensed person and the plan of care. The acts of delegation and supervision are of equal importance for ensuring the safety of nursing care for clients. If the delegating and supervising nurses are two different individuals, the following shall occur:

(a) The reasons for separation of delegation and supervision shall be justified from the standpoint of delivering effective client care;

(b) The justification shall be documented in writing;

(c) The supervising nurse agrees, in writing, to perform the supervision; and

(d) The supervising nurse is either present during teaching and delegation or is fully informed of the instruction, approves of the plan for teaching and agrees that the unlicensed person who is taught the task of nursing care is competent to perform the task.

(6) The Registered Nurse may transfer delegation and supervision to another Registered Nurse by using the following process. Transfer of delegation and supervision to another Registered Nurse, if it can be done safely, is preferable to rescinding delegation to ensure that the client continues to receive care:

(a) Review the client's condition, teaching plan, competence of the unlicensed person, the written instructions and the plan for supervision;

(b) Redo any parts of the delegation process which needs to be changed as a result of the transfer;

(c) Document the transfer and acceptance of the delegation/supervision responsibility, the reason for the transfer and the effective date of the transfer, signed by both Registered Nurses; and

(d) Communicate the transfer to the persons who need to know of the transfer.

(7) The Registered Nurse has the authority to rescind delegation. The decision to rescind delegation is the responsibility of the Registered Nurse who originally delegated the task of nursing care. The following are examples of, but not limited to, situations where rescinding delegation is appropriate:

(a) The unlicensed person demonstrates an inability to perform the task of nursing care safely;

(b) The condition of the client has changed to a level where delegation to an unlicensed person is no longer safe;

(c) The Registered Nurse determines that delegation and periodic supervision of the task and the unlicensed person is no longer necessary due to a change in client condition or because the task has been discontinued;

(d) The Registered Nurse is no longer able to provide periodic supervision of the unlicensed person, in which case the registered nurse has the responsibility to pursue obtaining supervision with the appropriate person or agency;

(e) The skill of the unlicensed person, the longevity of the relationship and the client's condition in combination make delegation no longer necessary.

(8) The Registered Nurse may delegate the administration of medications by the intravenous route to unlicensed person(s), specific to one client, provided the following conditions are met:

(a) The delegation is done by a Registered Nurse who is an employee of a licensed home health, home infusion or hospice provider.

(b) The tasks related to administration of medications which may be delegated are limited to flushing the line with routine, pre-measured flushing solutions, adding medications, and changing bags of fluid. Bags of fluid and doses of medications must be pre-measured and must be reviewed by a

licensed health care professional whose scope of practice includes these functions.

(c) A Registered Nurse is designated and available on call for consultation, available for on-site intervention 24 hours each day and regularly monitors the intravenous site.

(d) The agency has clear written policies regarding the circumstances for and supervision of the delegated tasks.

(e) Delegation does not include initiating or discontinuing the intravenous line.

(9) A Registered Nurse who is an employee of a licensed home health, home infusion or hospice provider may delegate the administration of a bolus of medication by using a preprogrammed delivery device. This applies to any route of intravenous administration.

(10) The Registered Nurse may not delegate medications by the intravenous route other than described in subsections (8) and (9) of this rule.

(11) The Registered Nurse may not delegate the administration of medications by the intramuscular route, except as provided in ORS 433.800 - 433.830, Programs to Treat Allergens and Hypoglycemia.

(12) The Registered Nurse has the right to refuse to delegate administration of medications by the intravenous route if the Registered Nurse believes it would be unsafe to delegate or is unable to provide the level and frequency of supervision required by these rules.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: NB 2-1988, f. & cert. ef. 6-24-88; NB 7-1989(Temp), f. & cert. ef. 10-4-89; NB 2-1990, f. & cert. ef. 4-2-90; NB 8-1992, f. & cert. ef. 7-27-92; Renumbered from 851-045-0011; BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

851-047-0040
Teaching the Performance of Tasks for an Anticipated Emergency

The Registered Nurse may teach tasks to unlicensed persons which prepare the persons to deal with an anticipated emergency under the following conditions:

(1) The Registered Nurse assesses the probability that the unlicensed persons will encounter an emergency situation. Teaching for an anticipated emergency should be limited to those who are likely to encounter such an emergency situation.

(2) The Registered Nurse teaches the emergency procedure.

(3) The Registered Nurse leaves detailed step-by-step instructions how to respond to the anticipated emergency.

(4) Preparation for an anticipation of an emergency includes the administration of injectable medications by the intramuscular route as provided in ORS 433.800 - 433.830, Programs to Treat Allergens and Hypoglycemia.

(5) The Registered Nurse periodically evaluates the unlicensed persons' competence regarding the anticipated emergency situation.

(6) The responsibility, accountability and authority to teach for an anticipated emergency remains with the Registered Nurse.

Stat. Auth.: ORS 678.150
Stats. Implemented: ORS 678.150
Hist.: BN 3-1998, f. & cert. ef. 3-13-98; Administrative Correction 5-12-98; BN 5-2004, f. & cert. ef. 2-26-04

••••••••••

Adm. Order No.: BN 6-2004
Filed with Sec. of State: 2-26-2004
Certified to be Effective: 2-26-04
Notice Publication Date: 1-1-04
Rules Amended: 851-050-0131
Subject: The Board is authorized by ORS 678.385 to determine by rule and revise periodically the drugs and medicines to be included in the formulary that may be prescribed by a nurse practitioner acting under ORS 678.375, including controlled substances listed in Schedules II, III, III N, IV and V. The amendments add the November and December 2003 and January 2004 updates to Drug Facts and Comparisons to the formulary.
Rules Coordinator: KC Cotton—(503) 731-4754

851-050-0131
Formulary for Nurse Practitioners with Prescriptive Authority

(1) The following definitions apply for the purpose of these rules:

(a) "Appliance or device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component part or accessory, which is required under federal or state law to be prescribed by a practitioner and dispensed by a pharmacist.

(b) "Formulary" means a specific list of drugs determined by the Board. The formulary for nurse practitioners with prescriptive authority shall be all the drugs in the Drug Facts and Comparisons dated January 2004 with the exception of certain drugs and drug groups, which are listed below.

(c) "Board" means the Oregon State Board of Nursing.

(2) The Board as authorized by ORS 678.385 (1993), shall determine the drugs which nurse practitioners may prescribe, shall periodically revise the formulary by rulemaking hearing at each regular Board meeting and shall transmit the list of those drugs which are exceptions to the formulary, and which nurse practitioners may not prescribe, to nurse practitioners with prescriptive authority and other interested parties.

(3) The formulary is constructed based on the following premises:

(a) Nurse practitioners may provide care for specialized client populations within each nurse practitioner category/scope of practice;

(b) Nurse practitioner prescribing is limited by the nurse practitioner's scope of practice and knowledge base within that scope of practice;

(c) Nurse practitioners may prescribe the drugs appropriate for patients within their scope of practice as defined by OAR 851-050-0005;

(d) Nurse practitioners may prescribe drugs for conditions the nurse practitioner does not routinely treat within the scope of their practice provided there is ongoing consultation/collaboration with another health care provider who has the authority and experience to prescribe the drug(s);

(e) Nurse practitioners shall be held strictly accountable for their prescribing decisions;

(f) All drugs on the formulary shall have Food and Drug Administration (FDA) approval.

(4) Nurse practitioners with prescriptive authority are authorized to prescribe:

(a) All over the counter drugs;

(b) Appliances and devices.

(5) Nurse practitioners are authorized to prescribe the following drugs as listed in Drug Facts and Comparisons dated January 2004:

(a) Nutrients and Nutritional Agents — all drugs;

(b) Hematological Agents — all drugs except Drotrecogin Alfa (Xigris); and Treprostinil Sodium (Romodulin).

(c) Endocrine and Metabolic Agents — all drugs except:

(A) I 131;

(B) Gallium Nitrate; and

(C) Mifepristone (Mifeprex).

(d) Cardiovasculars — all drugs except:

(A) Cardioplegic Solution;

(B) Fenoldopam Mesylate (Corlopam);

(C) Dofetilide (Tikosyn); and

(D) Bosentan (Tracleer).

(e) Renal and Genitourinary Agents — all drugs;

(f) Respiratory Agents — all drugs;

(g) Central Nervous System Agents:

(A) Class II Controlled Substances — Only the following drugs:

(i) Tincture of opium;

(ii) Codeine;

(iii) Hydromorphone;

(iv) Morphine;

(v) Oxycodone, Oxymorphone;

(vi) Topical Cocaine Extracts and Compounds;

(vii) Fentanyl;

(viii) Meperidine;

(ix) Amphetamines;

(x) Methylphenidates;

(xi) Pentobarbital;

(xii) Secobarbital;

(xiii) Methadone Hydrochloride (in accordance with OAR 851-045-0015(2)(n) and 851-050-0170); and

(xiv) Levorphanol.

(B) General Anesthetic Agents — no drugs which are general anesthetic barbiturates, volatile liquids or gases, with the exception of nitrous oxide; and

(C) Chymopapain is excluded.

(h) Gastrointestinal Agents — all drugs except: Monooctanoin;

(i) Anti-infectives, Systemic — all drugs;

(j) Biological and Immunologic Agents — all drugs except Basiliximab (Simulect);

(k) Dermatological Agents — all drugs except Psoralens;

(l) Ophthalmic and Otic Agents — all drugs except:

(A) Punctal plugs;

(B) Collagen Implants;
(C) Indocyanine Green;
(D) Hydroxypropal (Methyl) Cellulose;
(E) Polydimethylsiloxane;
(F) Fomivirsen Sodium (Vitravene);
(G) Verteporfin;
(H) Levobetaxolol HCL (Betaxon);
(I) Travoprost (Travatan);
(J) Bimatoprost (Lumigan); and
(K) Unoprostone Isopropyl (Rescula).
(m) Antineoplastic Agents — all drugs except:
(A) NCI Investigational Agents;
(B) Samarium Sm53;
(C) Denileukin Diftitox (Ontak);
(D) BCG, Intravesical (Pacis);
(E) Arsenic Trioxide (Trisenox);
(F) Ibritumomab Tiuxetan (Zevalin); and
(G) Tositumomab and Iodine 131 I-Tositumomab (Bexxar)
(n) Diagnostic Aids:
(A) All drugs except Arbutamine (GenESA);
(B) Thyrotropin Alfa (Thyrogen);
(C) Miscellaneous Radiopaque agents — no drugs from this category except:
(i) Iopamidol;
(ii) Iohexol; and
(iii) Ioxilan (Oxilan).
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 678.375 & 678.385
Stats. Implemented: ORS 678.385
Hist.: NB 11-1993(Temp), f. 10-26-93, cert. ef. 11-4-93; NB 2-1994, f. & cert. ef. 4-15-94; NB 7-1994, f. & cert. ef. 9-28-94; NB 3-1995, f. & cert. ef. 4-12-95; NB 6-1995(Temp), f. & cert. ef. 6-15-95; NB 8-1995, f. & cert. ef. 6-29-95; NB 11-1995, f. & cert. ef. 10-9-95; NB 1-1996, f. & cert. ef. 2-29-96; NB 3-1996, f. & cert. ef. 6-11-96; NB 8-1996, f. & cert. ef. 10-30-96; NB 10-1996, f. & cert. ef. 12-2-96; NB 5-1997, f. & cert. ef. 3-6-97; NB 7-1997, f. & cert. ef. 5-13-97; NB 8-1997, f. & cert. ef. 7-1-97; NB 13-1997, f. & cert. ef. 9-29-97; NB 14-1997, f. & cert. ef. 12-11-97; BN 4-1998, f. & cert. ef. 3-13-98; BN 5-1998, f. & cert. ef. 5-11-98; BN 8-1998, f. & cert. ef. 7-16-98; BN 12-1998, f. & cert. ef. 9-22-98; BN 13-1998, f. & cert. ef. 12-1-98; BN 1-1999, f. & cert. ef. 3-4-99; BN 3-1999, f. & cert. ef. 5-4-99; BN 5-1999, f. & cert. ef. 7-1-99; BN 9-1999, f. & cert. ef. 10-20-99; BN 13-1999, f. & cert. ef. 12-1-99; BN 3-2000, f. & cert. ef. 2-25-00; BN 5-2000, f. & cert. ef. 4-24-00; BN 8-2000, f. & cert. ef. 7-3-00; BN 9-2000, f. & cert. ef. 9-18-00; BN 10-2000, f. & cert. ef. 12-15-00; BN 2-2001, f. & cert. ef. 2-21-01; BN 6-2001, f. & cert. ef. 4-24-01; BN 9-2001, f. & cert. ef. 7-9-01; BN 13-2001, f. & cert. ef. 10-16-01; BN 4-2002, f. & cert. ef. 3-5-02; BN 11-2002, f. & cert. ef. 4-25-02; BN 14-2002, f. & cert. ef. 7-17-02; BN 19-2002, f. & cert. ef. 10-18-02; BN 21-2002, f. & cert. ef. 12-17-02; BN 2-2003, f. & cert. ef. 3-6-03; BN 4-2003, f. & cert. ef. 4-23-03; BN 8-2003, f. & cert. ef. 7-7-03; BN 10-2003, f. & cert. ef. 10-2-03; BN 13-2003, f. & cert. ef. 12-9-03; BN 6-2004, f. & cert. ef. 2-26-04

• • • • • • • • • •

Adm. Order No.: BN 7-2004
Filed with Sec. of State: 2-26-2004
Certified to be Effective: 2-26-04
Notice Publication Date: 1-1-04
Rules Amended: 851-002-0040
Subject: These rules cover the Nursing Assistant Schedule of Fees. The name of the fee is changed to be consistent with the licensing rules.
Rules Coordinator: KC Cotton—(503) 731-4754

851-002-0040
Nursing Assistant Schedule of Fees
(1) Certification by Examination — $106.
(2) Certification by Endorsement — $40.
(3) Reexamination — Manual Skills — $45.
(4) Reexamination — Written — $25.
(5) Oral Administration of Written Examination — $35.
(6) Written Verification of Certification — $10.
(7) Duplicate Certificate — $10.
(8) Biennial CNA Certificate Renewal — $40.
(9) CNA Reactivation Fee — $5.
(10) CNA Certification for RN or LPN. — $40.
(11) CNA Certification for Student Nurses. — $40.
(12) Initial Approval CNA Training Program. — $100.
(13) Approval of Revised CNA Training Program. — $75.
(14) Biennial Reapproval of CNA Training Program — $50.
(15) CNA Primary Instructor Approval — $10.
(16) Initial Approval of CNA Program Director — $25.
Stat. Auth.: ORS 678.150, 678.410
Stats. Implemented: ORS 678.410
Hist.: NB 9-1989(Temp), f. & cert. ef. 11-24-89; NB 5-1990, f. & cert. ef. 5-7-90; NB 7-1990(Temp), f. & cert. ef. 7-11-90; NB 9-1990, f. & cert. ef. 10-9-90; NB 5-1991(Temp), f. & cert. ef. 10-15-91; NB 3-1992, f. & cert. ef. 2-13-92; NB 12-1992, f. 12-15-92, cert. ef. 1-1-93; NB 2-1993, f. 2-8-93, cert. ef. 2-16-93; NB 15-1993, f. 12-27-93, cert. ef. 6-1-94; NB 9-1997, f. 7-22-97, cert. ef. 9-1-97; BN 4-1999, f. 5-21-99, cert. ef. 7-1-99, Renumbered from 851-060-0300; BN 7-1999, f. 8-10-99, cert. ef. 11-1-99; BN 10-1999, f. & cert. ef. 12-1-99; BN 6-2003, f. & cert. ef. 7-7-03; BN 7-2004, f. & cert. ef. 2-26-04

• • • • • • • • • •

Board of Optometry
Chapter 852

Adm. Order No.: OPT 1-2004
Filed with Sec. of State: 3-8-2004
Certified to be Effective: 3-8-04
Notice Publication Date: 1-1-04
Rules Adopted: 852-020-0029, 852-020-0031
Rules Amended: 852-001-0001, 852-001-0002, 852-020-0060
Subject: 852-001-0001 - Clarifies requirements for notification of proposed rule changes.
852-001-0002 - Deletes language describing optometric prescriptions. This language is now expanded in 852-020-0029.
852-020-0029 - Establishes rules for optometric prescription content and release.
852-020-0031 - Sets guidelines for delegation of optometric procedures.
Rules Coordinator: David W. Plunkett—(503) 373-7721, ext. 21

852-001-0001
Notice of Proposed Rule
Prior to the adoption, amendment, or repeal of any permanent rule, the Board of Optometry shall 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 twenty-one (21) days prior to the effective date of the rule;
(2) By mailing a copy of the notice to persons on the Board of Optometry's mailing list established pursuant to ORS 183.335(7) at least 28 days prior to the effective date of the rule;
(3) By mailing a copy of the notice to the legislators specified on ORS 183.335(15) at least 49 days before the effective date of the rule; and
(4) By mailing a copy of the notice to the following organizations and publications:
(a) Oregon Optometric Physicians Association;
(b) Capitol Press Room.
Stat. Auth.: ORS 182, 183 & 683
Stats. Implemented: ORS 183.341(4) & 182.466
Hist.: OE 24, f. 1-19-76, ef. 1-20-76; OE 3-1982, f. & ef. 3-25-82; OP 3-1994, f. & cert. ef. 10-11-94; OPT 1-2004, f. & cert. ef. 3-8-04

852-001-0002
Definitions
As used in this division:
(1) "Board" means the Oregon Board of Optometry.
(2) "Board's Office" means the facility located at 3218 Pringle Rd. SE, Ste. 270, Salem, OR 97302-6306.
(3) "Board Administrator" means the administrator for the Oregon Board of Optometry.
(4) "Firms" means an individual or firm technically and financially qualified to perform certain types of work classified as personal services.
(5) "Lenses" means pieces of glass or other transparent substances that have two opposite surfaces either both curved or one curved and the other plane that are used singly or in combination to aid the human eye in focusing rays of light. These devices shall not be confused with "contact lenses" which are designed to fit directly on the surface of the eye (cornea).
(6) "Spectacles" means ophthalmic frames and lenses.
(7) "Appurtenances" means an accessory or auxiliary device to ophthalmic frames.
(8) "Prescription" means the signed written prescription which a doctor of optometry shall immediately release to the patient at the time he/she would provide spectacles or contact lenses without additional examination.
Stat. Auth.: ORS 182 & ORS 683
Stats. Implemented: ORS 182.466; ORS 683.010 & ORS 683.335
Hist.: OP 1-1987, f. & ef. 4-30-87; OP 1-1991, f. & cert. ef. 4-12-91; OP 1-1992(Temp), f. & cert. ef. 5-6-92; OP 2-1992, f. & cert. ef. 10-21-92; OP 4-1994, f. & cert. ef. 10-11-94; OPT 1-2004, f. & cert. ef. 3-8-04

852-020-0029
Prescription Content
(1) Prescription specifications shall be reasonably based on the patient's vision and eye health concerns and shall include all information

required to insure that the patient receives the designated ophthalmic products.

(2) Spectacle prescriptions shall include the following information:

(a) Patient's name;

(b) Examination date;

(c) Prescription issuance date (the date on which the patient receives a copy of the prescription);

(d) Doctor's name, postal address, telephone number and facsimile telephone number;

(e) Sphere, Cylinder, Axis and/or ADD.;

(f) Any special features which may include, but are not limited to, type of bifocal, trifocal or progressive lens style, prism, material, tints, coatings or edge polish;

(g) A reasonable and clinically-prudent expiration date.

(3) Contact lens prescriptions shall include the following information:

(a) Patient's name;

(b) Examination date;

(c) Prescription issuance date (the date on which the patient receives a copy of the prescription);

(d) A reasonable and clinically-prudent expiration date;

(e) Doctor's name, postal address, telephone number and facsimile telephone number;

(f) Sphere, Cylinder, Axis and/or ADD.;

(g) Lens base curve or series;

(h) Lens diameter;

(i) Lens material and/or brand name;

(j) Any special features which may include, but are not limited to, type of bifocal, trifocal or progressive lens style, prism, material, tints, coatings or edge polish;

(k) The maximum number of refills;

(l) Any limitations, including wearing schedule and follow-up care.

(4) Contact lens prescriptions shall be written in a manner that allows the patient to have the prescription filled by an office or outlet of their choice.

(5) A seller may not alter a contact lens prescription. Notwithstanding the preceding sentence, if the same contact lens is manufactured by the same company and sold under multiple labels to individual providers, the seller may fill the prescription with a contact lens manufactured by that company under another label.

(6) Therapeutic pharmaceutical prescriptions shall conform to the administrative rules of the Oregon Board of Pharmacy regarding prescription format.

Stat. Auth.: ORS 182 & 682
Stats. Implemented: ORS 182.466, 683.010(2), 683.030(3), 683.335
Hist.: OPT 1-2004, f. & cert. ef. 3-8-04

852-20-0031
Prescription Release

(1) A doctor of optometry shall immediately release the signed written prescription to the patient at the time he/she would provide spectacles or contact lenses without additional examination.

(2) Upon direct communication from the patient or anyone designated to act on behalf of the patient, a doctor of optometry shall release or verify the patient's prescription to a third party.

(3) If a patient has not completed a contact lens fitting, the prescription released need only meet the spectacle prescription requirements.

(4) As used in this section, the term "direct communication" includes communication by telephone, facsimile, or electronic mail.

(5) A doctor of optometry may not:

(a) Require purchase of contact lenses or spectacles from any party as a condition of providing a copy of the prescription or verification of the prescription.

(b) Require payment in addition to, or as a part of, the fee for an eye examination, fitting, and evaluation as a condition of providing a copy of a prescription or verification of a prescription.

(c) Require the patient to sign a waiver or release as a condition of releasing or verifying a prescription.

Stat. Auth.: ORS 683; ORS 182
Stats. Implemented: ORS 683.010, 683.335 & 182.466
Hist.: OPT 1-2004, f. & cert. ef. 3-8-04

852-020-0060
Optometric Physician Responsibility, Supervision, and Delegation

(1) The optometric physician carries the sole responsibility for the patient's care.

(2) Direct supervision as used in 683.030 means that the optometric physician is monitoring the activities of all supervised individuals and has an appropriate intervention protocol in place.

(3) An optometric physician may not delegate ophthalmoscopy, gonioscopy, final central nervous system assessment, final biomicroscopy, final refraction, final determination of any prescription or treatment plans.

(4) Tonometry may be delegated to well-trained and directly supervised ancillary personnel. An Oregon licensed optometric physician must personally perform tonometry on glaucoma patients.

(5) Therapeutic procedures involving pharmaceutical agents may not be delegated other than to instill medication or provide educational information as instructed by the optometric physician.

Stat. Auth.: ORS 182 & 683
Stats. Implemented: ORS 182.466, 683.010(2) & ORS 683.030(3)
Hist.: OPT 3-2000, f. 6-26-00, cert. ef. 7-1-00; OPT 1-2004, f. & cert. ef. 3-8-04

• • • • • • • • • •

Board of Pharmacy
Chapter 855

Adm. Order No.: BP 1-2004
Filed with Sec. of State: 3-12-2004
Certified to be Effective: 3-12-04
Notice Publication Date: 2-1-04
Rules Amended: 855-031-0015, 855-031-0045
Subject: Revises internship regulations to allow a Preceptor to designate a non-pharmacist to be responsible for direct supervision of an intern in a clerkship administered by Oregon State University College of Pharmacy with prior approval from the Board.
Rules Coordinator: Karen Maclean—(503) 731-4032, ext. 223

855-031-0015
Approved Internship Experience Areas

(1) Internship shall be acquired in any one or a combination of the following approved internship experience areas:

(a) Pharmacy Practice Internship,

(b) Clerkship, or

(c) Other Internship

(2) In order for eligible pharmacy students to receive intern hours for clerkship experiences, Oregon State University College of Pharmacy must submit the syllabuses to the Oregon Board for approval before offering the course.

(a) The syllabus must show which of the competencies from the Oregon State University College of Pharmacy Competency Checklist will be included in the clerkship experience.

(b) For purposes of obtaining intern hours from the clerkship experience, the student must be responsible for licensing as an intern with the Board and maintaining the required Experience Affidavit/Hours Logs.

(c) The student's preceptor in the clerkship courses must also fulfill the responsibilities listed in OAR 855-031-0045.

(d) The preceptor must obtain prior approval from the Board if the preceptor wishes to designate a non-pharmacist to be responsible for the direct supervision of the intern during the clerkship experience.

Stat. Auth.: ORS 689.205
Stats. Implemented: ORS 689.151
Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; PB 7-1990, f. & cert. ef. 12-5-90; PB 1-1994, f. & cert. ef. 2-2-94; BP 1-2002, f. & cert. ef. 1-8-02; BP 1-2004, f. & ceert. ef. 3-12-04; BP 1-2004, f. & cert. ef. 3-12-04

855-031-0045
Preceptor Registration and Responsibilities

(1) The registration of a qualified pharmacy preceptor shall be issued by the Board upon receipt of a completed application. Registration of preceptors is required under ORS 689.005(28).

(2) A registered preceptor must have been an actively practicing pharmacist for at least one year immediately prior to supervising a pharmacy intern.

(3) A pharmacy preceptor registration is valid through the fourth May 31st from the date of issue.

(4) The preceptor may report to the Board voluntarily, the progress and aptitude of a pharmacy intern under the preceptor's supervision, or must do so upon request of the Board.

(5) The preceptor must provide the pharmacy intern with internship experience which in the preceptor's judgment will increase the intern's competency in the practice of pharmacy.

(6) The preceptor must be responsible for supervision of the majority of the pharmacy intern's hours unless the preceptor has obtained prior

approval pursuant to OAR 855-031-0015(2)(d). The preceptor must designate on the Internship Experience Affidavit/Hours Log the pharmacists who acted as supervisor during the preceptor's absence.

(7) The preceptor must certify the Internship Experience Affidavit/Hours Log. A separate Affidavit/Hours Log must be filed when the intern changes preceptors.

(8) A pharmacist must not supervise more than one intern simultaneously at a pharmacy practice site.

(9) A pharmacist must not supervise more than one intern simultaneously at a clerkship site without prior written approval of the Board. To apply for approval, the College of Pharmacy must submit:

(a) The course syllabus; and

(b) Proposed ratio of interns to supervising pharmacist.

(10) The preceptor must make certain the intern is currently licensed with the Board.

Stat. Auth.: ORS 689.205

Stats. Implemented: ORS 689.151

Hist.: 1PB 2-1979(Temp), f. & ef. 10-3-79; 1PB 2-1980, f. & ef. 4-3-80; PB 7-1990, f. & cert. ef. 12-5-90; PB 1-1994, f. & cert. ef. 2-2-94; PB 1-1996, f. & cert. ef. 4-5-96; BP 1-2002, f. & cert. ef. 1-8-02; BP 1-2004, f. & cert. ef. 3-12-04

• • • • • • • • • •

Board of Psychologist Examiners
Chapter 858

Adm. Order No.: BPE 1-2004(Temp)
Filed with Sec. of State: 3-2-2004
Certified to be Effective: 3-2-04 thru 8-29-04
Notice Publication Date:
Rules Amended: 858-010-0030, 858-050-0125
Subject: Amends the rules pertaining to the Procedures for Oral Examination for psychologist and psychologist associate candidates, effective for taking the April 17, 2004 administration. The temporary rule change amends committee procedures and scoring system, and examination decision and reconsideration. Failure to revise rules pertaining to the administration of the oral examination would result in serious prejudice to the interest of applicants taking the examination, and to the general public, as described in the Statement of Need and Justification.
Rules Coordinator: Martin Pittioni—(503) 378-4154, ext. 21

858-010-0030
Procedures for Oral Examination

(1) Oral Examination for Licensure as a Psychologist. Standard Examination:

(a) Candidates who have successfully completed the written examination for licensure and two years of approved supervised work experience shall be eligible to sit for the oral examination. An application for licensure must be received in the Board's office at least 60 days prior to an oral examination to be considered eligible.

(b) The purpose of the oral examination is to determine the competency of each candidate in knowledge of psychological principles and techniques; applicable laws and regulations; and ethical principles.

(c) Special Accommodations. Notice for request for special accommodations for verified disability or for English as a second language must be made at the time of application for licensure. If a disability occurs subsequent to application, a request for accommodation must be made in writing within 120 days of the onset of the disability. The request must include:

(A) Verified Disability: Written verification of disability from a qualified care provider (i.e. a person certified or licensed by the state to provide such services) detailing:

(i) Nature, extent and duration of disability;

(ii) Recommendation(s) for accommodation.

(B) English as a Second Language: Written request for reasonable accommodation detailing:

(i) Level of proficiency in English including, but not limited to, number of years speaking and/or writing English; list of all written or oral examinations, academic coursework, and dissertation in English language;

(ii) History of special accommodations granted in similar testing circumstances, for example, interpreter or extra time granted in oral examination process in other licensing jurisdictions or degree granting institution;

(iii) Statement documenting extent that English will or will not be the language in which professional services are provided;

(iv) Other information to support request for special accommodation;

(v) Recommendation(s) for accommodation.

(2) Oral Examination for Licensure as a Psychologist. Special Examination. Except for a person who has failed the oral examination prior to September 7, 2000, a person who qualifies under one of subsections (2)(a) through (d) may be licensed by the Board upon passing only the oral examination for Domains II and III described in subsection (6) of this section if the person:

(a) Possessed an Oregon Psychologist license that lapsed for nonpayment of fees or for failure to meet continuing education requirements by the deadline and who submits an application for licensure within 90 days after the license has lapsed.

(b) Holds a doctorate from an approved doctoral program in psychology in accordance with ORS 675.010 to 675.150; has not been disciplined by any psychologist licensing authority; and has been licensed to practice and has been engaged in active practice in a US state, Canadian province or US territory, or combination thereof for a continuous period of at least five years immediately preceding application for licensure and request to take the first oral examination for which the candidate would be eligible to sit.

(A) "Immediately preceding" means there has been no more than a continuous three-month period of professional inactivity in the required five-year period prior to the oral examination, except for vacations or illness.

(B) Candidates qualifying under subsection (2)(b) of the Special Examination rule must apply for licensure to be an Oregon psychologist within six months of domicile in Oregon.

(C) Failure to report to the Board disciplinary actions imposed by other jurisdictions, prior to sitting for the Special Examination, shall be grounds for disciplinary action including, but not limited to, revocation of a license to practice psychology in Oregon, if issued.

(c) Is a Diplomate of the American Board of Professional Psychology and is licensed in another state, Canadian province or US territory and who has not been disciplined by any psychologist licensing authority.

(d) Has been inactive in Oregon under OAR 858-040-0085 for more than five years, has satisfactorily completed the continuing education required rule and wishes to return to active status.

(3) Oral Examination Committees. The Board shall appoint oral examination committees for the purpose of conducting the examination. Each committee shall be comprised of two oral examiners. Each committee member shall be a psychologist who has been licensed and engaged in active practice for at least two years in Oregon and has not been sanctioned within three years. Oral examiners shall be given continuing education credit for their participation.

(4) Schedule of Oral Examinations. Oral examinations shall be given at least once a year. A candidate must request in writing to sit for an oral examination. The Board shall approve candidates to sit for the oral examination during its regularly scheduled meeting held prior to the month of the examination. The candidate must pay the oral examination fee at the time the examination is requested. The supervisor's final written evaluation of the supervision must accompany the written request. The evaluation must describe the candidate's areas of proficiency and skills the candidate possesses, and a summary of the candidate's training and experience which have led to competence areas. The evaluation must document the number of hours which the candidate has completed under the supervision of a psychologist. It is the candidate's responsibility to provide the Board a complete summary of all training experiences which are intended to fulfill the supervisory work requirement. When the Board has determined that the application is in order, the candidate shall be approved to sit for an oral examination. Once a candidate has been approved to sit for the examination, the fee is not refundable. At least thirty days prior to the oral examination date, written notification shall be given to candidates who have been approved to take the oral examination. Written notification shall include time, date, and location of the oral examination and a copy of Oregon law and administrative rules regarding psychologist and psychologist associate licensure. Appearances at the scheduled oral examination shall constitute a waiver of the prior written notice.

(5) Oral Examination Committee Procedures. Each oral examination committee shall score each candidate's performance on the oral examination and submit the committee's score to the Board. No later than at its next meeting, the Board shall review the scores and make a final decision whether the candidate has passed or failed the oral examination. Board staff shall notify each candidate in writing regarding the result of the oral examination in each subject area.

(6) Content of the Oral Examinations. The oral examination shall consist of three domains: Psychological Principles and Techniques, Professional Ethics, and Legal Mandates. The composition of the domains shall be as follows:

(a) Domain I. Psychological Principles and Techniques. This domain shall be comprised of the following six interrelated subsections:

(A) Assessment;

(B) Diagnosis;

(C) Treatment Planning and Implementation;

(D) Knowledge of Personal and Professional Competencies and Limitations;

(E) Knowledge of Human Diversity;

(F) Quality Assurance.

(b) Domain II. Legal Mandates. This domain shall be designed to measure the examinee's knowledge and application of federal, state and local laws and regulations related to the professional practice of psychology.

(c) Domain III. Professional Ethics. This domain shall be designed to measure the examinee's knowledge and application of the prescribed ethical principles of the profession.

(7) Oral Examination Scoring System. Examinees shall be given a rating of 0 to 4 by each examination committee for each question of an administered Domain: 0 Incompetent; 1 Highly ineffective; 2 Ineffective; 3 Effective; 4 Highly Effective. In order to pass each Domain, an examinee must receive a score of at least 9. A maximum score of 12 is possible.

(8) Administration of the Oral Examination.

(a) In advance of each oral examination, the Board, on its own motion or upon the recommendation of its delegates, shall determine the questions on which an applicant may be examined and shall agree upon the acceptable range of responses to each question and follow-up question.

(b) The Board or its delegates shall compile an orientation handbook which shall include a copy of the Board's oral examination rules and an explanation of Board requirements related to scheduling and the conduct of the examination. The handbook shall include the procedures for reconsideration and reexamination. The handbook shall be reviewed annually and may be revised, as deemed appropriate, and shall be provided to each applicant for examination at least thirty days prior to the examination.

(c) In addition to the examination committee, a Board member or Board staff may be present during an oral examination.

(9) Examination Decision. Reconsideration, Review and Reexamination.

(a) Reconsideration. Applicants shall be informed in writing of examination results for each domain. Within thirty days after notice of the examination decision, an applicant who fails the oral examination may petition the Board in writing for reconsideration of the results of the entire examination or the results with respect to a particular domain. The Board may conduct the oral examination review or delegate this responsibility to particular Board members. All exam review findings must be approved by the Board.

(b) Review. Any person desiring to inspect the electronic recording of his or her oral examination may, within a period of ninety days following the date of the examination and upon written request to the Board, obtain a copy of the record of the oral examination and inspect such examination materials at the Board's office in Salem during regular office hours. To maintain test security, the applicant shall sign a confidentiality agreement. No more than one inspection shall be allowed. At the time of inspection, no one other than the person inspecting his or her examination, the examinee's supervisor, and a representative of the Board may be present; nor may any notes be made at the time of inspection.

(c) Reexamination. An applicant who fails to pass all required domains shall be reexamined only on those domains which were failed. If a candidate does not pass the second oral examination and wishes to take a third oral examination, the candidate shall be examined by the Full Board at the candidate's written request. The Board shall conduct Full Board Oral Examinations at regularly scheduled Board meetings. If a candidate fails to pass the Full Board Oral Examination, the candidate's application for licensure shall be denied. The Board's decision based on the Full Board Oral Examination shall be final.

(10) Disqualification. A candidate sitting for the oral examination may be disqualified during or after the examination for conduct which affects the integrity of the candidate's performance or the examination including, but not limited to, giving or receiving aid, directly or indirectly, during the examination process, recording the examination, or removing or attempting to remove any examination related information from the premises. Disqualification shall invalidate the examination, result in forfeiture of the examination fee and denial of the application.

Stat. Auth.: ORS 675.030, 675.040, 675.045, 675.050, 675.065

Stats. Implemented: ORS 675.030, 675.040, 675.045, 675.050, 675.065

Hist.: PE 6, f. 12-19-73, ef. 1-11-74; PE 1-1979, f. & ef. 9-5-79; PE 1-1981(Temp), f. & ef. 12-9-81; PE 1-1982, f. 4-13-82, ef. 6-1-82; PE 2-1982, f. & ef. 7-23-82; PE 1-1985(Temp), f. & ef. 12-20-85; PE 1-1986, f. & ef. 7-1-86; PE 1-1988, f. & cert. ef. 7-25-88; PE 3-1988(Temp), f. & cert. ef. 11-30-88; PE 1-1990, f. & cert. ef. 2-16-90; PE 1-1991, f. & cert. ef. 4-3-91; PE 2-1991, f. 8-15-91, cert. ef. 8-16-91; PE 3-1992(Temp), f. & cert. ef. 12-10-91; PE 1-1992, f. & cert. ef. 1-16-92; PE 3-1992, f. & cert. ef. 7-14-92; PE 1-1995, f. & cert. ef. 2-16-95; PE 1-1996, f. & cert. ef. 6-25-96; PE 1-1997, f. & cert. ef. 6-17-97; BPE 1-2000(Temp), f. 3-8-00, cert. ef. 3-8-00 thru 9-4-00; BPE 3-2000, f. & cert. ef. 9-7-00; BPE 1-2001(Temp), f. & cert. ef. 8-31-01 thru 2-27-02; BPE 2-2002, f. & cert. ef. 2-27-02; BPE 4-2002, f. & cert. ef. 10-11-02; BPE 1-2004(Temp), f. & cert. ef. 3-2-04 thru 8-29-04

858-050-0125

Procedures for Oral Examination

(1) Oral Examination for Licensure as a Psychologist Associate (Masters Level):

(a) Candidates who have successfully complete the written examination and the requisite 36 months of fulltime supervised experience for licensure shall be eligible to sit for the oral examination. An application for licensure must be received at least 60 days prior to an oral examination to be considered eligible.

(b) The purpose of the oral examination is to determine the competency of each candidate in knowledge of psychological principles and techniques, applicable laws and regulations, and ethical principles.

(c) Special Accommodations. Notice for request for special accommodations for verified disability or for English as a second language must be made at the time of application for licensure. If a disability occurs subsequent to application, a request for accommodation must be made in writing within 120 days of the onset of the disability. The request must include:

(A) Verified Disability: Written verification of disability from a qualified care provider (i.e. a person certified or licensed by the state to provide such services) detailing:

(i) Nature, extent and duration of disability;

(ii) Recommendation(s) for accommodation.

(B) English as a Second Language: Written request for reasonable accommodation detailing:

(i) Level of proficiency in English including, but not limited to, number of years speaking and/or writing English; list of all written or oral examinations, academic coursework, and dissertation in English language;

(ii) History of special accommodations granted in similar testing circumstances, for example, interpreter or extra time granted in oral examination process in other licensing jurisdictions or degree granting institution;

(iii) Statement documenting extent that English will or will not be the language in which professional services are provided;

(iv) Other information to support request for special accommodation;

(v) Recommendation(s) for accommodation.

(2) Oral Examination Committees. The Board shall appoint oral examination committees for the purpose of conducting the examination. Each committee shall be comprised of two oral examiners. Each committee member shall be a psychologist who has been licensed and engaged in active practice for at least two years in Oregon and has not been sanctioned within three years. Oral examiners shall be given continuing education credit for their participation.

(3) Schedule of Oral Examinations. Oral examinations shall be given at least once a year. A candidate must request in writing to sit for an oral examination. The Board shall approve candidates to sit for the oral examination during its regularly scheduled meeting held prior to the month of the examination. The supervisor's final written evaluation of the supervision must accompany the written request. The evaluation must describe the candidate's areas of proficiency and skills the candidate possesses, and a summary of the candidate's training and experience which have led to competence areas. The evaluation must document the number of hours which the candidate has completed under the supervision of a psychologist. It is the candidate's responsibility to provide the Board a complete summary of all training experiences which are intended to fulfill the supervisory work requirement. When the Board has determined that the application is in order, the candidate shall be approved to sit for an oral examination. Once a candidate has been approved to sit for the examination, the fee is not refundable. At least thirty days prior to the oral examination date, written notification shall be given to candidates who have been approved to take the oral examination. Written notification shall include time, date, and location of the oral examination and a copy of Oregon law and administrative rules regarding psychologist and psychologist associate licensure. Appearances at the scheduled oral examination shall constitute a waiver of the prior written notice.

(4) Oral Examination Committee Procedures. Each oral examination committee shall score each candidate's performance on the oral examination and submit the committee's score to the Board. No later than at its next meeting, the Board shall review the scores and make a final decision whether the candidate has passed or failed the oral examination. Board staff

shall notify each candidate in writing regarding the result of the oral examination in each subject area.

(5) Content of the Oral Examinations. The oral examination shall consist of three domains: Psychological Principles and Techniques, Professional Ethics, and Legal Mandates. The composition of the domains shall be as follows:

(a) Domain I. Psychological Principles and Techniques. This domain shall be comprised of the following six interrelated subsections:

(A) Assessment;

(B) Diagnosis;

(C) Treatment Planning and Implementation;

(D) Knowledge of Personal and Professional Competencies and Limitations;

(E) Knowledge of Human Diversity;

(F) Quality Assurance.

(b) Domain II. Legal Mandates. This domain shall be designed to measure the examinee's knowledge and application of federal, state and local laws and regulations related to the professional practice of psychology.

(c) Domain III. Professional Ethics. This domain shall be designed to measure the examinee's knowledge and application of the prescribed ethical principles of the profession.

(6) Oral Examination Scoring System. Examinees shall be given a rating of 0 to 4 by each examination committee for each question of an administered Domain: 0 Incompetent; 1 Highly ineffective; 2 Ineffective; 3 Effective; 4 Highly Effective. In order to pass each Domain, an examinee must receive a score of at least 9. A maximum score of 12 is possible.

(7) Administration of the Oral Examination:

(a) In advance of each oral examination, the Board, on its own motion or upon the recommendation of its delegates, shall determine the questions on which an applicant may be examined and shall agree upon the acceptable range of responses to each question and follow-up question.

(b) The Board or its delegates shall compile an orientation handbook which shall include a copy of the Board 's oral examination rules and an explanation of board requirements related to scheduling and the conduct of the examination. The handbook shall include the procedures for reconsideration and reexamination. The handbook shall be reviewed annually and may be revised, as deemed appropriate, and shall be provided to each applicant for examination at least thirty days prior to the examination.

(c) In addition to the examination committee, a Board member or Board staff may be present during an oral examination.

(8) Examination Decision. Reconsideration, Review and Reexamination.

(a) Reconsideration. Applicants shall be informed in writing of examination results for each domain. Within thirty days after notice of the examination decision, an applicant who fails the oral examination may petition the Board in writing for reconsideration of the results of the entire examination or the results with respect to a particular domain. The Board may conduct the oral examination review or delegate this responsibility to particular Board members. All examination review findings must be approved by the Board.

(b) Review. Any person desiring to inspect the electronic recording of his or her oral examination may, within a period of ninety days following the date of the examination and upon written request to the Board, obtain a copy of the record of the oral examination and inspect such examination materials at the Board's office in Salem during regular office hours. To maintain test security, the applicant shall sign a confidentiality agreement. No more than one inspection shall be allowed. At the time of inspection, no one other than the person inspecting his or her examination and a representative of the Board may be present; nor may any notes be made at the time of inspection.

(c) Reexamination. An applicant who fails to pass all required domains must be reexamined only on those domains which were failed. If a candidate does not pass the second oral examination, the candidate shall be examined by the Full Board at the candidate's written request. The Board shall conduct Full Board Oral Examinations at regularly scheduled Board meetings. If a candidate fails to pass the Full Board Oral Examination, the candidate's application for licensure shall be denied. The Board's decision based on the Full Board Oral Examination is final.

(9) Disqualification. A candidate sitting for the oral examination may be disqualified during or after the examination for conduct which affects the integrity of the candidate's performance or the examination including, but not limited to, giving or receiving aid, directly or indirectly, during the examination process, recording the examination, or removing or attempting to remove any examination related information from the premises. Disqualification will invalidate the examination, result in forfeiture of the examination fee and denial of the application.

Stat. Auth.: ORS 675.030, 675.040, 675.045, 675.050, 675.065
Stats. Implemented: ORS 675.030, 675.040, 675.045, 675.050, 675.065
Hist.: PE 10, f. 4-10-75, ef. 5-11-75; PE 1-1979, f. & ef. 9-5-79; PE 1-1981(Temp), f. & ef. 12-9-81; PE 1-1982, f. 4-13-82, ef. 6-1-82; PE 2-1982, f. & ef. 7-23-82; PE 2-1990(Temp), f. & cert. ef. 10-11-90; PE 1-1991, f. & cert. ef. 4-3-91; Renumbered from 858-010-0125 & 858-010-0130; PE 2-1991, f. 8-15-91, cert. ef. 8-16-91; PE 1-1996, f. & cert. ef. 6-25-96; PE 1-1997, f. & cert. ef. 6-17-97; BPE 1-2000(Temp), f. 3-8-00, cert. ef. 3-8-00 thru 9-4-00; BPE 3-2000, f. & cert. ef. 9-7-00; BPE 1-2001(Temp), f. & cert. ef. 8-31-01 thru 2-27-02; BPE 2-2002, f. & cert. ef. 2-27-02; BPE 1-2004(Temp), f. & cert. ef. 3-2-04 thru 8-29-04

• • • • • • • • • •

Columbia River Gorge Commission
Chapter 350

Adm. Order No.: CRGC 1-2004
Filed with Sec. of State: 2-24-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Adopted: 350-120-0015, 350-120-0025, 350-120-0050
Rules Amended: 350-120-0010, 350-120-0020, 350-120-0030, 350-120-0040
Subject: The purpose of this rule is to define the process by which the Gorge Commission certifies economic development grants and loans, awarded by the Washington and Oregon investment boards, as consistent with the federal Columbia River Gorge National Scenic Area Act, the management plan, and land use ordinances adopted pursuant to the Act. This rule amendment establishes an expedited certification process for certain types of economic grants and loans. The amendment allows the Executive Director of the Gorge Commission to certify these grants and loans, rather than the full Gorge Commission, saving several weeks for applicants.
Rules Coordinator: Nancy A. Andring—(509) 493-3323

350-120-0010
Authority

Section 11(c)(1) of the Scenic Area Act requires the Commission to certify all activities undertaken under a National Scenic Area economic development grant and/or loan are consistent with the purposes of the Act, the management plan, and land use ordinances adopted pursuant to the Act.

Stat. Auth.: ORS 196.150
Stats. Implemented: RCW 43.97.015; 16 U.S.C. § 544 et seq.
Hist.: CRGC 1-1994(Temp), f. & cert. ef. 5-4-94; CRGC 3-1994, f. 10-3-94, cert. ef. 10-31-94; CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

350-120-0015
Definitions

For the purpose of this rule, the following definitions apply:

(1) "Activity" refers to the specific proposed action for which the grant or loan is being sought.

(2) "Project" refers to the ultimate business enterprise, development, and/or land use for which the activity supports or is a component part.

Stat. Auth.: ORS 196.150
Stats. Implemented: ORS 196.150, RCW 43.97.015; 16 U.S.C. § 544i
Hist.: CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

350-120-0020
Application for Certification

(1) The applicant shall submit one complete application to the Executive Director of the Commission.

(2) A complete application shall include:

(a) One complete copy of the application materials required by the state agency administering the grant or loan program, excluding confidential financial information;

(b) If the proposed project will be located entirely or partially within the general management area or special management area one complete copy of a Scenic Area land use ordinance development review decision, issued by the applicable county planning director, approving the proposed project as consistent with the ordinance requirements, or a copy of a letter from the applicable county planning director stating why the proposed project does not require review under the county's Scenic Area land use ordinance;

(c) One completed application for certification form, available from the Gorge Commission and/or the state agencies administering the grant or loan program. The form shall include the following information:

(A) Applicant's name and business address;

(B) Description of proposed project and activity for which a Scenic Area grant or loan is sought;

(C) legal description and map of the specific location of proposed project; if project has multiple or regional locations, these should be identified;

(D) Description of the existing use of the property or properties on which the project will be located and/or used;

(E) A statement setting forth any local, state or federal permits required and a report on their status; and

(F) Signature of applicant and property owner if, different from applicant.

(d) One copy of each of any state and federal environmental permits that have been issued for the proposed project. If permits have not been received, copies of permit applications shall be submitted instead.

(3) The Director shall review the application and determine if it is complete. If it is not complete, the applicant is required to submit the additional information requested by the Director. Once the Director determines the application is complete, the process of staff analysis shall begin.

Stat. Auth.: ORS 196.150
Stats. Implemented: ORS 196.150; RCW 43.97.015; 16 U.S.C. § 544 et seq.
Hist.: CRGC 1-1994(Temp), f. & cert. ef. 5-4-94; CRGC 3-1994, f. 10-3-94, cert. ef. 10-31-94; CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

350-120-0025
Certification Procedures

All applications for certification shall follow either the process in 350-120-030 through 040 or the process in 350-120-050.

Stat. Auth.: ORS 196.150
Stats. Implemented: ORS 196.150; RCW 43.97.015; 16 U.S.C. § 544 et seq.
Hist.: CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

350-120-0030
Recommendation of the Director

(1) In making a recommendation on a proposed grant or loan the Director shall:

(a) Consult with the applicant and such agencies as the Director deems appropriate;

(b) Consider information submitted by the applicant and all other relevant information available;

(2) The Director shall recommend a grant or loan for certification only if it is consistent with the purposes of the Act, the management plan and land use ordinances adopted pursuant to the Act.

(3) Within 21 days of acceptance of the application as complete, the Director shall issue a report setting forth the recommendation and the basis for it.

(4) The Director shall mail a copy of the report to the applicant, Gorge Commissioners, the Forest Service, the States of Oregon and Washington, the Indian Tribes with treaty rights in the Scenic Area, and the planning director of the applicable county or city.

Stat. Auth.: ORS 196.150
Stats. Implemented: ORS 196.150; RCW 43.97.015; 16 U.S.C. § 544 et seq.
Hist.: CRGC 1-1994(Temp), f. & cert. ef. 5-4-94; CRGC 3-1994, f. 10-3-94, cert. ef. 10-31-94; CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

350-120-0040
Review and Decision by Commission

(1) The Commission shall review the recommendation and report of the Director at a scheduled meeting. Public comment shall be allowed.

(2) The Commission may request further information at the meeting if it is deemed relevant to its decision.

(3) At the first Commission meeting occurring five (5) or more working days of after issuance of the Director's report, the Commission shall make a decision on the grant or loan, as follows:

(a) Approve the request, certifying the grant or loan is consistent with the purposes of the Act, the management plan and land use ordinances adopted pursuant to the Act;

(b) Approve the request contingent upon approval of certain required state and/or federal environmental permits;

(c) Defer the decision, pending receipt of further information; or

(d) Deny the request, stating that the grant or loan is not consistent with the purposes of the Act, the management plan and land use ordinances adopted pursuant to the Act.

(4) The Director shall notify the applicant, and the applicable state investment board of the Commission's decision.

Stat. Auth.: ORS 196.150
Stats. Implemented: ORS 196.150; RCW 43.97.015; 16 U.S.C. § 544 et seq.
Hist.: CRGC 1-1994(Temp), f. & cert. ef. 5-4-94; CRGC 3-1994, f. 10-3-94, cert. ef. 10-31-94; CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

350-120-0050
Expedited Certification.

(1) The Executive Director of the Gorge Commission may issue a decision for a certification application that meets all of the following criteria. The Executive Director may, at his or her discretion, require an application be reviewed pursuant to 350-120-0030 and 0040 above.

(a) The project and activity shall not involve ground disturbance or changes to structures that are 50 years old or older;

(b) The project shall be located wholly within an Urban Area;

(c) The project and activity shall be consistent with the economic development policies in the Management Plan

(d) The project and activity shall be consistent with the Economic Development Plans for Oregon and Washington as amended from time to time by the states consistent with Section 11 (a) of the Scenic Area Act;

(e) The project shall not involve relocation of a business from one National Scenic Area community to another;

(f) The activity shall not involve program administration; and

(g) The project shall occur only in counties that have in effect land use ordinances found consistent by the Commission and concurred on by the Secretary.

(2) In making a decision to certify a proposed grant or loan the Director shall:

(a) Consult with the applicant and such agencies as the Director deems appropriate, and

(b) Consider information submitted by the applicant and all other relevant information available.

(3) The Director shall approve a grant or loan for certification only if it is consistent with the purposes of the Act, and the management plan.

(4) Within 14 days of acceptance of the application as complete, the Director shall issue a decision along with findings of fact and conclusions of law setting forth the basis for the decision.

(5) The Director shall mail a copy of the decision to the applicant, the Forest Service, the States of Oregon and Washington, the Indian Tribes with treaty rights in the Scenic Area, the planning director of the applicable county or city, and any person who requests a copy of the decision.

(6) The Executive Director shall prepare periodic summaries of the certifications approved through this expedited process for submission to the Gorge Commission.

Stat. Auth.: ORS 196.150
Stats. Implemented: ORS 196.150; RCW 43.97.015; 16 U.S.C. § 544 et seq.
Hist.: CRGC 1-2004, f. 2-24-04, cert. ef. 4-1-04

• • • • • • • • • •

Construction Contractors Board
Chapter 812

Adm. Order No.: CCB 2-2004
Filed with Sec. of State: 2-27-2004
Certified to be Effective: 3-1-04
Notice Publication Date: 2-1-04
Rules Adopted: 812-001-0022
Rules Amended: 812-001-0000, 812-001-0015, 812-001-0020, 812-003-0015, 812-004-0110, 812-004-0250, 812-004-0440, 812-004-0535, 812-004-0540, 812-004-0550, 812-008-0050, 812-009-0100, 812-009-0120
Rules Repealed: 812-001-0020(T), 812-001-0022(T), 812-004-0110(T), 812-004-0250(T), 812-004-0440(T)
Subject: • 812-001-0000 is amended to include sending rule notices by email to interested parties who prefer to receive the rule notices by email rather than mail.

• 812-001-0015 is amended to allow a party who voluntarily paid for a four-year license to obtain a refund of a portion of the second two-year fee within the first two years of the license period if requested.

• OAR 812-001-0020 is amended to adopt the revised form "Notice of Compliance with Homebuyer Protection Act (HPA)". The form was revised to make it more user friendly; and to adopt the revised form "Information Notice to Property Owners About Construction Responsibilities" that contains obsolete phone numbers that need to be corrected.

• OAR 812-001-0022 is adopted to set out the requirements regarding who is required to give the "Notice of Compliance with

Homebuyer Protection Act (HPA)" and when the notice must be given because it is not clear from the legislation.

• 812-003-0015 is amended to comply Oregon and federal law require licensing agencies to collect Social Security numbers from individual licensees for purposes of child support enforcement. See ORS 25.750 to 25.785. Recently, the legislature enacted Chapter 610, Oregon Laws 2003 (HB 2783), which amends ORS 25.785 to provide that a licensing agency "may accept a written statement from an individual who has not been issued a Social Security number***." This provides an avenue for compliance for persons who may not have a Social Security number.

• OAR 812-004-0110 is amended to provide the processing fee under ORS 701.147 (as amended by Chapter 294, Oregon Laws 2003) only applies to residential claims, to require the claimant applying for a waiver of the claim processing fee to certify that the information is true, and provides that the fee doubles if claimant provides false information on an application of waiver of the claim processing fee.

• OAR 812-004-0250 is amended to provide for reimbursement of the claim processing fee as required by ORS 701.147.

• OAR 812-004-0440 is amended to clarify when a contractor receives notice of a claim for purposes of ORS 701.180 (regarding contracts with mediation or arbitration agreements), which was made necessary by the pre-claim notice provisions under ORS 701.147 as amended by the 2003 legislature.

• OAR 812-004-0535, 812-004-0540, 812-004-0550, 812-009-0100, and 812-009-0120 are amended to clarify the intent of the rules and make them more readable.

• 812-008-0050 is amended to provide a more reasonable testing timeline for applicant's taking the home inspector test.

Rules Coordinator: Cathy Heine—(503) 378-4621, ext. 4077

812-001-0000
Notice of Proposed Rule

Except as provided in OAR 812-001-0001, before adopting, amending, or repealing any permanent rule, the Construction Contractors Board shall give notice of the intended action:

(1) In the Secretary of State's Bulletin referred to in ORS 183.360 at least 21 days before the effective date of the rule.

(2) By mailing or emailing a copy of the notice to persons on the Construction Contractors Board's mailing list established pursuant to ORS 183.335(7) at least 28 days before the effective date of rule.

(3) By mailing or emailing a copy of the notice at least 28 days before the effective date of the rule to the:

(a) Associated Press;

(b) Oregon Labor Press;

(c) Capitol Press Room, State Capitol;

(d) Oregon Consumer League; and

(e) Oregon Department of Health.

(4) By mailing or emailing a copy of the notice to legislators specified in ORS 183.335(15) at least 49 days before the effective date of the rule.

Stat. Auth.: ORS 670.310, 701.235 & 701.280
Stats. Implemented: ORS 183.335, 183.341, 670.310 & 701.235
Hist.: 1BB 4, f. & ef. 12-29-75; 1BB 1-1978, f. & ef. 5-23-78; 1BB 6-1980, f. & ef. 11-4-80; 1BB 1-1982, f. 3-31-82, ef. 4-1-82; BB 3-1987, f. 12-30-87, cert. ef. 1-1-88; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 2-1992, f. & cert. ef. 4-15-92; CCB 2-1994, f. 12-29-94, cert. ef. 1-1-95; CCB 4-1997, f. & cert. ef. 11-3-97; CCB 4-1998, f. & cert. ef. 4-30-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-001-0015
Information Requests

(1) The agency will provide the following information in response to telephone and web site requests for license information relating to a specific entity:

(a) Whether or not the entity is or has ever been licensed.

(b) The license number(s).

(c) The business names used by the entity of record with the agency.

(d) Type of business organization (sole proprietorship, partnership, limited liability partnership, limited liability company, or corporation).

(e) Personal names of owners, partners, members or corporate officers.

(f) Last known address.

(g) Category of license (General Contractor — All-Structures, Specialty Contractor — All-Structures, General Contractor — Residential-Only, Specialty Contractor — Residential-Only, Limited Contractor, and Inspector).

(h) Employer status (exempt or nonexempt).

(i) Expiration date or date upon which the license became inactive or lapsed and the reason it became inactive or lapsed.

(j) The date the entity first became licensed.

(k) The number and type of inquiries and pending claims and claims closed during the past three years where the agency issued Final Orders requiring the contractor to pay the claimant.

(2) If more information is required than that listed in section (1) of this rule, the request for information should be made in writing.

(3) The agency shall provide certification of license or non-license relating to a specific entity upon written request and payment of required fee. This certification will include the following information:

(a) License number(s).

(b) Name of licensed entity and any assumed business names on file with the agency.

(c) Type of business (sole proprietorship, partnership, limited liability partnership, limited liability company, or corporation).

(d) Category of license (General Contractor — All-Structures, Specialty Contractor — All-Structures, General Contractor — Residential-Only, Specialty Contractor — Residential-Only, Limited Contractor, and Inspector).

(e) Employer status (exempt or nonexempt).

(f) Personal names of owner, partners, members, or corporate officers.

(g) The important dates in the license history and the action that took place on those dates.

(4) In response to telephone requests from consumers for claims information relating to a specific licensee, the agency will provide by mail a brief explanation of the claims process and the following information for each claim filed in the previous seven years:

(a) Type of each claim.

(b) Date on which the claim was filed.

(c) The status of the claim filed.

(d) Alleged amount of the claim, if known, or amount awarded.

(5) If more information is required than that listed in section (4) of this rule, the request for information should be specified in writing.

(6) The agency may make the following charges for records:

(a) $20 for each certification that an entity has or has not been licensed with the Construction Contractors Board.

(b) $20 for certified copies of documents.

(c) $5 for the first 20 copies made and 25 cents per page thereafter.

(d) $20 for duplicate tape recordings of, Board meetings and Appeal Committee meetings.

(e) $20 for duplicate tape recordings of a three hour agency hearing or arbitration and $10 for duplicate tape recordings of each additional 90 minutes or fraction thereof of the hearing or arbitration.

(f) Charge as determined by preparation time and production cost for mailing labels of licensees.

(g) $10 per half-hour unit or portion of a half-hour unit for research of records for each request from a person beginning with the 31st minute of research time.

(7) Refunds:

(a) The agency shall not refund fees or civil penalties overpaid by an amount of $20 or less unless requested by the payer in writing within three years after the date payment is received by the agency, as provided by ORS 293.445.

(b) Except as set forth in subsection (c) and (d) of this section, licensing fees are non-refundable and nontransferable.

(c) When an applicant withdraws their application for a new license prior to issuance or fails to complete the licensing process, the agency may refund the licensing fee, but will retain a processing fee of $40. When an applicant withdraws their application for renewal prior to issuance or fails to complete a renewal, the agency may refund the licensing fee, but will retain a processing fee of $40.

(d) If a licensee paid for a four-year license at their own discretion as authorized by ORS 701.115(1) and voluntarily terminates their license within the first two-year license period, the agency may refund the unused two-year renewal fee only if the following conditions are met:

(A) The licensee will submit a written request for a voluntary termination of the license and a refund of the unused two-year fee;

(B) The licensee will return the original license card(s) to the agency; and

(C) The agency will retain a $40 processing fee.

(e) If the agency receives payment of any fees or penalty by check and the check is returned to the agency as an NSF check, the payer of the fees will be assessed an NSF charge of $25 in addition to the required payment of the fees or penalty.

Stat. Auth.: ORS 293.445

Stats. Implemented: ORS 183.310, 183.500, 192.430, 701.235, 701.250, 701.252

Hist.: 1BB 1-1983, f. & ef. 3-1-83; 1BB 3-1984, f. & ef. 5-11-84; 1BB 3-1985, f. & ef. 4-25-85; BB 3-1987, f. 12-30-87, cert. ef. 1-1-88; BB 2-1988, f. & cert. ef. 6-6-88; BB 2-1989, f. 6-29-89, cert. ef. 7-1-89; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 2-1990, f. 5-17-90, cert. ef. 6-1-90; CCB 2-1992, f. & cert. ef. 4-15-92; CCB 1-1995, f. & cert. ef. 2-2-95; CCB 3-1995, f. 9-7-95, cert. ef. 9-9-95; CCB 1-1996, f. 4-26-96, cert. ef. 5-1-96; CCB 1-1997, f. & cert. ef. 5-15-97; CCB 4-1998, f. & cert. ef. 4-30-98; Administrative correction 7-28-98; CCB 6-1998, f. 8-31-98, cert. ef. 9-1-98; CCB 1-1999, f. 3-29-99, cert. ef. 4-1-99; CCB 3-1999(Temp), f. & cert. ef. 6-29-99 thru 12-25-99; CCB 5-1999, f. & cert. ef. 9-10-99; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 14-2000, f. & cert. ef. 12-4-00; 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 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-001-0020

Information Notice to Owners

(1) The Construction Contractors Board adopts the form entitled "Information Notice to Owner," as revised October 18, 2002. This form may be obtained from the agency. Previously adopted versions of the Information Notice may also be used.

(2) The Construction Contractors Board adopts the form "Information Notice to Property Owners About Construction Responsibilities" as revised December 9, 2003.

(3) The Construction Contractors Board adopts the form "Notice of Compliance with Homebuyer Protection Act (HPA) as revised December 16, 2003.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 87.093 & 701.055, 701.235

Stats. Implemented: ORS 87.093, 701.055, Ch. 778 OL 2003

Hist.: 1BB 4-1981, f. 11-24-81, ef. 1-1-82; 1BB 3-1982, f. 6-4-82, ef. 1-1-83; 1BB 1-1983, f. & ef. 3-1-83; Renumbered from 812-011-0076; 1BB 3-1983, f. 10-5-83, ef. 10-15-83; BB 2-1987, f. & ef. 7-2-87; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 5-1992, f. 7-31-92, cert. ef. 8-1-92; CCB 1-1999, f. 3-29-99, cert. ef. 4-1-99; CCB 5-1999, f. & cert. ef. 9-10-99; CCB 6-2000(Temp), f. 5-22-00, cert. ef. 5-22-00 thru 11-17-00; CCB 9-2000, f. & cert. ef. 9-24-00; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; CCB 11-2002, f. 12-20-02, cert. ef. 12-23-02; CCB 3-2003(Temp), f. & cert. ef. 3-11-03 thru 9-6-03; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 12-2003(Temp), f. & cert. ef. 12-9-03 thur 6-6-04; CCB 13-2003(Temp), f. 12-19-03, cert. ef. 1-1-04 thru 6-14-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-001-0022

Requirements for Notice of Compliance with Homebuyer Protection Act

(1) Under section 2 (3), chapter 778, Oregon Laws 2003, a seller of residential property must deliver a Notice of Compliance with Homebuyer Protection Act on or before the date the sale of the property closes to the purchaser of:

(a) A new single family residence, condominium or residential building; or

(b) An existing single-family residence, condominium or residential building where:

(A) The price for original construction, including but not limited to an addition to the single family residence, condominium or residential building, that is completed within three months prior to the date of the sale of the property is $50,000 or more; or

(B) The contract price for improvements to the single-family residence, condominium or residential building that are completed within three months prior to the date of the sale of the property is $50,000 or more.

(2) The seller must deliver the notice required under 2 (3), chapter 778, Oregon Laws 2003 on or before the close of the sale of the property.

(3) The notice required under section 2 (3), chapter 778, Oregon Laws 2003 shall be on the form adopted under OAR 812-001-0020.

(4) Under section 2 (3), chapter 778, Oregon Laws 2003, a seller of residential property may specify on the Notice of Compliance with Homebuyer Protection Act that section 2 (2), chapter 778, Oregon Laws 2003 does not apply to the sale of the property if the seller knows that no person may enforce a valid lien against the property because:

(a) The last day to perfect any lien on the property under ORS 87.035 was prior to the date of sale of the property; and

(b) No lien was perfected.

Stat. Auth.: ORS 670.310, 701.235, Ch. 778, OL 2003

Stats. Implemented: ORS 87, 701, Ch. 778, OL 2003

Hist.: CCB 13-2003(Temp), f. 12-19-03, cert. ef. 1-1-04 thru 6-14-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-003-0015

Applications for License

(1)(a) The application required under subsection (3)(a) of this rule together with the fee required and the original, fully-executed surety bond shall be on file with the agency before a license may be issued, except as provided in section (b) of this rule.

(b) The effective date of a license or renewal may be prior to the date of receipt of all documents and/or fees required by law and by these rules if the agency determines that delays in receipt of required documents and/or fees were caused by agency error. Additionally, if the agency determines that delays in receipt of a surety bond were caused by the surety through an error in executing the bond or through another error, the agency may issue a license prior to receipt of all documents and/or fees if the surety concurs with the agency's decision to pre-date the bond.

(2)(a) An applicant for a license or renewal shall certify that the applicant has procured insurance, from an insurance company authorized to do business in Oregon, as required by ORS 701.105 and will continue to meet those insurance requirements for as long as the applicant is licensed. New licensees shall provide a certificate of insurance issued by an insurance company licensed in Oregon. The agency may also require such certification from renewing licensees. As a minimum, for all licensees, certification shall include the name of the insurance company, policy or binder number, effective dates of coverage, and coverage amount, and may also include the agent's name, and agent's telephone number. The CCB must be listed as the certificate holder.

(b) This certification constitutes satisfactory evidence of insurance and is in lieu of any other evidence of insurance.

(c) If the requirements of subsection (2)(a) of this rule have been met, and the agency receives a notice of cancellation, the agency may send a notice to the licensee, by regular mail, reminding the licensee of the obligation imposed by the licensee's insurance certification.

(d) The licensee shall maintain and provide evidence to the agency of the insurance required by ORS 701.105. The insurance shall remain in effect continuously until the license is terminated, revoked, or expired. If the licensee, in performance of work subject or ORS Chapter 701, through failure to comply with this subsection, causes damage to another entity or to the property of another person for which that entity could have been compensated by an insurance company had the required insurance been in effect, the agency may assess a civil penalty against the licensee in an amount up to $l,000 in addition to such other action as may be taken under ORS 701.135.

(3)(a) A complete license application includes:

(A) A completed application form;

(B) A completed "Independent Contractor Certification Statement";

(C) A signed acknowledgment that if the licensee qualifies as an independent contractor the licensee understands that the licensee and any heirs of the licensee will not qualify for workers' compensation or unemployment compensation unless specific arrangements have been made for the licensee's insurance coverage and that the licensee's election to be an independent contractor is voluntary and is not a condition of any contract entered into by the licensee;

(D) The certification of insurance coverage showing not less than the minimum amount required per occurrence for property damage and personal injury;

(E) A properly executed bond; and

(F) The application fee.

(b) The agency may return an incomplete license application to the applicant with an explanation of the deficiencies.

(4)(a) The agency will not issue or renew a license unless an applicant provides his or her social security number on the application or renewal form. The applicant need not provide the social security number on the application for renewal, if the applicant's social security number has previously been provided to the agency and is in the record.

(b) If an applicant has not been issued a social security number by the United States Social Security Administration, the agency will accept a written statement from the applicant to fulfill the requirements of section (4)(a). The applicant may submit the written statement on a specified agency form with the requisite information. Any written statement must:

(A) Be signed by the applicant;

(B) Attest to the fact that no social security number has been issued to the applicant by the United States Social Security Administration; and

(C) Acknowledge that knowingly supplying false information under this section is a Class A misdemeanor, punishable by imprisonment of up to one year and a fine of up to $6,250.

(5) A license card shall be issued by the agency effective the date on which all fees required by law have been paid and all documents required by law and by those rules are on file with the agency.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 670.310, 701.235, 701.280, 701.992 & 183.310 - 183.500

Stats. Implemented: ORS 701.075, 25.278, Ch. 610 OL 2003

Hist.: 1BB 5, f. 6-15-76, ef. 7-1-76; 1BB 7, f. & ef. 11-14-77; 1BB 1-1978, f. & ef. 5-23-78; 1BB 2-1979, f. & ef. 12-29-79; 1BB 5-1980, f. & ef. 10-7-80; 1BB 6-1980, f. & ef. 11-4-80; 1BB 3-1981, f. 10-30-81, ef. 11-1-81; 1BB 1-1983, f. & ef. 3-1-83; Renumbered from 812-011-0025; 1BB 3-1984, f. & ef. 5-11-84; 1BB 4-1984, f. & ef. 8-16-84; 1BB 3-1985, f. & ef. 4-25-85; BB 2-1987, f. & ef. 7-2-87; BB 3-1987, f. 12-30-87, cert. ef. 1-1-88; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 2-1990, f. 5-17-90, cert. ef. 6-1-90, CCB 4-1990, f. 10-30-90, cert. ef. 11-1-90; CCB 7-1992, f. & cert. ef. 12-4-92; CCB 4-1995, f. & cert. ef. 10-5-95; CCB 4-1997, f. & cert. ef. 11-3-97; CCB 4-1998, f. & cert. ef. 4-30-98; CCB 6-1999, f. 9-10-99, cert. ef. 11-1-99; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 1-2004, f. & cert. ef. 2-2-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-004-0110

Claim Processing Fee; Waiver of Fee

(1) The claim processing fee authorized under ORS 701.147 is $50 for a claim filed under ORS 701.145. There is no claim processing fee for a claim filed under ORS 701.146.

(2) The agency shall collect the processing fee under OAR 812-004-0400.

(3) A claimant may request that the agency waive the claim processing fee described in section (1) of this rule by submitting a properly executed waiver request. The waiver request must be submitted on a form provided by the agency.

(4) The agency may waive the claim processing fee if the waiver request submitted by the claimant shows that:

(a) The claimant is an individual;

(b) Claimant has no significant assets except the home that is the subject of the claim and one automobile; and

(c) Claimant's gross income does not exceed the 2003 Department of Health and Human Services Poverty Guidelines published in the Federal Register, Vol. 68, No. 26, February 7, 2003, pp. 6456-6458.

(5) A claimant, who requests a waiver of the claim processing fee under section (3) of this rule, must certify that the information on the request is true.

(6) The agency may require that the claimant pay a claim processing fee of $97 if the agency finds that the claimant provided false information on a request for a waiver of the claim processing fee submitted under section (3) of this rule.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 670.310 & 701.235

Stats. Implemented: ORS 701.146 & 701.147, & Ch. 294, OL 2003

Hist.: CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 14-2003(Temp), f. 12-24-03, cert. ef. 1-1-04 thru 6-18-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-004-0250

Award of Attorney Fees, Interest and Other Costs

(1) Except as provided in section (2) of this rule and subject to OAR 812-010-0420, an order or arbitration award of the board awarding monetary damages in a claim that are payable from respondent's bond required under ORS 701.085, including, but not limited to an order of the board arising from a court order, may not include an award for:

(a) Attorney fees;

(b) Court costs;

(c) Interest;

(d) Costs to pursue litigation or the claim;

(e) Service charges or fees; or

(f) Other administrative damages.

(2) An order or arbitration award by the board awarding monetary damages that are payable from respondent's bond required under ORS 701.085 may include an award for attorney fees, costs, interest or other costs as follows:

(a) An order in a construction lien claim may include attorney fees, court costs, interest and service charges allowed under OAR 812-004-0530(5).

(b) An order or arbitration award in an owner claim may include interest expressly allowed as damages under a contract that is the basis of the claim.

(c) An order or arbitration award awarding monetary damages may include an award of a claim processing fee paid by the claimant under OAR 812-004-0110.

(d) An order or arbitration award may include attorney fees, court costs, other costs and interest included in an order or award of a court or other entity that are related to the portion of the order or award of the court or other entity that is within the jurisdiction of the board if the order or award of the court or other entity arises from litigation, arbitration or other proceedings authorized by law or the parties to effect a resolution to the dispute:

(A) That was initiated by the respondent; or

(B) That the agency required the claimant to initiate under ORS 701.145 because of the nature or complexity of the claim.

(3) This rule does not apply to a claim filed and processed under ORS 701.146.

Stat. Auth.: ORS 670.310, 701.145 & 701.235

Stats. Implemented: ORS 813.415, 183.460 & 70.145, 701.146

Hist.: CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2001, f. & cert. ef. 4-6-01; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 14-2003(Temp), f. 12-24-03, cert. ef. 1-1-04 thru 6-18-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-004-0440

Contracts with Arbitration Agreements

(1) If a claim is based on a contract that contains an agreement by the parties to mediate or arbitrate disputes arising out of the contract, the specific terms of the mediation or arbitration agreement supersede agency rules except as set forth in ORS 701.180. Unless the contract requires mediation or arbitration by the agency, the agency shall take the following action:

(a) The agency shall inform the claimant in a written notice that complies with the requirements of OAR 812-004-0260 that the agency will close the claim unless the agency receives within 30 days of the date of the notice:

(A) A written waiver of mediation or arbitration under the contract signed by the claimant; or

(B) Evidence that the claimant or respondent initiated mediation or arbitration under the contract to resolve the same facts and issues raised in the claim.

(b) If the agency does not receive the written waiver or evidence of initiation of mediation or arbitration required under subsection (a) of this section from the claimant within 30 days of the date of the written notice described in subsection (a) of this section, the agency may close the claim under OAR 812-004-0260. The agency may not close the claim under this subsection if the respondent initiates mediation or arbitration under the contract prior to the expiration of the 30-day period for providing the waiver or evidence of initiation of mediation or arbitration.

(c) The agency will request that respondent sign and submit to the agency a written waiver of mediation or arbitration under the contract. If the respondent does not waive mediation or arbitration under the contract, the agency will allow the respondent the time allowed under ORS 701.180 to commence mediation or arbitration. If the contractor fails to submit evidence to the agency that mediation or arbitration under the contract commenced within the time allowed under ORS 701.180 and if the claimant waived mediation or arbitration within the time allowed under subsection (a) of this section, the agency will continue to process the claim.

(d) If mediation or arbitration under the contract is properly commenced under this section, the agency shall suspend processing the claim until the mediation or arbitration is complete.

(2) If a claim is based on a contract that contains an agreement by the parties to mediate and arbitrate disputes arising out of the contract, the claim shall be processed as required under section (1) of this rule, except that the respondent will be deemed to have commenced mediation and arbitration within the time allowed under ORS 701.180 if:

(a) The respondent commences mediation within the time allowed under ORS 701.180; and

(b) If the claim is not resolved in mediation, the respondent submits to arbitration within 30 days of the completion of mediation, unless the parties to the claim mutually agree on a different schedule.

(3) Notwithstanding receipt of a notice of intent to file a claim under ORS 701.147 or any prior communication from the agency referencing a claim, for purposes of ORS 701.180, a respondent receives notice of a claim when the agency sends the respondent the request under section (1) of this rule for a written waiver of mediation or arbitration or evidence that mediation or arbitration has been commenced.

(4) Nothing in this rule prevents the parties from mutually agreeing to have the agency arbitrate the dispute, rather than process the claim as a contested case.

Stat. Auth.: ORS 670.310, 701.145 & 701.235

Stats. Implemented: ORS 701.145 & 701.180

Hist.: 1BB 6-1980, f. & ef. 11-4-80; 1BB 1-1982, f. 3-31-82, ef. 4-1-82; 1BB 4-1982, f. & ef. 10-7-82; 1BB 1-1983, f. & ef. 3-1-83; Renumbered from 812-011-0053; 1BB 3-1984, f. & ef. 5-11-84; 1BB 2-1985(Temp), f. & ef. 3-5-85; 1BB 3-1985, f. & ef. 4-25-85; BB 2-1987, f. & ef. 7-2-87; BB 3-1987, f. 12-30-87, ef. 1-1-88; Renumbered from 812-004-0015; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 2-1990, f. 5-17-90, cert. ef. 6-1-90; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98, Renumbered from 812-004-0042; CCB 2-2001, f. & cert. ef. 4-6-01; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 14-2003(Temp), f. 12-24-03, cert. ef. 1-1-04 thru 6-18-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-004-0535
Elements of Claim that Must Be Proved

The following provisions apply to OAR 812-004-0540(5), 812-004-0550(2), 812-009-0100 and 812-009-0120:

(1) Except as provided in section (3) of this rule, in order for the agency to award damages to claimant the record of the claim must contain evidence that persuades the agency, arbitrator or administrative law judge that:

(a) Claimant suffered damages;

(b) Respondent caused those damages by acts or omissions within the scope of ORS 701.140; and

(c) The monetary value of those damages is substantiated on the record.

(2) The agency shall dismiss the claim if the evidence in the record of the claim does not persuade the agency, arbitrator or administrative law judge of the existence of the facts described in section (1) of this rule.

(3) Notwithstanding the presence of evidence described in section (1) of this rule, a claim for damages must be dismissed if the record of the claim contains evidence that persuades the agency, arbitrator or administrative law judge that the claimant is not entitled to recover the damages. Evidence that the claimant may not be entitled to recover all or part of the damages claimed includes, but is not limited to a valid release of liability or a valid limitation of damages.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.139, 701.140, 701.143, 701.145, 701.146 & 701.147
Hist.: CCB 2-2003, f. & cert. ef. 3-4-03; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-004-0540
Establishing Monetary Damages and Issuing Proposed Default Order or Referral for Hearing

(1) A claimant may seek monetary damages if the agency has not closed the claim and:

(a) The claimant disagrees with the resolution recommended by the agency;

(b) The respondent cannot or will not comply with the recommended resolution; or

(c) The parties signed the settlement agreement proposed by the agency but, through no fault of the claimant, the terms of the settlement agreement have not been fulfilled by the respondent, and the agency is so advised in writing by the claimant within 30 days of the date the settlement agreement was to have been completed.

(2) If the claimant seeks monetary damages or the agency so requests, the claimant shall file a declaration of damages stating the amount the claimant alleges the respondent owes the claimant, limited to claim items listed in the Statement of Claim and those claim items added up to and through any initial on-site meeting. The agency may require the claimant to submit, in support of the amount alleged:

(a) One or more estimates from licensed contractors for the cost of correction of the claim items; or

(b) Other bases for a monetary award.

(3) If the agency does not hold an on-site meeting, the agency may issue a proposed default order or refer the claim for an arbitration or contested case hearing under section (4) of this rule after each party to the claim has had an opportunity to provide evidence supporting its position with regard to the claim. The agency may require that the claimant file a declaration of damages and supporting evidence described under section (2) of this rule, except that the declaration of damages shall be limited to claim items listed in the Statement of Claim.

(4) After documentation required under sections (2) or (3) is received, the agency may:

(a) Issue a proposed default order proposing dismissal of the claim under OAR 812-004-0550(2) or payment of an amount by the respondent to the claimant; or

(b) Refer the claim to the Office of Administrative Hearings for an arbitration or contested case hearing to determine the validity of the claim and whether the amount claimed, or some lesser amount is proper.

(5)(a) The agency may issue a proposed default order that the respondent pay damages to claimant only if the record of the claim supports an award of damages under OAR 812-004-0535.

(b) The agency may issue a proposed default order that is not described in subsection (a) of this section only if the record of the claim contains evidence that persuades the agency of the existence of facts necessary to support the order.

(6) The provisions of OAR 812-004-0560 apply to a proposed default order or a referral to the Office of Administrative Hearings issued under this rule.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 183.415, 183.460, 183.470, 701.145 & 701.147
Hist.: CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 1-2000(Temp), f. 1-20-00, cert. ef. 1-24-00 thru 7-22-00; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 2-2001, f. & cert. ef. 4-6-01; CCB 5-2002, f. 5-28-02, cert. ef. 6-1-02; CCB 10-2002, f. & cert. ef. 11-20-02; Hist.: CCB 2-2003, f. & cert. ef. 3-4-03; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-004-0550
Proposed Default Order to Dismiss, Other Resolution of Claim by Proposed Default Order

(1) The agency may issue a proposed default order proposing dismissal of a claim if the evidence in the claim record persuades the agency that one of the following grounds for dismissal exists:

(a) The claim is not the type of claim that the agency has jurisdiction to determine under ORS 701.140.

(b) The claim was not filed within the time limit specified under ORS 701.143.

(c) The claimant did not permit the respondent to comply with agency recommendations under ORS 701.145(3)(b).

(d) The claim must be dismissed for lack of jurisdiction under OAR 812-004-0320(4) or (5).

(e) The respondent breached a contract or performed work negligently or improperly, but the monetary value of damages sustained by the claimant is less than an amount due to the respondent from the claimant under the terms of the contract.

(f) The claimant contends that the respondent failed to fulfill the terms of a settlement that resolved the claim but the agency finds that the respondent fulfilled the respondent's obligation under the settlement agreement.

(2) The agency may issue a proposed default order proposing dismissal of a claim if the agency investigates the claim and after the investigation finds that the record of the claim supports dismissal under OAR 812-004-0535.

(3) If the claimant makes a timely request for a hearing after the agency issued a proposed default order under section (1) or (2) of this rule, the agency may:

(a) Refer the claim for an arbitration or contested case hearing solely to determine whether the dismissal was proper; or

(b) Require that the claimant file a declaration of damages stating an amount the claimant alleges the respondent owes the claimant and refer the claim for an arbitration or contested case hearing to determine if the claim should be dismissed and if not, the validity of the claim and whether the amount claimed, or some lesser amount is proper.

(4) The provisions of OAR 812-004-0560 apply to a proposed default order or a referral to the Office of Administrative Hearings issued under this rule.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 183.415, 183.460, 183.470, 701.145 & 701.147
Hist.: CCB 1-2000(Temp), f. 1-20-00, cert. ef. 1-24-00 thru 7-22-00; CCB 3-2000(Temp), f. 3-10-00, cert. ef. 3-10-00 thru 7-22-00; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 2-2001, f. & cert. ef. 4-6-01; 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 2-2003, f. & cert. ef. 3-4-03; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-008-0050
Testing Requirements

(1) The agency shall provide a written test for certification of individuals.

(2) The test shall be divided into five sections and weighted as follows:

(a) 20 percent: Structure, roofing, site, exterior, and interior.

(b) 20 percent: Heating, cooling, insulation, ventilation, fireplaces and wood stoves.

(c) 20 percent: Electrical.

(d) 20 percent: Plumbing.

(e) 20 percent: Agreements, reports and standards.

(3) To be certified, applicants must successfully pass the test.

(4) Applicants shall schedule an appointment with the agency, or designated proctors throughout the state, to take the test after receipt of a letter of authorization from the agency and payment of the fee prescribed in division 8.

(5) The passing score shall be 75 percent or higher based on 100 percent possible.

(6) Applicants shall score 75 percent or higher on each of five sections of the test.

(7) Applicants shall not take the same test version on consecutive attempts.

(8) The agency will notify applicants by mail of their test scores on each section of the test.

(9) Applicants who fail one or more sections of the test need not retake test sections already passed except as provided in (10) below.

(10) Applicants shall pass all sections of the test within one year of the date the person first took the test or retake all sections of the test.

(11) Applicants shall complete the certification process within one year from the date the person passed all sections of the test or retake the entire test.

(12) Applicants shall show picture identification before taking the test.

(13) Applicants shall not be accompanied by another individual while taking the test unless it is a translator.

(14) Applicants needing a translator shall pay for translator.

(15) Applicants taking the test shall not leave the testing room.

(16) Applicants shall not retain notes or other materials during the test.

(17) Applicants who attempt and fail the first test may take all subsequent tests in no less than 30 days.

(18) Applicants shall not review test questions or answer sheets.

Stat. Auth.: ORS 670.310, 701.235 & 701.350
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 4-1998, f. & cert. ef. 4-30-98; CCB 5-1998(Temp), f. & cert. ef 5-28-98 thru 7-1-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 6-1999, f. 9-10-99, cert. ef. 11-1-99; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-009-0100
Burden of Proof and Failure to Meet Burden

Claimant must submit sufficient credible evidence into the record to support an award of damages under OAR 812-004-0535. If claimant fails to carry this burden of proof, the administrative law judge shall dismiss the claim.

Stat. Auth.: ORS 670.310, 701.235
Stats. Implemented: ORS 183 & 701
Hist.: CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 3-2000(Temp), f. 3-10-00, cert. ef. 3-10-00 thru 7-22-00; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 2-2001, f. & cert. ef. 4-6-01; CCB 2-2003, f. & cert. ef. 3-4-03; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

812-009-0120
Determination of Validity of Claim

In determining the validity of the claim, the administrative law judge shall determine:

(1) Whether the claim arose out of a transaction within the scope of ORS Chapter 70l;

(2) Whether the agency has jurisdiction over the matters at issue; and

(3) Whether the record of the claim supports an award of damages under OAR 812-004-0535.

Stat. Auth.: ORS 670.310, 701.235
Stats. Implemented: ORS 183 & 701
Hist.: CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 3-2000(Temp), f. 3-10-00, cert. ef. 3-10-00 thru 7-22-00; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 2-2003, f. & cert. ef. 3-4-03; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 2-2004, f. 2-27-04, cert. ef. 3-1-04

• • • • • • • • • • •

Adm. Order No.: CCB 3-2004
Filed with Sec. of State: 2-27-2004
Certified to be Effective: 7-1-04
Notice Publication Date: 2-1-04
Rules Amended: 812-003-0000
Subject: OAR 812-003-0000 is amended to reflect the fee increase and change to a flat fee structure effective July 1, 2004. The 2003 legislature authorized a fee increase effective July 1, 2003. The agency delayed implementation of a fee increase until January 1, 2004; however, the Board determined at their December 2, 2003 Board meeting to further delay a fee increase due to increased revenue receipts. The rules were then repealed that would have implemented a fee increase effective January 1, 2004. This rule filing is to implement the original fee increase with an effective date of July 1, 2004, which reflects the one year delay in implementation of a fee increase and to require a flat reinstatement fee for all categories rather than the current two-tiered system which can be confusing.
Rules Coordinator: Cathy Heine—(503) 378-4621, ext. 4077

812-003-0000
Licensing Generally

(1) A license and its identifying license number will be issued to one entity only. Other entities shall not be included in that license, but each shall be separately licensed and shall separately meet the licensing requirements. No entity may perform work subject to ORS Chapter 701 through the use of another entity's license.

(2) The Board adopts the form "Independent Contractor Certification Statement" as approved October 24, 1989, as required by ORS 701.075(3).

(3) If an entity licensed as a sole proprietorship, partnership, corporation, limited liability company, limited liability partnership, or joint venture seeks to change to another entity, the former license may be terminated. The new entity must license anew.

(4) All partners within a partnership shall be on record with the Construction Contractors Board. Partnerships consisting of spouses shall be treated the same as partnerships consisting of unrelated persons. License becomes invalid upon any change in the composition of that partnership.

(5) Each entity shall:

(a) List on its license application or renewal all assumed business names under which business as a contractor is conducted. All assumed business names listed shall be on record with the Corporation Division; and

(b) Provide evidence to the agency that the applicant's responsible managing individual has completed the education required by ORS 701.280 as governed by Division 6 of these rules.

(c) List on its license application or renewal the Standard Industrial Classification (SIC) code number of its main construction activities.

(6) (a) A license card is valid for the term for which it is issued only if the following conditions are met throughout the license period:

(A) The surety bond remains in effect and undiminished by payment of Construction Contractors Board final orders; and

(B) The insurance required by ORS 701.105 remains in effect; and

(C) If the licensee is a sole proprietorship, survival of the sole proprietorship; or

(D) If the licensee is a partnership or limited liability partnership, no change in the composition of that partnership, by death or otherwise; or

(E) If the licensee is a corporation or limited liability company, survival of that corporation or limited liability company, including compliance with all applicable laws governing corporations or limited liability companies.

(b) If the licensee's bond is cancelled, the license will lapse 30 days from the date the cancellation is received by the agency.

(c) An entity whose license has lapsed is considered unlicensed from the date the lapse occurred until the date the license is backdated and renewed, reissued, or reinstated. During a period of lapse, the entity shall not perform the work of a contractor.

(d) A period of lapse will end and the license previously issued will again become valid on the date upon which the agency receives the missing items that caused the lapse. This includes but is not limited to a new bond or a notice of reinstatement for the existing bond or on the effective date of a backdated bond or backdated reinstatement for the existing bond.

(e) If a license becomes invalid, the agency may require the return of the license and pocket card(s).

(7) No person shall advertise or otherwise hold out to the public that person's services as a contractor unless that person holds a current, valid license, nor shall any person claim by advertising or by any other means to be licensed, bonded, insured, or licensed unless that person holds a current, valid license.

(8) License number in advertising and contracts:

(a) All newsprint classified advertising and newsprint display advertising for work subject to ORS chapter 701 prepared by a contractor or at the contractor's request or direction, shall show the contractor's license number.

(b) All written bids, written inspection reports and building contracts subject to ORS Chapter 701 shall show the contractor's license number.

(c) All telephone directory space ads and display ads shall show the contractor's license number.

(d) Except as set forth in sub paragraph (e) all business cards, business letterhead, business signs at construction sites, all advertising, shall show the contractor's license number. This rule is effective upon filing for all contractors filing for new license, and is effective for all existing contractors when they purchase new business cards, business letterhead, and business signs for construction sites, or January 1, 1998, whichever date occurs sooner.

(e) Sub paragraph (d) does not apply to a company whose primary business is other than construction and has a Standard Industrial Classification (SIC) code from other than Major Groups 15, 16, and 17.

(9) The initial two-year license fee for all license applications received on or after July 1, 2004 is $295 for all categories.

(10) The two-year renewal fee for all license renewals with a renewal date of July 1, 2004, and after and all other license renewal applications received by the agency on or after July 1, 2004 is $295 for all categories.

(11) The reinstatement fee is $20 for all categories.

(a) Except as set forth in (b), the reinstatement fee shall be charged for any renewal, reissue, or reinstatement received by the agency after the prior license expiration date.

(b) The agency may waive the reinstatement fee if:

(A) The properly-completed renewal form and correct fee are received by the agency prior to the expiration date and all other renewal requirements are met within one month after the expiration date; or

(B) The licensee's failure to meet the renewal date was caused entirely or in part by an agency error or omission.

(12) A person licensed as a General Contractor — All-Structures may also perform the work of a Specialty Contractor — All-Structures. A person licensed as a General Contractor — Residential-Only may also perform the work of a Specialty Contractor — Residential-Only.

(13) A Limited Contractor may perform Specialty Contractor, General Contractor, residential, small commercial and large commercial construction work, so long as all of the following conditions are met:

(a) The licensee's annual gross business sales do not exceed $40,000;

(b) The licensee does not enter into a contract in which the contract price exceeds $5,000;

(c) If the contract price in a contract for work performed by the licensee is based on time and materials, the amount charged by the licensee shall not exceed $5,000;

(d) The licensee consents to inspection by the Construction Contractors Board of its Oregon Department of Revenue tax records to verify compliance with subsection (a).

(e) For purposes of this section, "contract" includes a series of agreements between the licensee and a person for work on any single work site within a one-year period.

(14) An Inspector may perform inspections, but may not construct, alter, repair, add to, subtract from, improve, move, wreck or demolish for another, any building, highway, road, railroad, excavation or other structure, project, development or improvement attached to real estate or do any part thereof, or act as a contractor performing construction management on a project that involves any of these activities.

(15) The following surety bond amounts are required:

(a) For those applicants applying for a new license or reissue prior to July 1, 1999, and for those applicants applying for renewal prior to August 1, 1999, the bond amount required is as follows:

(A) General Contractor — All Structures — $10,000.

(B) General Contractor — Residential — $10,000.

(C) Specialty Contractor — All Structures — $5,000.

(D) Specialty Contractor — Residential — $5,000.

(E) Limited Contractor — $2,000.

(b) As required by ORS 701.085 as amended by chapter 325, 1999 Session Laws, for those applicants applying for a new license or reissue on or after July 1, 1999, and for those applicants applying for renewal on or after August 1, 1999, or with an expiration date of August 1, 1999, or later the bond amount required is as follows:

(A) General Contractor — All Structures — $15,000.

(B) General Contractor — Residential — $15,000.

(C) Specialty Contractor — All Structures — $10,000.

(D) Specialty Contractor — Residential — $10,000.

(E) Limited Contractor — $5,000.

(F) Inspector — $10,000.

(G) Licensed Developer — $15,000.

(c) A contractor may obtain or maintain a bond in an amount that exceeds the amount required under subsection (b) of this section if the bond obtained or maintained is in an amount that is equal to an amount required under subsection (b) of this section.

(16) The following general liability insurance amounts are required:

(a) For those applicants applying for a new license or reissue prior to July 1, 1999, and for those applicants applying for renewal prior to August 1, 1999, the following general liability insurance amount is required as follows:

(A) General Contractor — All Structures — $500,000.

(B) General Contractor — Residential — $100,000

(C) Specialty Contractor — All Structures — $500,000.

(D) Specialty Contractor — Residential — $100,000.

(E) Limited Contractor — $100,000.

(b) As required by ORS 701.105, for those applicants applying for a new license or reissue on or after July 1, 1999, and for those applicants applying for renewal on or after August 1, 1999, or with an expiration date of August 1, 1999, or later the following general liability insurance amount is required as follows:

(A) General Contractor — All Structures — $500,000.

(B) General Contractor — Residential — $500,000.

(C) Specialty Contractor — All Structures — $500,000.

(D) Specialty Contractor — Residential — $300,000.

(E) Limited Contractor — $100,000.

(F) Inspector — $300,000.

(G) Licensed Developer — $500,000.

(17) A fee of $20 shall be charged for any changed license category.

(18) On all construction projects regulated under the state Prevailing Wage Law, ORS 279.348 to 279.365 or the Davis Bacon Act and related acts, 40 USC 276a, the primary contractor shall provide the list of subcontractors required by ORS 701.055(11) to the contracting public agency and to the Wage and Hour Division of the Bureau of Labor and Industries, 800 NE Oregon #32, Portland, OR 97232.

(a) The initial list of subcontractors will be submitted to the contracting public agency and to the Wage and Hour Division of the Bureau of Labor and Industries on the same date that the initial Payroll and Certified Statement form (WH-38) is due. Instructions for submitting form WH-38 are contained in OAR 839-016-0010.

(b) The primary contractor will prepare and submit updated lists of subcontractors with each submittal of the Payroll and Certified Statement form (WH-38).

(19) A contractor shall not engage in dishonest or fraudulent conduct injurious to the welfare of the public.

(20) A contractor shall cooperate fully with any investigation undertaken by the Board pursuant to ORS 701.225.

[ED. NOTE: Forms & Publications referenced are available from the agency.]

Stat. Auth.: ORS 670.310, 701.235, 701.280, 701.992 & 183.310 - 183.500

Stats. Implemented: ORS 701.055, 701.075, 701.102, 701.125 & 701.280

Hist.: 1BB 5, f. 6-15-76, ef. 7-1-76; 1BB 7, f. & ef. 11-14-77; 1BB 1-1978, f. & ef. 5-23-78; 1BB 3-1980(Temp), f. 6-2-80, ef. 7-1-80; 1BB 4-1980, f. & ef. 7-14-80; 1BB 6-1980, f. & ef. 11-4-80; 1BB 3-1981, f. 10-30-81, ef. 11-1-81; 1BB 1-1982, f. 3-31-82, ef. 4-1-82; 1BB 2-1982, f. 4-1-82, ef. 7-1-82; 1BB 1-1983, f. & ef. 3-1-83; Renumbered from 812-011-0010; 1BB 2-1983, f. & ef. 7-6-83; 1BB 3-1983, f. 10-5-83, ef. 10-15-83; 1BB 3-1984, f. & ef. 5-11-84; BB 1-1987, f. & ef. 3-5-87; BB 2-1987, f. & ef. 7-2-87; BB 3-1987, f. 12-30-87, cert. ef. 1-1-88; BB 2-1988, f. & cert. ef. 6-6-88; BB 2-1989, f. 6-29-89, cert. ef. 7-1-89; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 3-1991, f. 9-26-91, cert. ef. 9-29-91; CCB 2-1992, f. & cert. ef. 4-15-92; CCB 5-1992, f. 7-31-92, cert. ef. 8-1-92; CCB 7-1992, f. & cert. ef. 12-4-92; CCB 8-1992(Temp), f. & cert. ef. 12-4-92; CCB 1-1993, f. & cert. ef. 2-1-93; CCB 3-1993, f. & cert. ef. 6-9-93; CCB 5-1993, f. 12-7-93, cert. ef. 12-8-93; CCB 1-1994, f. 6-23-94, cert. ef. 7-1-94; CCB 1-1995, f. & cert. ef. 2-2-95; 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 4-1996, f. 11-7-96, cert. ef. 11-8-96; CCB 5-1996, f. 11-25-96, cert. ef. 11-27-96; CCB 7-1996, f. & cert. ef. 12-11-96; CCB 2-1997, f. 7-7-97, cert. ef. 7-8-97; CCB 4-1997, f. & cert. ef. 11-3-97; CCB 1-1998, f. & cert. ef. 2-6-98; CCB 6-1998, f. 8-31-98, cert. ef. 9-1-98; CCB 1-1999, f. 3-29-99, cert. ef. 4-1-99; CCB 3-1999(Temp), f. & cert. ef. 6-29-99 thru 12-25-99; CCB 5-1999, f. & cert. ef. 9-10-99; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 4-2002(Temp), f. & cert. ef. 5-23-02 thru 11-19-02; CCB 5-2002, f. 5-28-02, cert. ef. 6-1-02; CCB 8-2002, f. & cert. ef. 9-3-02; CCB 5-2003, f. 6-3-03, cert. ef. 10-1-03; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 8-2003, f. 8-8-03 cert. ef. 1-1-04; CCB 9-2003, f. 9-29-03, cert. ef. 1-1-04; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 3-2004, f. 2-27-04, cert. ef. 7-1-04

• • • • • • • • • •

Department of Administrative Services
Chapter 125

Adm. Order No.: DAS 1-2004(Temp)
Filed with Sec. of State: 3-5-2004
Certified to be Effective: 3-5-04 thru 9-1-04
Notice Publication Date:
Rules Adopted: 125-125-0050, 125-125-0100, 125-125-0150, 125-125-0200, 125-125-0250, 125-125-0300, 125-125-0350, 125-125-0400, 125-125-0450
Subject: Establish a procedure for statewide facilities reporting and incorporate the functions of the Capitol Planning Commission (CPD) into the Capital Projects Advisory Board structure while the CPC rules are suspended through June, 2005.
Rules Coordinator: Kristin Keith—(503) 378-2349, ext. 325

125-125-0050
Purpose, Application, and Authority

These rules are adopted under ORS 276.227. They set forth the statewide facility planning process for state agencies and the duties of the Board, which assists the Department with the planning process. State agencies other than institutions of higher education are required to provide information about their facilities and projects to the Department. Additionally, for the period of time between July 1, 2003 and June 30, 2005, they implement a planning and review process for facilities and projects within the area described in ORS 276.028.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0100
Definitions

As used in these rules, the following terms have the meanings indicated, unless the context requires otherwise:

(1) "Area Plan" means a plan for development in one of the specified geographical areas as described in ORS 276.010.

(2) "Building Maintenance Plan" means a plan to be completed by an agency that owns a building of 10,000 or more square feet.

(3) "Board" means the Capital Projects Advisory Board, which is advisory to the Director of the Department.

(4) "Committee" means the Capitol Mall Project Review Committee, reviews projects on the Capitol Mall for compliance with the Capitol Mall Area Plan standards and policy.

(5) "Department" means the Department of Administrative Services.

(6) "Director" means the Director of the Department of Administrative Services.

(7) "Statewide Program" means a program of the Facilities Division of the Department of Administrative Services that implements these rules.

(8) "Project Plan" means a plan to be completed for each major capital construction project of $500,000 or more that an agency is anticipating within the next three biennia.

(9) "Space Needs Plan" means a plan to be completed by agencies that own or plan to build or buy a building with 10,000 or more square feet; lease or plan to lease a site with 25,000 or more square feet of conditioned space for a term of ten years or more; plan to seek any legislative or Emergency Board approval for a major construction, acquisition or leasing project; or plan to seek planning funds for a project that is anticipated to cost more than $500,000 over the next three biennia.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0150
Statewide Facility Planning Process

(1) The statewide planning process provides a means of evaluating if state facilities are planned, financed, acquired, constructed, managed and maintained in a manner that maximizes and protects this investment.

(2) The Department shall implement and maintain a planning process. This process shall coordinate state facilities' data, standards, maintenance planning, and capital project planning. The Department shall use the Board to assist in the review of agency plans and other associated documents and to advise the Director.

(3) The Statewide Facilities Program shall develop the State Facilities Planning Process Manual. The manual shall provide definitions, examples, and detailed descriptions of required reports to aid agencies in supplying information to the Statewide Program. The manual shall be reviewed biennially before the budget process begins and updated, if needed.

(4) Following the guidelines contained in the State Facilities Planning Process Manual, Agencies shall submit a State Facility Plan through the statewide facilities coordinator if it meets one or more of the following criteria:

(a) The agency owns buildings or plans to build or buy a building of 10,000 or more square feet;

(b) The agency plans a major re-organization;

(c) The agency proposes to enter into a lease of 25,000 or more square feet of conditioned space for a period of ten years or more;

(d) The agency proposes to request a budget to construct a major capital project;

(e) The agency plans to seek a legislative or Emergency Board approval for a major construction or acquisition project.

(f) The agency plans to seek planning funds for a major construction or acquisition project for which the total cost will be $500,000.

(5) To best coordinate and distribute the facilities data, the Statewide Program shall maintain a State Facility Inventory. The inventory shall be a database of state agency facilities covered under this rule and valued over $1 million, which shall be updated biennially by agencies. The inventory shall include basic information on these buildings, such as the age, roof replacement schedule, deferred maintenance plan, etc. The data shall be used to make effective decisions on capital projects, space needs, and maintenance of the buildings.

(6) The described budget review process program does not apply to institutions of higher education, community colleges, Oregon Health Sciences University, SAIF Corporation, Lottery, Secretary of State, Treasurer's Office, or to the Legislative or Judicial branches.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0200
Capital Projects Advisory Board

(1) CPAB shall assist the Department in the review of agency plans. It shall be comprised of seven members. Five members shall be public members knowledgeable about construction, facilities management, and maintenance issues. Two members may be state employees. The Director shall appoint the chairperson of the Board.

(2) The term of each member of the Board is determined by the Director.

(3) The Board shall meet monthly or at times deemed advisable by the majority of its members. In addition, the Director may call the Board to meet for the purpose of considering agency reports.

(4) The Board members shall serve without compensation from the Department for travel or per diem.

(5) The Board is advisory to the Director of the Department and is not a governing board of a public body under ORS 192.610. Meetings of the Board shall be treated as public meetings and shall follow the notification and other procedures described in the Attorney General's Public Records and Meetings Manual and ORS 192.610 to 192.690. The Department shall send notice of upcoming meetings to an established and iterative mailing list of interested parties, using electronic methods, where practical. The Department shall also provide information regarding meetings on the Department's website.

(6) The Board shall provide a place on the agenda for public comment. Public comment should be limited to the review process criteria listed in ORS 276.227(3)(d). The Board will accept public comment only on the review items listed on the meeting agenda. The Board shall acknowledge any public comment presented and include them in the formal review record.

(7) The Board will not make a recommendation on a plan or other document reviewed without at least four majority of its members present. If a duly scheduled and noticed meeting does not have at least four members present, those present will be considered to be a subcommittee of the Board. The subcommittee will report to the next scheduled Board meeting when a majority is present, and formal action may be taken at that time.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0250
Procedure for Submitting Reports for Review

(1) Each state agency shall report to the Board by July 1 of even-numbered years a long-range facility plans and funding strategies that reflect changes in technology and priorities. The reports shall include a Space Needs Plan, a Project Plan, and a Building Maintenance Needs Plan.

(2) The Board shall review the information submitted and presented under OAR 125-125-0250(1) and make recommendations to the Director by September 1 of even-number years related to long-range plans, the condition of facilities, maintenance schedules, funding strategies and options for new facilities.

(3) The statewide facilities coordinator shall request updated plans from agencies biennially and establish a submittal schedule. This schedule shall include the report due dates and presentation date for each agency to appear before the Board.

(4) The Agency shall provide one electronic copy to the statewide facilities coordinator no later than the due date stated for the agency on the facility planning schedule.

(5) The statewide facilities coordinator will provide a substantive analysis of the plans, including review for completeness and responsiveness to issues and provide the information to the Board. The coordinator may return a list of questions to the agency or recommended changes.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0300
Procedure for Board Review

(1) Following review of the information by the Department, the agency shall present its plans before the Board, for the purpose of determining if the projects are compatible with the criteria established in the State Facilities Planning Process Manual. The Board may pose further questions to the agency or determine additional action is required and postpone acceptance or comment on the plans.

(2) In order to grant acceptance or favorable comment on the plans, the Board must find the project is compatible with the criteria listed in the State Facilities Planning Process Manual and the Budget Instructions.

(3) No agency subject to this rule shall seek Legislative or Emergency Board approval of projects meeting the criteria of 125-125-0150 without first having obtained review of the project by the Board.

(4) The Board shall accept the report after consideration of agency submissions, testimony, and public testimony, if any. Their comments shall be kept in the formal meeting minutes and provided to the Director and budget analysts for inclusion in the agency's budget package.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0350
Salem-Keizer Area Project Review

(1) The Department shall conduct a special review process for projects located within the boundaries of the cities of Salem and Keizer, and the areas that are situated outside the boundaries of any incorporated city in Marion or Polk Counties. This review process applies to any state officer, board, commission or department authorized by law to engage in capital construction or improvement projects in the areas described by ORS 276.010.

(2) The Department shall use the Board to assist with this review. Reviews will be based upon the development standards and policies contained in the Area Plans previously developed by the Capitol Planning Commission or as modified by the Department after review by the Board.

(3) Area Plans cover the following state properties: Capitol Mall Area; Airport Road Area; East Salem Area; State Fair and Exposition Center Area; Oregon State Hospital and Penitentiary Properties Area; Oregon School for the Blind Area; and, Oregon School for the Deaf Area.

(4) For the purposes of the review required under this section, project means expenditures for capital construction or for capital improvement. A project does not include the following :

(a) Interior remodeling that does not substantially change the existing use of space to another use (e.g., office space, or space used by the public);

(b) Repair or maintenance that does not substantially change the existing use of space, that does not add additional square footage to a building, and that does not change exterior building design;

(c) Individual plantings within an established landscape plan that do not alter the overall plan concept.

(5) No state agency may expend funds for any project subject to the requirements of this section unless the project has been reviewed and approved through the described review process.

(6) An agency seeking project review will submit a written request to the Statewide Facilities Program, not less than 21 days before the next scheduled meeting of the Board. The Department shall provide a standard form for agencies to use to request project review. The Department may waive the notification period for good cause. The requesting agency shall provide 10 copies of materials submitted.

(7) Projects for minor improvements to the building or grounds shall include:

(a) A completed project application form;

(b) A written description of the project;

(c) Site, architectural, and landscaping plans (if applicable) for the project;

(d) Sufficient information to demonstrate compliance with the applicable Area Plan; and

(e) Sufficient information to demonstrate compliance with local zoning and other applicable standards;

(8) Projects for major improvements to buildings or grounds and additions or new construction shall include an initial submittal including:

(a) A completed project application form;

(b) A written description of the project;

(c) Preliminary site, architectural, and landscaping plans (if applicable) for the project;

(d) A description of the process planned to be used to ensure compliance with the Area Plan and local zoning and other applicable standards; and

(e) A description of any planned meetings with neighborhood groups or other interested members of the public.

(9) After the design is completed, projects for major improvements to buildings or grounds and additions or new construction shall make a final submittal, which shall include:

(a) Site, architectural, and landscaping plans (if applicable) at a design development stage or later;

(b) Sufficient information to demonstrate compliance with the applicable Area Plan;

(c) Sufficient information to demonstrate compliance with local zoning and other applicable standards;

(d) A record of meetings with neighborhood groups or other interested members of the public.

(10) If the project is within the areas included in the Capitol Mall Area Plan, the required submittals shall also include the conclusions from the Capitol Mall Project Review Committee according to the requirements of OAR 125-125-045.

(11) The Board shall review the material submitted by the agency and acknowledge if the applicable requirements were met. The Board shall also provide an opportunity for interested members of the public to comment about the projects compliance with the Area Plan. The Board will then pass the record of the project review to the agency and the Director.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0400
Area Plan Update Responsibilities

(1) Each agency owning property in the Salem-Keizer area shall be responsible for helping maintain an Area Plan for property they own.

(2) The Department shall develop a standard template for these plans, which shall structure any modifications to existing plans. The Department shall also develop and maintain a coordination plan that addresses the interrelationship among the different Area Plans and the state's presence in the City of Salem.

(3) The Department shall develop and maintain a review schedule for the Area Plans and a process for coordinating any required changes with the affected agencies and the City of Salem. If outside assistance is required to update the plan, it shall be at the expense of the property owning agency or agencies.

(4) The review schedule shall result in each Area Plan being reviewed before the Board at least once every five years and updated as may be required. At the time of the review, the Board shall provide an opportunity for public comment on any proposed revisions to the plan.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

125-125-0450
Capitol Mall Area Project Review

(1) The Department shall create and maintain a special Capitol Mall Project Review Committee to provide an additional level of design review for Capitol Mall projects. The committee will be comprised of the following members: the manager of the Statewide Program; a representative from the Legislative Assembly; a representative from the City of Salem; and a private design practitioner.

(2) In addition to the procedures described for Salem-Keizer Area projects, projects covered by the Capitol Mall Area Plan shall have these additional requirements:

(a) Before submitting the materials for Salem-Keizer Area Project Review, the agency shall submit the material to Capitol Mall Project Review Committee.

(b) The Committee will determine if the proposed project is consistent with the policies and design standards for the Capitol Mall.

(c) The Committee will pass its conclusions to the Board.

(d) For major projects, both the initial submittal and final design submittal will require review.

Stat Auth: ORS 276.227, 276.028
Stats. Implemented:
Hist.: DAS 1-2004(Temp), f. & cert. ef. 3-5-04 thru 9-1-04

Department of Administrative Services,
Human Resource Services Division
Chapter 105

Adm. Order No.: HRSD 1-2004
Filed with Sec. of State: 3-5-2004
Certified to be Effective: 3-5-04
Notice Publication Date: 2-1-04
Rules Amended: 105-040-0030
Rules Repealed: 105-040-0030(T)
Subject: Language was added to ensure system programming is consistent with other HRSD administrative rules and State policies as it relates to the use of salary range versus salary rate in determining when to remove an applicant's name from various applicant lists.
Rules Coordinator: Kristin Keith—(503) 378-2349, ext. 325

105-040-0030
Use of Applicant Lists

Applicability: Classified unrepresented and management service positions, and initial appointment to all classified positions. Not applicable to represented positions where in conflict with a collective bargaining agreement.

(1) It is the policy of the State of Oregon to establish and maintain lists of qualified applicants to facilitate a selection process based upon required knowledge and skills.

(a) The order in which applicant lists are to be used shall be in accordance with Administrative Rule 105-040-0020, Types and Order of Applicant Lists, or as specified in collective bargaining agreements.

(b) Lists of eligibles necessary to provide an adequate number of qualified candidates shall, except for agency layoff or agency informational lists, be established and maintained on the Division's central system.

(c) When a vacant position is to be filled, an appointing authority, when appropriate, shall request a list of qualified applicants and receive a "certificate of eligibles" prior to conducting interviews.

(d) The certificate of eligibles shall be issued in one of the following formats, whichever is applicable:

(A) All applicants listed in rank order from the highest to lowest score;

(B) All applicants who meet the minimum qualifications for the position;

(C) A limited number of applicants selected at random from a list of all applicants who meet the minimum qualifications for the position.

(e) When a certificate of eligibles is issued in rank order from the highest to lowest score, applicants for interviews shall be selected in that same order. When certificates issued contain tied scores, all applicants with that score shall be offered an interview if one applicant with that score is interviewed.

(f) When a certificate of eligibles is issued for all applicants who meet the minimum qualifications for the position or for a limited number of applicants selected at random from such a list, all applicants shall be interviewed unless a valid screening process is developed and documented to select only the most qualified candidates for interview. If not all qualified applicants are to be interviewed, the job announcement shall inform applicants of the selection process being used. If the selection process includes ranking applicants using a numerical score or any other method of ranking applicants that does not result in a score, veterans' preference points shall be added, where applicable, at the time of ranking.

(g) When a certificate of eligibles is issued for a limited number of applicants selected at random from a longer list of all qualified candidates and the agency has not met its affirmative action goals, the certificate may include the same proportion of protected class candidates as the list of all qualified candidates. An appointing authority may supplement a randomly selected certificate of eligibles in the following manner:

(A) When a random certificate is requested to fill a vacant position for which there is an existing temporary appointment, an appointing authority may interview the temporary employee, or all temporary employees in the agency or work unit, in addition to the candidates listed on the randomly selected certificate of eligibles, provided that the temporary employee is included in the list of all qualified candidates and is performing the same duties of the vacant position.

(B) A randomly selected certificate of eligibles may be supplemented with the names of all qualified candidates who are clients of the Department of Human Services or Juvenile Justice Division programs described under OAR 105-040-0060, Limited-Competitive and Non-competitive Appointments.

(h) The number of candidates on the certificate of eligibles shall be determined by the appointing authority. However, all names with the same score, where scores are used, shall be included.

(i) A related applicant list of a classification having similar knowledge and skills may be used. However, applicants must meet the minimum qualifications for the position being filled.

(j) New and existing applicant lists may be consolidated, as necessary, provided minimum qualifications and the exam requirements are the same.

(k) Except for the expiration of the term of eligibility on an applicant list, any person whose name is removed from a list shall be promptly notified by the Administrator or delegated agency appointing authority of the reason for such removal.

(l) Appointment to a classification from an applicant list will automatically inactivate the applicant from all applicant lists except for agency layoff list, for classifications that:

(A) have a top step salary rate equal to or less than the appointed classification top step salary rate; and

(B) have a salary range number equal to or less than the appointed classification salary range number.

(m) The Administrator or delegated agency may remove a name from an applicant list for reasons including, but not limited to the following:

(A) Failure to respond within a reasonable time period to any inquiry to availability for appointment;

(B) Expiration of the term of eligibility on the list;

(C) Willful violation of these rules or policies, or provisions of the law;

(D) Falsifying statements on the application;

(E) Failure to pass required and job related criminal record or driving record checks;

(F) Cancellation of a list;

(G) Appointment made from a lay-off list to any classification;

(n) A disposition code shall be reported for each candidate appearing on the certificate of eligibles who was invited to interview.

(2) A certificate of eligibles is a list of candidates certified to a position, as a result of submitting of an application and meeting the minimum qualifications on the job announcement, passing the exam, where applicable, and were included in the number requested by the agency.

(3) A disposition code is a standardized code assigned by an appointing authority or designee to an applicant on a Certificate. The code identifies the action taken and if their name is inactivated or removed from the List. Documentation retention requirements are outlined under HRSD State Policy 40.010.01, Recruitment and Selection Record Retention.

(4) A protected class candidate is a female or person of color in one of the following groups:

(a) Asian or Pacific Islander: Persons having origins in any of the peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, The Philippine Islands and Samoa.

(b) African American (not of Hispanic origin): Persons having origins in any of the black ethnic groups.

(c) Hispanic: Persons having origins in any of the Mexican, Puerto Rican, Cuban, Central or South American or other Spanish cultures, regardless of ethnicity.

(d) Native American or Alaskan Native: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

(5) "Affirmative action goals" means those goals established in the state's Affirmative Action Plan.

Stat. Auth.: ORS 184.340 & 240.145
Stats. Implemented: ORS 240.010 & 240.306
Hist.: PD 2-1994, f. & cert. ef. 8-1-94; PD 3-1995, f. & cert. ef. 11-3-95; HRSD 1-2000, f. 1-28-00 cert. ef. 2-1-00; HRSD 14-2003, f. 7-15-03, cert. ef. 7-21-03; HSRD 21-2003(Temp), f. & cert. ef. 9-23-03 thru 12-19-03; HRSD 23-2003(Temp), f. 12-19-03, cert. ef. 12-20-03 thru 3-20-04; HRSD 1-2004, f. & cert. ef. 3-5-04

• • • • • • • • • •

Adm. Order No.: HRSD 2-2004
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04
Notice Publication Date: 2-1-04
Rules Amended: 105-040-0050
Subject: Language was added for clarification to ensure that agencies understand all of the criteria required before an agency head may make a direct appointment. Revised language brings the OAR in line

with statutory requirements by ensuring that agencies understand they must meet at least one of the criteria describing the circumstances under which a direct appointment may be made, as well as the criteria regarding the minimum qualifications of the candidate. Reference to executive service positions was removed as the applicability of this rule only extends to classified and management service positions.
Rules Coordinator: Kristin Keith—(503) 378-2349, ext. 325

105-040-0050
Direct Appointment

Applicability: Classified unrepresented and management service positions, and initial appointment to all classified positions. This rule provides state agencies an alternative method to the open competitive process when making appointments to positions in state service. Through this alternative method, as in the competitive process, agency heads shall take proactive steps to achieve a diverse workforce representative of the Oregon community as a means of fulfilling their Affirmative Action Plans.

(1) The agency head has the delegated authority and discretion to make direct appointments consistent with the criteria established in (a) and (b) below:

(a) Criteria for direct appointment:

(A) A recent open competitive recruitment results in no suitable candidates as determined, documented, and certified by the agency head. To be considered recent, an open competitive recruitment must have been completed within the previous six (6) months. When a recent statewide or agency promotion recruitment results in no suitable candidates, OAR 105-040-0020, Types and Order of Applicant Lists, requires an open competitive recruitment to be completed before a direct appointment can be made; or

(B) The appointment is made consistent with a court or administrative order, consent decree, court or administrative settlement, or negotiated tort claim settlement; or

(C) The position requires special or unique skills at the professional level. Special or unique skills at the professional level are those which require specialized knowledge typically acquired from college coursework at the bachelor degree level or beyond; or

(D) The position being filled has critical timing requirements affecting recruitment. Critical timing requirements affecting recruitment means that the position is critical to agency operations and there is a demonstrated need to fill the position quickly; and

(b) Minimum Qualifications:

(A) The individual to be direct appointed meets the minimum qualifications of the classification; or

(B) The individual is appointed as an underfill and will meet the minimum qualifications of the position within 12 months of the appointment.

(2) The agency head has the delegated authority and discretion to make direct appointments consistent with HRSD State Policy 30.005.01, Effect of Position Change on Incumbents.

(3) Each direct appointment shall be documented. The documentation shall be retained for a minimum of three (3) years. The documentation shall cite the applicable rule criteria, results of any open competitive recruitment, the qualifications of the individual selected, and the agency appointing authority authorization signature.

Stat. Auth.: ORS 240.306(5), 240.145(3) & 240.250
Stats. Implemented: ORS 240.145(3), 240.250, 240.306, 240.311 & 240.321(2)
Hist.: PD 7-1981, f. & ef. 12-18-81; PD 4-1982, f. & ef. 7-1-82; PD 1-1985, f. & ef. 3-1-85; PD 1-1986, f. & ef. 1-23-86; PD 1-1989, f. & cert. ef. 2-10-89; PD 2-1989, f. & cert. ef. 12-1-89; Suspended by PD 1-1993(Temp), f. & cert. ef. 2-17-93; PD 2-1993(Temp), f. & cert. ef. 8-27-93; PD 1-1994, f. & cert. ef. 2-23-94; PD 2-1994, f. & cert. ef. 8-1-94; Renumbered from 105-043-0005; PD 3-1995, f. & cert. ef. 11-3-95; HRSD 2-1997, f. & cert. ef. 11-5-97; HRSD 16-2003, f. 7-15-03, cert. ef. 7-21-03; HRSD 23-2003(Temp), f. & cert. ef. 11-25-03 thru 3-23-04; HRSD 2-2004, f. & cert. ef. 3-15-04

• • • • • • • • • •

Department of Agriculture
Chapter 603

Adm. Order No.: DOA 9-2004
Filed with Sec. of State: 3-12-2004
Certified to be Effective: 3-12-04
Notice Publication Date: 2-1-04
Rules Adopted: 603-054-0027
Subject: This rule requires recipients of imported tree and shrub nursery stock to notify the Oregon Department of Agriculture. Notification can be via mail, FAX or e-mail and must occur no later than two business days after its arrival. ODA will contact nurseries within one business day of receipt of notification if the imported nursery stock must be held for inspection.
Rules Coordinator: Sherry Kudna—(503) 986-4757

603-054-0027
Notification of Imported Trees and Shrubs

(1) Recipients of tree and shrub nursery stock imported into the state of Oregon from any out-of-state source are required to notify the Oregon Department of Agriculture. Notification shall be via mail, FAX or e-mail to: Nursery Program Supervisor, Plant Division, Oregon Department of Agriculture, 635 Capitol St. NE, Salem, OR 97301; FAX 503-986-4564; quarantine@oda.state.or.us.

(2) For purposes of this section, "tree and shrub nursery stock" means woody forest and ornamental trees, shrubs and vines grown or kept for propagation or sale, including bareroot, balled and burlaped, and containerized plants, liners, budwood, seedlings and cuttings. Fruit, seeds and tissue culture plantlets are not considered tree and shrub nursery stock.

(3) Notice under (1) of this section in advance of arrival of the shipment is encouraged but must be no later than two business days (Monday through Friday) after its arrival. Notification shall include the species of plant(s), quantities, source, and recipient's contact information. Copies of regular shipping documents, e.g. load lists, with this information are encouraged. ODA may approve alternative notification systems if such systems allow ODA at least one business day to determine if an inspection is necessary.

(4) ODA will contact nurseries within one business day of receipt of notification if the tree and shrub nursery stock must be held for inspection under ORS 571.220 and 570.305. Recipients are not obligated to hold the imported tree and shrub nursery stock for inspection unless contacted directly by an ODA inspector, except that the imported tree and shrub nursery stock must not be sold or distributed to untraceable buyers, e.g. final consumers, for one business day after notifying ODA.

(5) Failure to comply with this rule could result in criminal penalties authorized in 571.991 of up to $5,000. Violation of this rule by a licensed nursery may also result in license suspension or revocation.

(6) Review of this Quarantine: The continued necessity for this regulation and its effectiveness will be reviewed by the department and other interested parties by December of 2005.

Stat. Auth.: ORS 570.305, 571.220
Stats. Implemented: ORS 561.190
Hist.: DOA 9-2004, f. & cert. ef. 3-12-04

• • • • • • • • • •

Department of Consumer and Business Services, Building Codes Division
Chapter 918

Adm. Order No.: BCD 3-2004(Temp)
Filed with Sec. of State: 3-8-2004
Certified to be Effective: 3-8-04 thru 9-3-04
Notice Publication Date:
Rules Amended: 918-225-0691, 918-225-0920
Subject: During each calendar license period, certain licensed pressure vessel installers, building service mechanic boilermakers, and pressure piping mechanics are required to complete at least eight hours of Division approved continuing education. The present rule requires licensees to secure division approval of a proposed continuing education program by August 1 of each calendar year. The present rule also requires specific information concerning proposed continuing education programs to be provided to the Division. In addition, the rule requires the minimum number of hours of continuing education for certain licensees to be completed by June 30, 2004 and for other classes of licensees by June 30, 2005.

The proposed amendments remove the continuing education program approval deadline of August 1 and specific references to June 30, 2004 and June 30, 2005. Removal of references to specific dates allows licensees greater flexibility in selecting and attending continuing education programs offered throughout the calendar year and standardizes the continuing education requirement for all non-exempt licensees.
Rules Coordinator: Richard J. Baumann—(503) 373-7559

918-225-0691

Boiler, Pressure Vessel and Pressure Piping Installation, Alteration or Repair Certification Requirements

Persons installing, altering or repairing boilers and pressure vessels shall be certified under these rules and may only work within the scope of their certification.

(1) Persons desiring to obtain certification under these rules shall:

(a) Meet the qualifications for that certification;

(b) Apply on a division form; and

(c) Pay the appropriate fee.

(2) An applicant may request the Board of Boiler Rules to approve alternate verification of training and work experience on a case-by-case basis when required by the certifications in sections (5) through (10) of this rule.

(3) Definitions. For the purpose of this rule:

(a) "Direct Supervision" means the person supervised is in the physical presence of a qualified certified person at the job site and the person doing the supervision is directly assigned to monitor and direct the activities of the person supervised;

(b) "Qualified Certified Person" means a person who holds a Class 2, 3, 4, 5, 5-A or 5-B certification and is authorized to do the work involved without supervision;

(c) "Supervision" means the individual person assigned to perform supervision under section (10) of this rule is directly and specifically assigned to monitor and direct the activities of the person being supervised. Both the person performing supervision and those being supervised shall be prepared to identify each other.

(d) "Verifiable" means the matter asserted by an applicant for certification is corroborated by independent evidence or by the sworn statements of others with actual knowledge.

(4) Class 1 Trainee/Helper Certification. A person holding this certification may install, alter or repair boilers, pressure vessels and pressure piping providing the work is of a mechanical nature only. Work performed shall be under the direct supervision of a qualified certified person. Direct supervision must be on a ratio of one qualified certified person to one trainee/helper. No **ASME Code** welding is permitted. This certification has no fixed or limited duration. A person may be permanently certified under this category. There are no minimum qualifications required for applicants to obtain this certification.

(5) Class 2 Pressure Vessel Installer Certification. A person holding this certification may install or repair unfired pressure vessels by any non-welded method of attachment.

(a) There are no minimum qualifications required to obtain this certification. Applicants shall pass an examination testing the applicant's knowledge of the Boiler and Pressure Vessel Law, ORS 480.510 to 480.665; OAR chapter 918, division 225; and **American Society of Mechanical Engineers**, **Boiler and Pressure Vessel Code**, **Section VIII**, **Division 1**, **General Requirements**.

(b) Persons who install refrigeration process equipment assembled and sold as a modular unit by the manufacturer and who do not attach piping to a pressure vessel during the installation, are exempt from this rule. To qualify for this exemption, the attachment shall be made by any method other than fusion welding.

(6) Class 3 Building Service Mechanic Certification. A person holding this certification may install or repair boilers (including boiler and non-boiler external piping) and unfired pressure vessels by a non-welded method of attachment. Applicants shall:

(a) Have at least 2,000 hours of verifiable experience installing and repairing boilers;

(b) Pass an examination testing the applicants knowledge of:

(A) Boiler and Pressure Vessel Laws, ORS 480.510 to 480.665; OAR chapter 918, division 225; and the general requirements of the **American Society of Mechanical Engineers**, **Boiler and Pressure Vessel Code**, **Sections I**, **IV and VIII**, and **CSD-1**;

(B) The State of Oregon Boiler Safety Program Study Guide;

(C) Building Service Systems (Hydronics) for boilers and related appurtenances, **American Society of Mechanical Engineers/ASME B31.1 Power Piping** and **B31.9 Building Service Piping**; and

(D) Structural and mechanical blueprints with the ability to interpret specifications.

(7) Class 4 Boilermaker Certification. A person holding this certification may install, alter or repair boilers and pressure vessels (excluding non-boiler external piping) by welding or other methods of attachment. Applicants shall:

(a) Have 2,000 hours of verifiable experience doing welding and 2,000 hours of verifiable experience doing non-welding applications involving boilers or pressure vessels. The verification must cover welding and non-welding applications separately; and

(b) Pass an examination testing the applicant's knowledge of:

(A) Boiler and Pressure Vessel Laws, ORS 480.510 to 480.665; OAR chapter 918, division 225; and the general requirements of the **American Society of Mechanical Engineers, Boiler and Pressure Vessel Code, Sections I**, **II**, **IV**, **V**, **VIII** and **IX**, **CSD-1**, **B31.1** and **B31.9**;

(B) General boilermaker skills and procedures;

(C) Blueprint reading, layout and shop mathematics;

(D) Interpreting plans and specifications covering installation, alteration, repair, fabrication and erection of boilers and pressure vessels;

(E) Welding process, metallurgy and other procedures particularly applicable to boilers and pressure vessels; and

(F) The State of Oregon Boiler Safety Program Study Guide.

(c) Class 4 Boilermakers may also perform the scope of work allowed under section (8) of these rules providing;

(A) Work may only be done under the supervision of a qualified certified person under section (8) of these rules; and

(B) Prior to any welding, the individual must qualify to supervisor's employer's welding procedures.

(8) Class 5 Pressure Piping Mechanic Certification. A person holding this certification may:

(a) Fabricate, install, alter and repair pressure piping;

(b) Install boilers and pressure vessels by attachment of piping connections; and

(c) Install, assemble and repair cast iron sectional boilers.

(A) Applicants shall have a minimum of 2,000 hours of verifiable experience performing pipe-welding on ASME B31 pressure piping and 2,000 hours of verifiable experience performing work on pressure piping and boilers; and

(B) Pass an examination testing the applicant's knowledge of:

(i) American Society of Mechanical Engineers Boiler and Pressure Vessel Code, Sections I and IV, CSD-1 and B31 Pressure Piping;

(ii) Structural and mechanical blueprints with the ability to interpret specifications;

(iii) Pressure piping systems and controls;

(iv) Boiler and Pressure Vessel Laws, ORS 480.510 to 480.665 and OAR chapter 918, division 225;

(v) The State of Oregon Boiler Safety Program Study Guide; and

(vi) Welding and brazing processes, heat treatment, metallurgy and other procedures applicable to pressure piping systems.

(d) Class 5 Pressure Piping Mechanics may also perform the scope of work allowed under section (7) of these rules providing;

(A) Work may only be done under the supervision of a qualified certified person under section (7) of these rules; and

(B) Prior to any welding, the individual must qualify to supervisor's employer's welding procedures.

(9) Class 5-A Process Piping Mechanic Certification. A person holding this certification may fabricate, install, alter or repair B31.3 process piping. Applicants shall:

(a) Have a minimum of 2,000 hours of verifiable experience performing pipe-welding or brazing on B31.3 process piping and 2,000 hours of verifiable experience performing work on pressure piping; and

(b) Pass an examination testing the applicant's knowledge of:

(A) **American Society of Mechanical Engineers Boiler and Pressure Vessel Code**, **Section B31.3**;

(B) Structural and mechanical blueprints with the ability to interpret specifications;

(C) Pressure piping controls;

(D) Boiler and Pressure Vessel Laws, ORS 480.510 to 480.665 and OAR chapter 918, division 225; and

(E) Welding, brazing, chemical bonding procedures, heat treatment, metallurgy and other procedures applicable to pressure piping systems.

(10) Class 5-B Refrigeration Piping Mechanic Certification. A person holding this certification may fabricate, install, alter or repair B31.5 refrigeration piping. Applicants shall:

(a) Have a minimum of 2,000 hours of verifiable experience performing pipe-welding or brazing on B31.5 refrigeration piping and 2,000 hours of verifiable experience performing work on pressure piping; and

(b) Pass an examination testing the applicant's knowledge of:

(A) **American Society of Mechanical Engineers Boiler and Pressure Vessel Code**, **Section B31.5**;

(B) Structural and mechanical blueprints with the ability to interpret specifications;

(C) Pressure piping controls;

(D) Boiler and Pressure Vessel Laws, ORS 480.510 to 480.665 and OAR chapter 918, division 225; and

(E) Welding, brazing, heat treatment, metallurgy and other procedures applicable to pressure piping systems.

(11) Class 6 Welder Certification. A person holding this certification may weld on boilers, pressure vessels or pressure piping while employed by an approved welding employer. Work may only be performed under the supervision of a person certified under sections (7) through (10) of this rule as applicable. More than one welder may be supervised by one appropriately qualified certified person under this certification.

(a) A Class 6 Welder may also perform the scope of work under section (4) of this rule providing the work performed is under the direct supervision of a qualified certified person under sections (5) through (10) of these rules.

(b) Applicants shall be qualified as a welder in accordance with the **American Society of Mechanical Engineers Boiler and Pressure Vessel Code**, **Section IX**, **Part QW**. The employer shall attest in writing that the applicant is qualified under that code section and is currently qualified to that employer's welding procedures. This written statement is not transferable to another employer.

(12) Certifications may be renewed annually providing the person is in good standing and:

(a) Completes 8 hours of division-approved continuing education; and

(b) Pays renewal fee.

(13) Class 1 Trainee/Helpers and Class 6 Welders are exempt from the continuing education requirements.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 480.545 & 480.630

Stats. Implemented: ORS 480.630

Hist.: BCD 7-2003, f. 3-14-03, cert. ef. 7-1-03; BCD 13-2003, f. 6-26-03, cert. ef. 7-1-03; BCD 3-2004(Temp), f. & cert. ef. 3-8-04 thru 9-3-04

918-225-0920
Program Approval Procedure

(1) Applications for program approval shall include:

(a) The name and description of the program;

(b) A program outline, including a process for student evaluation;

(c) The name, address and telephone number of the contact person;

(d) The proposed instructor and instructor qualifications;

(e) A class schedule (date, time and location);

(f) A list or sample of program materials;

(g) Credit hours requested;

(h) Any limitations on who can attend and, if open to the public, the fee; and

(i) Agreement for division monitoring and evaluation. Upon request by the division, attendees will be requested to make program and instructor evaluations.

(2) The division shall report programs approved or denied to the board.

(3) Unless otherwise stated, program and instructor approvals shall be effective for one calendar year. Subsequent applications for the same program may incorporate by reference all or part of the original application.

Stat. Auth.: ORS 480.630

Stats. Implemented: ORS 480.630

Hist.: BCD 2-2003, f. & cert. ef. 2-3-03; BCD 3-2004(Temp), f. & cert. ef. 3-8-04 thru 9-3-04

• • • • • • • • • •

Department of Consumer and Business Services, Insurance Division
Chapter 836

Adm. Order No.: ID 2-2004
Filed with Sec. of State: 2-20-2004
Certified to be Effective: 2-20-04
Notice Publication Date: 1-1-04
Rules Amended: 836-053-0430
Subject: This rulemaking deletes provisions of a rule that implemented the Insurance Division's interpretation of ORS 743.769. The rule required a carrier that had accepted an individual for individual health insurance coverage to allow the individual to choose any individual health benefit plan offered by the carrier. The deleted provisions are obsolete because 2003 legislation (Section 1, chapter 590 Oregon Laws 2003 (Enrolled House Bill 3431, 2003 Regular Session)) amended ORS 743.769 specifically to authorize a carrier that has accepted an individual for coverage under an individual health benefit plan to limit the individual plans in which the individual may enroll.

Copies of this rule as amended can be accessed on our website at www.oregoninsurance.org. If you do not have Internet access, you can obtain a paper copy of the rule text by contacting Sue Munson at (503) 947-7272.

Rules Coordinator: Sue Munson—(503) 947-7272

836-053-0430
Marketing

The application forms used by a carrier in marketing individual health benefit plans may require applicants to make a preliminary election of a specific plan, but all application forms must briefly describe the variety of individual health benefit plans and optional benefit riders offered by the carrier and inform the applicant that additional information is available.

Stat. Auth.: ORS 743.769

Stats. Implemented: ORS 743.766 - 743.769

Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 23-2002, f. & cert. ef. 11-27-02; ID 2-2004, f. & cert. ef. 2-20-04

• • • • • • • • • •

Department of Consumer and Business Services, Workers' Compensation Division
Chapter 436

Adm. Order No.: WCD 2-2004
Filed with Sec. of State: 2-19-2004
Certified to be Effective: 2-29-04
Notice Publication Date: 1-1-04
Rules Adopted: 436-030-0023
Rules Amended: 436-030-0002, 436-030-0003, 436-030-0005, 436-030-0007, 436-030-0009, 436-030-0010, 436-030-0015, 436-030-0017, 436-030-0020, 436-030-0034, 436-030-0035, 436-030-0036, 436-030-0038, 436-030-0055, 436-030-0065, 436-030-0066, 436-030-0115, 436-030-0125, 436-030-0135, 436-030-0145, 436-030-0155, 436-030-0165, 436-030-0175, 436-030-0185, 436-030-0575, 436-030-0580, 436-060-0005, 436-060-0008, 436-060-0009, 436-060-0010, 436-060-0015, 436-060-0017, 436-060-0019, 436-060-0020, 436-060-0025, 436-060-0030, 436-060-0035, 436-060-0040, 436-060-0060, 436-060-0095, 436-060-0105, 436-060-0135, 436-060-0140, 436-060-0147, 436-060-0150, 436-060-0180, 436-060-0190, 436-060-0195, 436-060-0200, 436-060-0500
Rules Repealed: 436-030-0003(T), 436-030-0005(T), 436-030-0007(T), 436-030-0009(T), 436-030-0010(T), 436-030-0034(T), 436-030-0035(T), 436-030-0115(T), 436-030-0125(T), 436-030-0135(T), 436-030-0145(T), 436-030-0165(T), 436-030-0185(T), 436-030-0581, 436-060-0210
Rules Ren. & Amended: 436-030-0045 to 436-060-0018
Subject: These rules have been amended to replace temporary rules issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature:

• Senate Bill 233 changed the time frame for appeal of a proposed order or proposed assessment of civil penalty from 60 days following the party's receipt of notice to 60 days from the date the order is mailed by the department. Related rule changes affect OAR 436-030.

• Senate Bill 285 allowed an insurer or self-insured employer to contest its Notice of Closure if it disagrees with the findings used to rate impairment, and OAR 436-030 has been revised accordingly.

• Senate Bill 914 eliminated the requirement for insurers and self-insured employers to report disabling claims to the director within 21 days of the employer's knowledge of the claim, and the director proposes to amend OAR 436-060 to require reporting within 14 days after acceptance or denial of the claim. Senate Bill 914 also clarified the statute regarding the department's obligation both to administer and pay supplemental disability benefits if the insurer or self-insured employer chooses to have the department do so, and OAR 436-060 has been amended accordingly.

• House Bill 2305 addressed how medical records may be released, consistent with the federal Health Insurance Portability and Accountability Act, and OAR 436-060 has been amended accordingly.

• House Bill 3669 gave additional authority to nurse practitioners to treat injured workers and authorize temporary disability payments. OAR 436-030 and 436-060 have been amended accordingly. This bill was a result of legislative action after development of the legislative concepts by nurse practitioners and the Management Labor Advisory Committee.

In addition, these rules - 436-030: • Prescribe the conditions under which a Notice of Closure may be corrected or rescinded by the insurer or self-insured employer.

• Move rule 0045, "Disabling/Nondisabling Reporting Requirements and Change in Status Determinations" to OAR 436-060.

• Clarify criteria for determination and periodic review of permanent total disability; define "withdrawn from the workforce"; require that preexisting disability be included in redetermination of permanent total disability status.

• Reorganize procedural requirements for reconsideration of the notice of closure.

• Require that medical arbiter panel requests be received within ten working days of the start of the reconsideration.

• Prescribe the conditions for submission of surveillance videotapes.

• Provide for a medical arbiter deselection process; if the claim qualifies for the process, each party may eliminate one physician from the list of arbiters provided by the director.

• Repeal the rule prescribing how the director issues penalty orders.

436-060: • Revise the requirements and limitations for release of medical information by the insurer.

• Adopt rule 0018, "Nondisabling/Disabling Reclassification (amended and renumbered from 436-030-0045); Requires the insurer to reclassify a non-disabling claim to disabling within 14 days of receiving information that any condition already accepted meets the disabling criteria; simplifies related notification requirements.

• Require that if permanent partial disability is paid monthly, it be paid at 4.35 times the weekly temporary disability rate.

• Require the insurer to send a lump-sum application (for payment of a permanent partial disability award) to the worker or his or her attorney within ten business days of a request.

• Clarify actions required if the worker cooperates after the insurer has requested suspension of benefits or if the worker documents that the failure to cooperate was reasonable.

• Require that notices of claim acceptance be copied to the worker's representative and attending physician.

• Require a claim denial notice to include one of three specific statements if the denial was based in whole or in part on an insurer medical examination.

• Require that if the insurer receives medical bills after claim denial, it send a copy of the denial to the medical provider and explain the status of the denial.

• Require the insurer to pay for a worker requested medical examination that the worker fails to attend, but not for a subsequent examination unless the worker failed to attend the first exam for reasons beyond the worker's control.

• Require that if claim responsibility is at issue, insurers share claim information without charge.

• Provide time frames for monetary adjustments among insurers.

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; or e-mail fred.h.bruyns@state.or.us. Rules are available on the internet: http://www.oregonwcd.org/policy/rules/rules.html#permrules

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630.

Rules Coordinator: Fred Bruyns—(503) 947-7717

436-030-0002
Purpose of Rules

The purpose of these rules is to provide standards, conditions, procedures and reporting requirements for:

(1) Requests for closure by the worker;

(2) Claim closure under ORS 656.268(1);

(3) Determining medically stationary status;

(4) Determining temporary disability benefits;

(5) Awards of permanent partial disability;

(6) Review and determination of the disabling or nondisabling status of a claim;

(7) Determining permanent total disability awards;

(8) Review for reduction of permanent total disability awards;

(9) Review and determination of prior unscheduled permanent partial disability awards; and

(10) Reconsideration of notices of closure.

Stat. Auth.: ORS 656.268, 656.726, 1995 OL Ch. 332 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.262, & 1999 OL 313
Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0002, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0003
Applicability of Rules

(1) Except as provided in section (3) of this rule, these rules apply to all accepted claims for workers' compensation benefits and all requests for reconsideration received by the department on or after the effective date of these rules.

(2) All orders issued by the division to carry out the statute and these rules are considered an order of the director.

(3) These rules take the place of the rules adopted on January 1, 2001, by Workers' Compensation Division Administrative Order 00-058, and carry out ORS 656.005, 656.214, 656.262, 656.268, 656.273, 656.277, 656.278, 656.325, and section 22(3), chapter 865, Oregon Laws 2001.

(a) OAR 436-030-0009, 030-0020, 030-0030, 030-0115 (except section (4)), 030-0125, 030-0135, 030-0145, 030-0155, 030-0165 (except subsection (10)(b)), 030-0175, and 030-0185 apply to all determinations or claims for workers who become medically stationary after July 1, 1990. For claims in which the worker became medically stationary prior to July 2, 1990 OAR 436-030-0020, 030-0030, 030-0050 as adopted by WCD Administrative Order 13-1987 effective January 1, 1988 will apply.

(b) OAR 436-030-0017(1) applies to all requests for closure made on or after January 1, 2002.

(c) OAR 436-030-0055(3)(b), (3)(d) and (4)(a) apply to all claims with dates of injury on or after January 1, 2002.

(d) OAR 436-030-0115(4) and 436-030-0165(10)(b) apply to all claims closed on or after January 1, 2002.

(e) The changes to the following rules effective January 1, 2004, apply to all claims closed on or after January 1, 2004: OAR 436-030-0009, 030-0010, 030-0115, 030-0125, 030-0135, 030-0145, 030-0165, and 030-0185.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.262, 656.268, 656.277, 656.325, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0003, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1991(Temp), f. 8-20-91, cert. ef. 9-1-91; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 12-2000(Temp), f. 12-22-00, cert. ef. 1-1-01 thru 6-29-01; Administrative correction 11-20-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 1-2002(Temp), f. & cert. ef. 1-15-02 thru 7-13-02; WCD 4-2002, f. 4-5-02, cert ef. 4-8-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0005
Definitions

Except where the context requires otherwise, the construction of these rules is governed by the definitions given in the Workers' Compensation Law and as follows:

(1) "Administrator" means the administrator of the Workers' Compensation Division, Department of Consumer and Business Services, or the administrator's delegate for the matter.

(2) "Authorized Nurse Practitioner" means a nurse practitioner authorized to provide compensable medical services under ORS 656.245 (§3, ch. 811, OL 2003) and OAR 436-010.

(3) "Director" means the director of the Department of Consumer and Business Services, or the director's delegate for the matter.

(4) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(5) "Insurer" means the State Accident Insurance Fund, or an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in Oregon, a self-insured employer or a self-insured employer group.

(6) "Mailed or Mailing Date," for the purposes of determining timeliness under these rules, means the date a document is postmarked. Requests submitted by electronic transmission (by facsimile or "fax") will be considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests will be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, will be considered mailed as of the date of the request.

(7) "Notice of Closure" means a notice to the worker issued by the insurer to close an accepted disabling claim or to reduce permanent total disability to permanent partial disability.

(8) "Notice of Refusal to Reclassify" means the insurer's written response, to a worker's request, which notifies the worker of the insurer's decision regarding the nondisabling status of a claim.

(9) "Reconsideration" means review by the director of an insurer's Notice of Closure.

(10) "Statutory closure date" means the date the claim satisfies the criteria for closure under ORS 656.268(1)(b) and (c).

(11) "Statutory appeal period" means the time frame for appealing a Notice of Closure or Order on Reconsideration.

(12) "Worksheet" means a summary of facts used to derive the awards stated in the Notice of Closure.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.005, 656.268, 656.726 & OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), 12-30-81, ef. 1-1-82; Renumbered from 436-065-0004, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0007
Administrative Review

(1) Dispute resolution before the director:

(a) Notices of Closure issued by insurers are appealed to the director and processed in accordance with the reconsideration procedures described in OAR 436-030-0115 through 436-030-0185.

(b) Abating, withdrawing or amending an Order on Reconsideration: The director may abate, withdraw, and/or amend the Order on Reconsideration until the Order is final by operation of law.

(c) Notices of Refusal to Reclassify issued by insurers are appealable by the worker to the director under ORS 656.273 and 656.277. A worker need not be represented in the administrative review process to make a request for review of the insurer's classification decision.

(A) The worker's request for review must be made to the director no later than the 60th day after the date the Notice of Refusal to Reclassify is mailed.

(B) The insurer must provide the director with the complete medical record used and all other relevant documents within 14 days of notification by the director of the request for review. The insurer may be subject to penalties under OAR 436-030-0580 for failure to provide the claim documents in a timely manner. The worker may also submit, within the same 14 days, any additional evidence the worker wishes the director to consider.

(C) When providing information to the director, the submitting party must also provide copies to all other parties at the same time.

(D) After receiving the relevant documents, the director will issue an order. The parties will have 30 days from the date of the order to appeal to the Hearings Division of the Workers' Compensation Board.

(E) The director may reconsider, abate, or withdraw any order before a hearing on that order has been requested and before the order becomes final by operation of law.

(2) Cases brought before the Hearings Division of the Workers' Compensation Board:

(a) Orders on Reconsideration are appealable to the Hearings Division of the Workers' Compensation Board as follows:

(A) The party must send the request for hearing in writing to the Hearings Division in accordance with ORS 656.283 and the rules of procedure adopted by the Workers' Compensation Board.

(B) Under OAR 436-030-0145(1)(b) for claims medically stationary on or after June 7, 1995, for the purpose of filing such appeal, the time will be 30 days from the mailing date of the Order.

(C) Under OAR 436-030-0145(1)(a) for claims medically stationary before June 7, 1995, for the purpose of filing such appeal, the time required to complete the reconsideration proceeding will not be included in the time limit. The request for hearing must be filed within the statutory appeal period.

(b) A party may request a hearing before the Hearings Division of the Workers' Compensation Board on any other action taken under these rules where a worker's right to compensation or the amount thereof is directly an issue under ORS Chapter 656.

(3) Contested Case Hearings of Sanctions and Civil Penalties: Under ORS 656.740 (§9, ch. 170, OL 2003), any party aggrieved by a proposed order or proposed assessment of a civil penalty issued by the director under ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division as follows:

(a) The party must send the request for hearing in writing to the director within 60 days after the mailing date of the proposed order or assessment. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The Workers' Compensation Division will forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(c) An Administrative Law Judge from the Hearings Division, acting on behalf of the director, will conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(4) Director's Administrative Review of other actions: Except as covered under sections (1) through (3) of this rule, any party seeking an action or decision by the director or aggrieved by an action taken by any other party under these rules, may request administrative review by the director as follows:

(a) The party must send the request in writing to the director within 90 days of the disputed action and must specify the grounds upon which the action is taken, unless the director determines that there was good cause for delay or that substantial injustice may result otherwise.

(b) The director may require and allow such evidence as it deems appropriate to complete the review.

(c) A director's order will be issued and will specify if the order is final or if it may be appealed.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0009
Appeals of Notices of Closure

If the worker or insurer disagrees with a Notice of Closure and the worker was determined medically stationary after July 1, 1990, or the worker is not medically stationary and the claim is closed under ORS 656.268(1)(b) or (c) (ch. 429, OL 2003), the worker or insurer must first request a reconsideration by the director under these rules. If the worker was determined medically stationary on or before July 1, 1990, WCD Admin. Order 13-1987 rules apply.

Stat. Auth: ORS 656.268, ORS 656.726, OL Ch. 332 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 & 1999 OL Ch. 313
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; Renumbered from 436-030-0020(3); WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0010
Director Responsibility

(1) The director, when requested by a worker, is responsible for reviewing the disabling/nondisabling status of a claim.

(2) The director, when requested by a worker or insurer, is responsible for conducting the reconsideration proceeding when the worker or insurer is dissatisfied with a Notice of Closure, and assessing penalties and attorney fees where appropriate.

(3) Applicable to these rules, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.210, 656.212, 656.214, 656.268, 656.277, 656.325, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 5-1975, f. 2-6-75, ef. 2-25-75; WCD 8-1978(Admin), f. 6-30-78, ef. 7-10-78; WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82;

Renumbered from 436-065-0005, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0015
Insurer Responsibility

(1) When an insurer issues a Notice of Closure, the insurer is responsible for:

(a) Providing the director, the parties, and the worker's attorney if the worker is represented, a copy of the Notice of Closure, a copy of the worksheet upon which the Notice is based, a completed "Insurer Notice of Closure Summary" and an Updated Notice of Acceptance at Closure that specifies which conditions are compensable, as prescribed in section (2) of this rule;

(b) Maintaining a copy of the worksheet and records upon which the Notice of Closure is based in its claim file for audit purposes under OAR 436-050; and

(c) Providing the Updated Notice of Acceptance at Closure in a timely manner. For purposes of this rule, a timely Updated Notice of Acceptance at Closure must be issued no sooner than the date the claim qualified for closure, or 30 days prior to claim closure (whichever occurs closer to actual closure), but not later than the mailing date of the closure. The Updated Notice of Acceptance at Closure must contain the following title, information and language:

(A) Title: "Updated Notice of Acceptance at Closure";

(B) Information: all compensable conditions that have been accepted, even if the accepted condition was ordered by litigation and is under appeal; however, any conditions under appeal must be specifically identified;

(C) Language, in bold print:

"Notice to Worker: This notice restates and includes all prior acceptances for the current claim opening only, but does not include conditions which have been denied. The insurer or self-insured employer is not required to pay any disability compensation for any condition specifically identified as under appeal unless and until the condition is found to be compensable after all litigation is complete. These are the only conditions considered at the time of claim closure. If you believe a condition has been incorrectly omitted from this notice, or this notice is otherwise deficient, you must communicate the specific objection to the insurer in writing.";

(d) The insurer or self-insured employer is not required to pay any disability compensation for any condition under appeal and specifically identified as such, unless and until the condition is found to be compensable after all litigation is complete.

(e) In the event an omission or error requires a corrected updated notice of acceptance at closure, the word "CORRECTED" must appear in capital letters adjacent to the word "updated".

(f) In the event that the "initial notice of acceptance" is the same as the "updated notice of acceptance at closure," both titles must appear near the top of the document.

(2) Copies of Notices of Refusal to Close must be mailed to the director and the parties, and to the worker's attorney, if the worker is represented.

(3) In claims involving unscheduled injuries to, or disease of, body parts or conditions under OAR 436-035-0330 through 436-035-0450, the insurer must consider the worker's work history and education including:

(a) The worker's level of education; and

(b) The worker's work history under OAR 436-035-0300 and 436-035-0310 including the job at injury and work history for five years preceding the Notice of Closure with dates or period of time spent at each position.

(4) The insurer must consider any other records or information pertinent to claim determination prior to issuing a Notice of Closure.

(5) The insurer must notify the worker and the worker's attorney, if the worker is represented, in writing, when the insurer receives information that the worker's claim qualifies for closure under these rules.

(a) The insurer must send the written notice within three working days from the date the insurer receives the information, unless the claim has already been closed.

(b) The notice must advise the worker of his or her impending claim closure and that any time loss disability payments will end soon.

(c) The insurer must, within 14 days, provide the worker's attorney the same documents relied upon for claim closure.

(6) The insurer must not issue a Notice of Closure on an accepted nondisabling claim. Notices of Closure issued by the insurer in violation of this rule are void and without legal effect. Medically stationary status in nondisabling claims may be documented by the attending physician's statement of medically stationary status.

(7) When a condition is accepted after a closure and the claim has been reopened under ORS 656.262, the insurer must issue a Notice of Closure, considering only the newly accepted condition.

(8) Denials issued under ORS 656.262(7)(b), must clearly identify the phrase "major contributing cause" in the text of the denial.

(9) When a claim is closed where a designation of paying agent order (ORS 656.307) has been issued and the responsibility issue is not final by operation of law, the insurer processing the claim at the time of closure must send copies of the closure notice to the worker, the worker's attorney if the worker is represented, the director, and all parties involved in the responsibility issue.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.331, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; Renumbered from 436-030-0020 & 436-030-0040; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0017
Requests for Claim Closure by the Worker

(1) A worker may request closure from the insurer. The insurer must issue a Notice of Closure or Notice of Refusal to Close within 10 days of receipt of a written request.

(2) If an insurer issues a notice of refusal to close the claim, the notice must be identified in capital letters as a "NOTICE OF REFUSAL TO CLOSE" and must include the following information and appeal language:

(a) Name of the worker;

(b) Date of injury;

(c) Insurer's claim number;

(d) Mailing date of the notice;

(e) The accepted and denied conditions;

(f) Rationale for the insurer's decision; and

(g) The following language, in bold print:

"If you disagree with this Notice of Refusal to Close your claim, you must file a letter of disagreement with the Workers' Compensation Board within sixty (60) days from the date of this notice. Your letter must state that you want a hearing, note your address and the date of your accident, if you know the date. You must mail your letter of disagreement to the Workers' Compensation Board, [INSURER: Insert current address of Workers' Compensation Board here]. If your claim qualifies and you request it, you may receive an expedited hearing (within 30 days). Your request cannot, by law, affect your employment. If you do not file your letter of disagreement within sixty (60) days from the date of this notice, your hearing will be denied as the appeal time has passed. You may be represented by an attorney if you so choose."

(3) If the worker disagrees with the Notice of Refusal to Close, the worker may request a hearing from the Workers' Compensation Board.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.319, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0020
Requirements for Claim Closure

(1) Provided the worker is not enrolled and actively engaged in training, the insurer must issue a Notice of Closure on an accepted disabling claim within 14 days when:

(a) Medical information establishes there is sufficient information to determine the extent of permanent disability under ORS 656.245(2)(b)(B), and indicates the worker's compensable condition is medically stationary;

(b) The accepted injury/condition is no longer the major contributing cause of the worker's combined or consequential condition(s), a major contributing cause denial has been issued, and there is sufficient information to determine the extent of permanent disability;

(c) The worker fails to seek medical treatment for 30 days for reasons within the worker's control and the worker has been notified of pending actions in accordance with these rules; or

(d) The worker fails to attend a mandatory closing examination for reasons within the worker's control and the worker has been notified of pending action(s) in accordance with these rules.

(2) For purposes of determining the extent of disability, "sufficient information" requires the following:

(a) A closing medical examination and report when there is a reasonable expectation of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s) based on evidence in the record or the physician's opinion. The closing medical examination report must describe in detail all measurements and findings regarding any permanent impairment, residuals or limitations

attributable to the accepted condition(s) under OAR 436-010-0280 and 436-035; or

(b) A physician's written statement that clearly indicates there is no permanent impairment, residuals or limitations attributable to the accepted condition(s), and there is no reasonable expectation, based on evidence in the record, of loss of use or function, changes in the worker's physical abilities, or permanent impairment attributable to the accepted condition(s). If the physician indicates there is no impairment, but the record reveals otherwise, a closing examination and report under (a) of this section is required.

(3) When determining disability, the insurer must:

(a) Apply OAR 436-030-0034 regarding major contributing cause denials, worker's failure to seek treatment, and worker's failure to attend a mandatory examination;

(b) Apply OAR 436-030-0035 regarding medically stationary status;

(c) Apply OAR 436-030-0036 regarding temporary disability;

(d) Apply OAR 436-030-0020, 436-030-0038, and 436-030-0066 regarding permanent partial disability;

(e) Apply OAR 436-030-0055 and 436-030-0065 regarding permanent total disability and review of permanent total disability; and

(f) Prepare a summary worksheet, "Notice of Closure Worksheet", Form 440-2807 (Form 2807), which contains all the information described by bulletin of the director.

(4) The "Notice of Closure", Form 440-1644 (Form 1644), is effective the date it is mailed to the worker and to the worker's attorney if the worker is represented, regardless of the date on the Notice itself. The notice must be in the form and format that the director prescribes by bulletin. The notice must include the following:

(a) The worker's name, address, and claim identification information;

(b) The appropriate dollar value of any permanent disability based on the statutory value for the degree;

(c) The body part(s) awarded disability, coded to the table of body part codes as prescribed by the director, the percentage of loss, and the number of degrees that loss represents;

(d) If there is no permanent disability award for this Notice of Closure, a statement to that effect;

(e) The duration of temporary total and temporary partial disability compensation;

(f) The date the Notice was mailed;

(g) The medically stationary date or the date the claim statutorily qualifies for closure under OAR 436-030-0035 or 436-030-0034, respectively;

(h) The date the worker's aggravation rights end;

(i) The worker's appeal rights;

(j) The right of the worker to consult with the Ombudsman for Injured Workers;

(k) The rate schedule (dollars per degree) at which permanent disability, if any, will be paid based on date of injury;

(l) The worker's return to work status; and

(m) A general statement that the insurer has the authority to recover an overpayment.

(5) The Notice of Closure must be accompanied by the following:

(a) The brochure "Understanding Claim Closure and Your Rights";

(b) A copy of the summary worksheet containing information and findings which result in the data appearing on the Notice of Closure; and

(c) A cover letter that:

(A) Explains why the claim has been closed;

(B) Lists and describes enclosed documents; and

(C) Notifies the worker about the end of temporary disability benefits, if any, and the anticipated start of permanent disability benefits, if any.

(6) A copy of the Notice of Closure must be mailed to each of the following persons at the same time, with each copy clearly identifying the intended recipient:

(a) The worker;

(b) The employer;

(c) The director; and

(d) The worker's attorney, if the worker is represented.

(7) The worker's copy of the Notice of Closure must be mailed by both regular mail and certified mail return receipt requested.

(8) An insurer may use electronically produced Notice of Closure forms if consistent with the form and format prescribed by the director.

(9) Insurers may allow adjustments of benefits awarded to the worker under the documentation requirements of OAR 436-060-0170 for the following purposes:

(a) To recover payments for permanent disability which were made prematurely;

(b) To recover overpayments for temporary disability; and

(c) To recover overpayments for other than temporary disability such as prepaid travel expenses where travel was not completed, prescription reimbursements or other benefits payable under ORS 656.001 to 656.794.

(10) The insurer may allow overpayments made on a claim with the same insurer to be deducted from compensation to which the worker is entitled but has not yet been paid.

(11) If after claim closure, the worker became enrolled and actively engaged in an approved training program under OAR 436-120:

(a) Unscheduled permanent disability must be redetermined by the insurer when the worker has ended training and the worker's condition is medically stationary or the claim otherwise qualifies for closure in accordance with these rules.

(b) If the worker has remained medically stationary throughout training and the closing examination is six months or older, a current medical examination will be required for redetermination unless the worker's attending physician provides a written statement that there has been no change in the worker's accepted condition since the previous closing examination.

(c) No redetermination of permanent disability will be made for a scheduled condition or a scheduled direct medical sequela if the worker became medically stationary on or after June 7, 1995. The scheduled permanent disability must remain unchanged from the last award of compensation in that claim.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.268 & 656.270, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999

Hist.: WCD 4-1980(Admin), f. 3-20-80, ef. 4-1-80; WCD 5-1981(Admin), f. 12-30-81, ef. 1-1-82; Renumbered from 436-065-0006, 5-1-85; WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1991, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0023
Correcting and Rescinding Notices of Closure

(1) An insurer may rescind or correct its Notice of Closure prior to the expiration of the appeal period for that Notice and prior to or on the same day that the director receives a request for reconsideration of the Notice of Closure.

(2) The form, format, and completion of the Correcting and Rescinding Notices of Closure are the same as those of the Notice of Closure except that, to correct a Notice of Closure, a Form 440-1644c (Form 1644c) must be used and, to rescind a Notice of Closure, a Form 440-1644r (Form 1644r) must be used.

(3) The "Date of closure (mailing date)" on the Correcting or Rescinding Notice of Closure must be the date the correction or rescission is mailed. The mailing date of the Notice of Closure being rescinded or corrected must be identified within the body of the Correcting or Rescinding Notice of Closure.

(4) The worker's copy of the Correcting and Rescinding Notices of Closure must be mailed by both regular mail and certified mail return receipt requested, consistent with OAR 436-030-0020(6) and (7).

(5) Rescinding Notices of Closure, Form 1644r, are used to rescind the Notice of Closure and return the claim to open status. Examples of appropriate uses of Rescinding Notices of Closure include: the worker was not medically stationary at the time the Notice of Closure was issued; the closure was otherwise premature; to grant PPD when the Notice of Closure being rescinded granted TTD only.

(6) The Rescinding Notice of Closure must:

(a) Advise the worker that the claim remains open and no aggravation rights end date has been established, if it is rescinding the first closure of the claim;

(b) Initiate a 60-day appeal period during which any request for reconsideration must be received by the director;

(c) Explain the reason for the action being taken; and

(d) Be distributed and mailed to the parties consistent with these rules.

(7) When a Notice of Closure granting only timeloss has been issued, if the insurer determines the worker's medically stationary status is unchanged and the worker is entitled to an award of permanent disability, the insurer must use a Notice of Closure, Form 1644, to rescind and reissue the closure. In such cases, the Notice of Closure must:

(a) Contain all required information consistent with these rules;

(b) Bear the heading "Rescind and Reissue;

(c) Explain the reason the action being taken;

(d) Identify the permanent disability award being granted consistent with OAR 436-030 and 436-035;,

(e) Establish a new 60-day appeal period;

(f) Set a new aggravation rights end date if the Notice of Closure being rescinded is the first closure of the claim; and

(g) Be distributed and mailed to the parties consistent with these rules.

(8) Correcting Notices of Closure, Form 1644c, are used to correct errors or omissions and do not change the closure status or the action taken by the Notice of Closure being corrected. Correcting Notices of Closure must not be used to grant permanent disability in claims where the Notice of Closure being corrected did not include an award of permanent disability. Examples of appropriate uses of Correcting Notices of Closure include: permanent disability award computation errors (dollars, degrees, percentages); the "mailing date" was incorrect; return-to-work status errors or omissions; incorrect/incomplete statement of temporary disability.

(9) A Correcting Notice of Closure must:

(a) Be issued when the director has instructed the insurer to do so because the Notice of Closure did not contain the information required by OAR 436-030-0020(4);

(b) Not be used to add a new condition to the claim closure, rate a new condition not considered in the Notice of Closure being corrected, or rescind a Notice of Closure;

(c) State only the information being corrected on the Notice of Closure and the basis for the correction in the body of the order;

(d) Not change the appeal period for the Notice of Closure being corrected; and

(e) Initiate a new 60-day appeal period during which any request for reconsideration must be received, but only for those items being corrected.

[Forms: Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.268 & 656.270, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999

Hist.: WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0034

Claim Closure When the Worker Is Not Medically Stationary

(1) The insurer must close a claim if a worker fails to seek treatment for more than 30 days without the instruction or approval of the attending physician or authorized nurse practitioner. In order to close a claim under this rule, the insurer must send the worker written notification by certified mail that the claim will be closed unless the worker establishes within 14 days that the worker has resumed treatment by attending or scheduling a new appointment, or that the reasons for not treating were outside the worker's control.

(2) The date the claim qualifies for closure, when a worker fails to seek treatment for a period in excess of 30 days, is the latest (most chronologically recent) of the following which occurs prior to the closure:

(a) 30 days from the last treatment provided or authorized by the attending physician or authorized nurse practitioner;

(b) The date the worker failed to attend a follow-up visit that was recommended by the attending physician or authorized nurse practitioner for reasons within the worker's control;

(c) The date the worker returns to or is released to regular work if it is after the last examination date; or

(d) The 14th day after the notice required in section (1) of this rule, or if the worker responds within that 14 day period, the date of the response if it fails to establish that the worker has resumed treatment or that the reasons for not treating were outside the worker's control.

(3) A claim must be closed when the worker is not medically stationary, and the worker fails to attend a mandatory closing examination for reasons within the worker's control, and

(a) The insurer has notified the worker, by certified letter, at least 10 days prior to the mandatory examination, that claim closure will result for failure to attend a mandatory closing examination. The notification letter must inform the worker of the worker's responsibility to attend the mandatory closing examination and of the consequences for failing to do so, including but not limited to claim closure and the possible loss or reduction of a disability award.

(b) Workers have 7 days from the date of exam to demonstrate good cause for failing to attend, before any further action is taken by the insurer toward claim closure.

(c) Where the worker fails to attend a mandatory closing examination for reasons within the worker's control, the date the claim qualifies for closure is the date of the failed mandatory closing examination.

(d) Where a closing exam has been scheduled between a worker and attending physician directly, insurers may close under (1) of this section.

(4) A claim may be closed when the worker is not medically stationary, and a major contributing cause denial has been issued on an accepted combined condition.

(a) The major contributing cause denial must inform the worker that claim closure may result from the issuance of the denial and provide all other information required by these rules.

(b) When a "major contributing cause" denial has been issued following the acceptance of a combined condition, the date the claim qualifies for closure is the date the insurer receives sufficient information to determine the extent of any permanent disability under OAR 436-035-0007(5) and 436-030-0020(2) or the date of the denial, whichever is later.

(5) When any two of the above occur concurrently, the earliest date the claim qualifies for closure is used to close the claim and noted on the notice.

(6) The attending physician or authorized nurse practitioner must be copied on all notification and denial letters applicable to this rule.

(7) When the director has issued a suspension order, under OAR 436-060-0095 and 436-060-0105, the date the claim qualifies for closure is the date of the suspension order.

(8) When a worker fails to seek treatment with an attending physician as defined by ORS 656.005 or authorized nurse practitioner, the claim must be closed under sections (1) and (2) of this rule. All notices must clearly identify the reason for the closure is because of failure to treat with an attending physician or authorized nurse practitioner.

Stat. Auth.: ORS 656.262, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Hist.: WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0035

Determining Medically Stationary Status

(1) A worker's compensable condition is medically stationary when the attending physician, authorized nurse practitioner, or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

(2) When there is a conflict in the medical opinions as to whether or not a worker's compensable condition is medically stationary, more weight is given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and clear and concise reasoning.

(3) Where there is not a preponderance of medical opinion stating a worker's compensable condition is or is not medically stationary, deference will generally be given to the opinion of the attending physician. However, in cases where expert analysis is important, deference is given to the opinion of the physician with the greatest expertise in, and understanding of, the worker's condition.

(4) When there is a conflict as to the date upon which a worker's compensable condition became medically stationary, the following conditions govern the determination of the medically stationary date. The date a worker is medically stationary is the earliest date that a preponderance is established under sections (1) and (2) of this rule. The date of the examination, not the date of the report, controls the medically stationary date.

(5) The insurer must request the attending physician's concurrence or comments when the attending physician arranges, or refers the worker for, a closing examination with another physician to determine the extent of impairment, or when the insurer refers a worker for an insurer medical examination. A concurrence with another physician's report is an agreement in every particular, including the medically stationary impression and date, unless the physician expressly states to the contrary and explains the reasons for disagreement. Concurrence can not be presumed in the absence of the attending physician's response.

(6) A worker is medically stationary on the date of the examination when so specified by a physician. When a specific date is not indicated, a worker is presumed medically stationary on the date of the last examination, prior to the date of the medically stationary opinion. Physician projected medically stationary dates cannot be used to establish a medically stationary date.

(7) If the worker is incarcerated or confined in some other manner and unable to freely seek medical treatment, the insurer must arrange for medical examinations to be completed at the facility where the worker is located or at some other location accessible to the worker.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Stats. Implemented: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999

Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-

98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0036
Determining Temporary Disability

(1) Temporary disability must be determined under ORS Chapter 656, OAR 436-060 and this rule, less time worked. Beginning and ending dates of each authorized period of temporary total disability and temporary partial disability must be noted on the Notice of Closure, as well as the statements "Less time worked" and "Temporary disability was determined in accordance with the law."

(2) Except as provided for in section (3) of this rule and ORS 656.268(9), a worker is not entitled to any award for temporary disability for any period of time in which the worker is medically stationary.

(3) Awards of temporary disability must include the day the worker is medically stationary or the date the claim otherwise qualifies for closure, unless temporary disability is not authorized for another reason at that time.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.005, 656.160, 656.210, 656.212, 656.236, 656.245, 656.262, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0038
Permanent Partial Disability

The standards developed under ORS 656.726(4) and contained in OAR 436-035 must be applied when evaluating a worker's permanent partial disability.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.214, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0055
Determining Permanent Total Disability

(1) A worker is permanently and totally disabled if permanently incapacitated from regularly performing work in a suitable and gainful occupation. For the purpose of this rule and OAR 436-030-0065:

(a) "Incapacitated from regularly performing work" means that the worker does not have the necessary physical and mental capacity and the work skills to perform work on a regular basis. Employment in a sheltered workshop is not considered regular employment unless this was the worker's job at the time of injury.

(b) "Suitable occupation" means those occupations that exist in a theoretically normal labor market, within a reasonable geographic distance, for which a worker has the training or experience, and abilities to realistically perform the job duties, with or without rehabilitation.

(c) "Gainful occupation" means those types of general occupations that pay wages equivalent to, or greater than, the state mandated hourly minimum wage. Those types of general occupations that pay on a commission or piece-work basis, as opposed to a wage or salary basis, may not be "gainful employment" depending upon the facts of the individual situation.

(d) "Work skills" means those skills acquired through experience or training that are necessary to gain and adequately perform skilled, semi-skilled or unskilled occupations. Unskilled types of general occupations require no specific skills that would be acquired through experience or training to be able to gain and adequately perform the unskilled occupation. Every worker has the necessary work skills to gain and adequately perform unskilled types of general occupations with a reasonable period of orientation.

(e) A "reasonable geographic distance" means either of the following unless the worker is medically precluded from commuting:

(A) The area within a 50-mile radius of the worker's place of residence at the time of:

(i) The original injury;

(ii) The worker's last gainful employment;

(iii) Insurer's determination; or

(iv) Reconsideration by the director.

(B) The area in which a reasonable and prudent uninjured and unemployed person, possessing the same physical capacities, mental capacities, work skills and financial obligations as the worker does at the time of his rating of disability, would go to seek work.

(f) "Types of general occupations" means groups of jobs which actually exist in a normal labor market, and share similar vocational purpose, skills, duties, physical circumstances, goals, and mental aptitudes. It does not refer to any specific job or place of employment for which a job or job opening may exist in the future.

(g) "Normal labor market" means a labor market that is undistorted by such factors as local business booms and slumps or extremes of the normal cycle of economic activity or technology trends in the long-term labor market.

(h) "Withdrawn from the workforce" means a worker who is not employed, is not willing to be employed, or although willing to be employed is not making reasonable efforts to find employment, unless such efforts would be futile. The receipt of retirement benefits does not establish a worker has withdrawn from the workforce.

(2) All disability which existed before the injury must be included in determining permanent total disability.

(3) In order for a worker to be determined permanently and totally disabled, a worker must:

(a) Prove permanent and total disability;

(b) Be willing to seek regular and gainful employment;

(c) Make reasonable effort to find work at a suitable and gainful occupation or actively participate in a vocational assistance program, unless medical or vocational findings, including the residuals of the compensable injury, make such efforts futile; and

(d) Not have withdrawn from the workforce during the period for which benefits are being sought.

(4) A worker retaining some residual functional capacity and not medically permanently and totally disabled must prove:

(a) The worker has not withdrawn from the workforce for the period for which benefits are being sought;

(b) Inability to regularly perform work at a gainful and suitable occupation; and

(c) The futility of seeking work if the worker has not made reasonable work search efforts by competent written vocational testimony. Competent written vocational testimony is that which is available at the time of closure or reconsideration and comes from the opinions of persons fully certified by the State of Oregon to render vocational services.

(5) Notices of Closure and Orders on Reconsideration which grant permanent total disability must notify the worker that:

(a) The claim must be reexamined by the insurer at least once every two years, and may be reviewed more often if the insurer chooses.

(b) The insurer may require the worker to provide a sworn statement of the worker's gross annual income for the preceding year. The worker must make the statement on a form provided by the insurer in accordance with the requirements under section (6) of this rule.

(6) If asked to provide a statement under subsection (5)(b) of this rule, the worker is allowed 30 days to respond. Such statements are subject to the following:

(a) If the worker fails to provide the requested statement, the director may suspend the worker's permanent total disability benefits. Benefits must be resumed when the statement is provided. Benefits not paid for the period the statement was withheld must be recoverable for no more than one year from the date of suspension.

(b) If the worker provides a report which is false, incomplete or inaccurate, the insurer must investigate. The investigation may result in suspension of permanent total disability benefits.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0065
Review of Permanent Total Disability Awards

(1) The insurer must reexamine each permanent total disability claim at least once every two years or when requested to do so by the director to determine if the worker is capable of regularly performing a suitable and gainful occupation. The insurer must notify the worker and the worker's attorney if the worker is represented whenever the insurer intends to reexamine the worker's permanent total disability status. Workers who fail to cooperate with the reexamination may have benefits suspended under OAR 436-060-0095.

(2) Any decision by the insurer to reduce permanent total disability must be communicated in writing to the worker, and to the worker's attorney if the worker is represented, and accompanied by documentation supporting the insurer's decision. That documentation must include: medical reports, including sufficient information necessary to determine the extent of permanent partial disability, vocational and/or investigation reports (including visual records, if available) which demonstrate the worker's ability to regularly perform a suitable and gainful occupation, and all other applicable evidence.

(3) An award of permanent total disability for scheduled injuries before July 1, 1975, must be considered for reduction only when the insurer has evidence that the medical condition has improved.

(4) Except for section (3) of this rule, an award of permanent total disability may be reduced only when the insurer has a preponderance of evidence that the worker is regularly working at a suitable and gainful occupation or is currently capable of doing so. Preexisting disability must be included in redetermination of the worker's permanent total disability status.

(5) When the insurer reduces a permanent total disability claim, the insurer must, based upon sufficient information to determine the extent of permanent partial disability, issue a Notice of Closure which reduces the permanent total disability and awards permanent partial disability, if any.

(6) Any party to the claim who does not agree with the Notice of Closure may, within the statutory period, appeal the order under OAR 436-030-0007(1)(a). Appeal is to the Hearings Division for workers that were medically stationary on or before July 1, 1990.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.206, 656.214, 656.268, 656.283, 656.319, 656.325, 656.331, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 13-1987, f. 12-18-87, ef. 1-1-88; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0066
Review of Prior Unscheduled Permanent Partial Disability Awards

An award for unscheduled permanent partial disability is subject to periodic examination and adjustment under ORS 656.268 and 656.325 and in accordance with the following conditions:

(1) Requests for review and adjustment must be made in writing to the Workers' Compensation Division.

(2) The party requesting review of permanent disability must send a copy of the request to all other affected parties at the time the request is made. The worker may submit any information in rebuttal.

(3) All pertinent medical, vocational, and other applicable evidence must be submitted with the request, including sufficient information to determine the extent of permanent partial disability. The request must state the basis for the request and provide supporting evidence. If the director finds that the worker has failed to accept treatment as provided in this rule, the director will make any necessary adjustments under OAR 436-035-0270 through 436-035-0450.

(4) The basis for the request for adjustment in the disability award must be failure of the worker to make a reasonable effort to reduce the disability and be so stated in the request for adjustment.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.325, 656.331, 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 5-1990(Temp), f. 6-18-90, cert. ef. 7-1-90; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0115
Reconsideration of Notices of Closure

(1) A worker or insurer may request reconsideration of a Notice of Closure by mailing or delivering the request to the director within the statutory appeal period as defined in OAR 436-030-0005(6) and 030-0145(1). The reconsideration proceeding begins as described in OAR 436-030-0145(2).

(2) For the purpose of these rules, "reconsideration proceeding" means the procedure established to reconsider a Notice of Closure and does not include personal appearances by any of the parties to the claim or their representatives, unless requested by the director. All information to correct or clarify the record and any medical evidence regarding the worker's condition as of the time of claim closure that should have been but was not submitted by the attending physician or authorized nurse practitioner at the time of claim closure and all supporting documentation must be presented during the reconsideration proceeding. When the reconsideration proceeding is postponed because the worker's condition is not medically stationary under OAR 436-030-0165(10), medical evidence submitted may address the worker's condition after claim closure as long as the evidence satisfies the conditions of OAR 436-030-0145(3).

(3) All parties have an opportunity to submit documents to the record regarding the worker's status at the time of claim closure. Other factual information and written argument may be submitted for incorporation into the record under ORS 656.268(6) within the time frames outlined in OAR 436-030-0145. Such information may include, but is not limited to, responses to the documentation and written arguments, written statements and sworn affidavits from the parties.

(4) The worker may submit a deposition to the reconsideration record subject to ORS 656.268(6) and the following:

(a) The deposition must be limited to the testimony and cross-examination of a worker about the worker's condition at the time of claim closure.

(b) The deposition must be arranged by the worker and held during the reconsideration proceeding time frame unless a good cause reason is established. If a good cause reason is established, the time frame for holding the deposition may be extended but must not extend beyond 30 days from the date of the Order on Reconsideration. The deposition must be held at a time and place that permits the insurer or self-insured employer the opportunity to cross-examine the worker.

(c) The insurer or self-insured employer must, within 30 days of receiving a bill for the deposition, pay the fee of the court reporter and the costs for the original transcript and its copies. An original transcript of the deposition must be sent to the department and each party must be sent a copy of the transcript.

(d) If the transcript is not completed and presented to the department prior to the deadline for issuing an Order on Reconsideration, the Order on Reconsideration may not be postponed to receive a deposition under this rule and the order will be issued based on the evidence in the record. However, the transcript may be received as evidence at a hearing for an appeal of the Order on Reconsideration.

(5) Only one reconsideration proceeding may be completed on each Notice of Closure and the director will do a complete review of that notice. Once the reconsideration proceeding is initiated, any additional issues must be raised and further evidence submitted within the time frames allowed for processing the reconsideration request. When the director requires additional information to complete the record, the reconsideration proceeding may be postponed under ORS 656.268(6).

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 11-1995(Temp), f. & cert. ef. 8-23-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0125
Reconsideration Form and Format

A request for reconsideration may be in the form and format the director provides by bulletin. A reconsideration request should include at least the following:

(1) Worker's name;
(2) Date of injury;
(3) Date of the closure being appealed;
(4) Any specific issues regarding the Notice of Closure;
(5) The name of the worker's attorney;
(6) The name of the insurer's attorney;
(7) Any special language needs;
(8) Whether there is disagreement with the specific impairment findings used to determine permanent disability at the time of claim closure;
(9) Any information and documentation deemed necessary to correct or clarify any part of the claim record believed to be erroneous; and
(10) Any medical evidence that should have been but was not submitted at the time of the claim closure including clarification or correction of the medical record based on the examination(s) at, before, or pertaining to claim closure.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0135
Reconsideration Procedure

(1) If the director assists the worker in completing the request for reconsideration, the director will notify the worker that the proceeding may result in an increase, decrease, or no change in entitlement to benefits.

(2) Upon starting the reconsideration proceeding , the director will send the parties a letter of acknowledgement which includes:

(a) The proceeding's start date;

(b) The timelines for submitting additional information to be included in the record;

(c) A certification that the letter has been mailed to the listed parties; and

(d) The last date an Order on Reconsideration can be issued or the proceeding postponed, and the status of the request if the director fails to issue an Order on Reconsideration or postponement under the time limits specified in ORS 656.268.

(3) The insurer must furnish, to the director and the worker or the worker's attorney, within 10 working days from the beginning of the reconsideration proceeding, all documents pertaining to the claim.

(4) The request for reconsideration and all other information submitted to the director by any party during the reconsideration process must be copied to all interested parties. Failure to comply with this requirement may result in the information not being included as part of the record on reconsideration. The director may assist a worker in meeting this requirement.

(5) The director will issue an order rescinding a notice of closure when the director finds, upon reconsideration:

(a) The claim was closed prematurely because the worker's accepted condition(s) was not medically stationary and the claim did not qualify for closure under ORS 656.268(1)(a); or

(b) The claim was not closed according to the requirements of these rules and ORS 656.268(1)(b) or (c).

(6) When a worker has requested and cashed a lump sum payment, under ORS 656.230, of an award granted by a Notice of Closure, the director will not consider the adequacy of that award in a reconsideration proceeding.

(7) When a new condition is accepted after a prior claim closure, and the newly accepted condition is subsequently closed, the director and the parties may mutually agree to consolidate requests for review of the closures into one reconsideration proceeding, provided the director has jurisdiction and neither of the closures have become final by operation of law.

(8) The reconsideration order will address issues raised by the parties and will address compensation as follows:

(a) Compensation reduced in a reconsideration order will be "in lieu of" any compensation awarded by the Notice of Closure.

(b) Additional compensation awarded in a reconsideration order will be "in addition to" any compensation awarded by the Notice of Closure. The reconsideration order may award total compensation due less any compensation previously ordered.

(c) Any compensation affirmed in a reconsideration order will be so stated.

(d) The dollar rate per degree of disability will be listed.

(9) A copy of the reconsideration order will be sent to the worker, employer(s), insurer(s), worker's attorney if the worker is represented, and the insurer's attorney(s), if the insurer is represented.

(10) When a party does not discover until after the reconsideration order has been issued that additional documents were not provided by the opposing party, in accordance with this rule, the Order on Reconsideration may be abated and withdrawn to give the party an opportunity to respond to the new information.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268(6) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0145
Reconsideration Time Frames and Postponements

(1) Statutory time frames for appealing a Notice of Closure:

(a) For claims with a medically stationary date prior to June 7, 1995, the appeal period is 180 days from the claim closure. The time required to complete the reconsideration proceeding pursuant to this rule must not be included in the 180 days from the mailing date of the Notice of Closure to request a hearing.

(A) The 180-day time limit will be tolled upon receipt of the request for reconsideration from the mailing date of the request for reconsideration until the reconsideration request is either dismissed or an Order on Reconsideration is issued.

(B) The 180-day time limit will not be tolled when a request for reconsideration is withdrawn under OAR 436-030-0185.

(b) For claims with a medically stationary date, or date the claim statutorily qualifies for closure, on or after June 7, 1995, a request for reconsideration must be mailed within 60 days of the mailing date of the Notice of Closure. A request for hearing must be made within 30 days of the mailing date of the Order on Reconsideration.

(c) For claims closed on or after January 1, 2004, the insurer's request for reconsideration is limited to the findings used to rate impairment and must be mailed within seven days of the mailing date of the Notice of Closure.

(2) The reconsideration proceeding begins upon;

(a) The director's receipt of the worker's request for reconsideration, if the insurer has not previously requested reconsideration consistent with subsection (1)(c) of this rule; or

(b) The 61st day after the closure of the claim, if the insurer has requested reconsideration consistent with subsection (1)(c) of this rule; unless the director receives, within the appeal time frames in section (1) of this rule, a request for reconsideration or a statement by the worker instructing the director to start the reconsideration proceeding.

(3) Ten working days after the date the reconsideration proceeding begins, the reconsideration request and all other appropriate information submitted by the parties will become part of the record used in the reconsideration proceeding.

(a) Evidence received or issues raised subsequent to the tenth working day deadline will be considered in the reconsideration proceeding to the extent practicable.

(b) Upon review of the record the director may request, in accordance with ORS 656.268(6), any additional information deemed necessary for the reconsideration and set appropriate time frames for response.

(d) Except as provided in section (5) and (6) of this rule, the director will either mail an Order on Reconsideration within 18 working days from the date the reconsideration proceeding begins or notify the parties that the reconsideration proceeding is postponed for not more than 60 additional days in accordance with the provisions of ORS 656.268(6).

(4) Medical arbiter panel requests must be received by the department within the ten (10) working day time frame beginning on the date the reconsideration proceeding starts.

(5) When the director provides notice the worker failed to attend the medical arbiter examination without good cause or failed to cooperate with the arbiter examination and suspends benefits, under ORS 656.268(7), the reconsideration proceeding will be postponed for up to 60 additional days from the date the director determines and provides notice, to allow completion of the arbiter process.

(6) When the reconsideration proceeding has been stayed, the director will notify the parties that it has been stayed for one of the following reasons:

(a) To determine whether temporary rules amending "the standards" are required to properly rate the worker's impairment, under ORS 656.726(4)(f);

(b) The parties consent to postponing the reconsideration proceeding, under ORS 656.268(7)(i)(B), when the medical arbiter examination is not medically appropriate because the worker's medical condition is not stationary; or

(c) When a Claim Disposition Agreement (CDA) is filed with the Workers' Compensation Board, the reconsideration proceeding is stayed until the CDA is either approved by a final order of the Board or the Board sets aside the disposition.

(7) If the director fails to mail an Order on Reconsideration or a Notice of Postponement under the time frames specified in ORS 656.268, the reconsideration request is automatically deemed denied. The parties may immediately thereafter proceed as though the director had issued an Order on Reconsideration affirming the Notice of Closure. Under section (1) of this rule, the counting of the 180-day time limit for requesting a hearing under former ORS 656.268(6)(b) will resume on the date after the director should have issued an Order on Reconsideration.

(8) Notwithstanding any other provision regarding the reconsideration proceeding, the director may extend nonstatutory time frames to allow the parties sufficient time to present evidence and address their issues and concerns.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268, ORS 656.726(3)(f)(C) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0155
Reconsideration Record

(1) The record for the reconsideration proceeding includes all documents and other material relied upon in issuing the Order on Reconsideration as well as any additional material submitted by the parties, but not considered in the reconsideration proceeding. The record is maintained in the Workers' Compensation Division's claim file and consists of all documents and material received and date stamped by the director prior to the issuance of the Order on Reconsideration, unless the document(s) is an exact duplicate of what is in the file then the director is not required to retain the duplicate document(s).

(2) Except as noted below, the medical record submitted by the director for arbiter review will consist of all medical documents and medical material produced by the claim under reconsideration, provided the information is allowable under ORS 656.268.

(a) The director may not submit non-medical information, nursing notes, or physical therapy treatment notes to the arbiter unless:

(A) A party requests the director to submit those specific materials to the arbiter;

(B) The party identifies and provides the director with specific dates of those materials requested to be submitted; and

(C) The materials otherwise meet the requirements of this rule.

(b) All medical documents and other medical materials not submitted by the director to the medical arbiter will be stamped in the lower right hand corner "not sent to arbiter".

(3) When any surveillance videotape obtained prior to closure has been submitted to physician(s) involved in the evaluation or treatment of the worker, it must be provided for arbiter review. All written materials previously forwarded to physician(s) along with the surveillance videotape, such as investigator field notes, summary or narrative reports, and cover letters, must also be submitted. Surveillance videotape must be labeled according to the date(s) and total time of the recording(s).

(4) When reconsideration is requested, the insurer is required to provide the director and the other party(ies) with a copy of all documents contained in the record at claim closure. Any information the director adds to the record, such as the medical arbiter report, will be copied to all parties. Responses of the parties to the medical arbiter report will be included in the record if received prior to completion of the reconsideration proceeding.

(5) Since all parties will have a complete copy of the record at reconsideration prior to the issuance of a reconsideration order, additional certified copies of the record will be made at a charge to the requesting party.

(6) When a hearing is scheduled following the appeal of a reconsideration order and the parties or the administrative law judge requests the director to provide the record at reconsideration, either the original claim file or a certified copy of the claim file will be delivered to the Hearings Division two days prior to the hearing. The original claim file must be returned to the director within two days after the hearing.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268(6) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0165
Medical Arbiter Examination Process

(1) When a worker or insurer requests reconsideration and disagrees with the impairment findings used in rating the worker's disability at the time of claim closure, the director will refer the claim to a medical arbiter or panel of arbiters.

(a) When the director determines that sufficient medical information is not available to rate disability, the director may refer the claim to a medical arbiter or panel of arbiters.

(b) The director will notify the parties within 18 working days from the date the reconsideration proceeding begins that a medical arbiter review will be scheduled.

(2) The director will select a medical arbiter physician or a panel of physicians in accordance with ORS 656.268(7)(d).

(a) Any party that objects to a physician on the basis that the physician is not qualified under ORS 656.005(12)(b) must notify the director prior to the examination of the specific objection. If the director determines that the physician is not qualified to be a medical arbiter on the specific case, an examination will be scheduled with a different physician. All costs related to the completion of the medical arbiter process in this rule must be paid by the insurer.

(b) When the worker resides outside the state of Oregon, a medical arbiter examination may be scheduled out-of-state with a physician who is licensed within that state to provide medical services in the same manner as required by ORS 656.268(7).

(c) Arbiters or panel members will not include any medical service providers whose examination or treatment is the subject of the review.

(3) When the director has determined a claim qualifies for medical arbiter deselection, a list of appropriate physicians will be faxed or sent by overnight mail to the parties.

(a) Each party may eliminate one physician from the list by crossing out the physician's name.

(b) The parties may agree to one physician from the list by responding in writing. The parties must also deselect one physician from the list in case the agreed upon physician is unavailable.

(c) All responses must be signed and received by the director within three (3) business days. No further opportunity will be given for the parties to provide input regarding the arbiter deselection process once the three (3) business day period has expired. No further attempts at deselection will be made when continuing the arbiter deselection process is not practical.

(4) The director will notify the parties of the time and place of the medical arbiter examination. This notice will also inform the worker that failure to attend the medical arbiter examination or to cooperate with the medical arbiter will result in suspension of all disability benefits effective on the date of the examination unless the worker establishes a "good cause" reason for missing the examination or for not cooperating with the arbiter. The appointment letter will instruct the worker to call the director within 24 hours after failing to attend the examination to provide any "good cause" reason for missing the exam.

(a) Notice of the examination will be considered adequate notice if the appointment letter is mailed to the last known address of the worker and to the worker's attorney if the worker is represented.

(b) For the purposes of this rule, non-cooperation includes, but is not limited to, refusal to complete any reasonable action necessary to evaluate the worker's impairment. However, it does not include circumstances such as a worker's inability to carry out any part of the examination due to excessive pain or when the physician reports the findings as medically invalid.

(c) Failure of the worker to respond within the time frames outlined in statute for completion of the reconsideration proceeding may be considered a failure to establish "good cause."

(5) If a worker misses the medical arbiter examination, the director will determine whether or not there was a "good cause" reason for missing the examination.

(6) Upon determination that there was not a "good cause" reason for missing the examination, or that the worker failed to cooperate with the arbiter, the director will:

(a) Issue a notice to the worker that disability benefits are suspended and that the reconsideration proceeding is postponed up to an additional 60 days, and

(b) Reschedule an examination for the worker to complete the medical arbiter review within the additional 60-day postponement period.

(7) As addressed in the Order on Reconsideration, the suspension will be lifted if any of the following occurred during the additional 60-day postponement period:

(a) The worker established a "good cause" reason for missing or failing to cooperate with the examination;

(b) The request for reconsideration was withdrawn by the worker; or

(c) The worker attended and cooperated with a rescheduled arbiter examination.

(8) If none of the events which end the suspension under section (7) of this rule occurred prior to the expiration of the 60-day additional postponement, the director will complete the reconsideration proceeding under ORS 656.268(7) and the Order on Reconsideration will order the suspension of benefits to remain in effect.

(9) The medical arbiter or panel of medical arbiters must perform a record review or examine the worker as requested by the director and perform such tests as may be reasonable and necessary to establish the worker's impairment. The director will provide notice of the examination of the worker to all parties.

(a) The parties must submit any issues they wish the medical arbiter or panel of medical arbiters to address within 10 working days after the date the reconsideration proceeding begins. The parties must not submit issues directly to the medical arbiter or panel of medical arbiters. The director will only submit issues appropriate to the reconsideration proceeding to the medical arbiter or panel of medical arbiters.

(b) The medical arbiter or panel of medical arbiters must address all questions raised by the director in the report.

(c) The director will instruct the medical arbiter to provide copies of the arbiter report to the director, the worker or the worker's attorney, and the insurer(s) within five (5) working days after completion of the arbiter review. The cost of providing copies of such additional reports must be reimbursed according to OAR 436-009-0070 and must be paid by the insurer.

(10) When the worker's medical condition is not stationary on reconsideration which may result in difficulties in obtaining findings of impairment by the arbiter, the director will, where appropriate, send a letter to the parties requesting consent to postpone the reconsideration proceeding.

(a) If the parties agree to the postponement, the reconsideration proceeding will be postponed until the medical record reflects the worker's condition has stabilized sufficiently to allow for examination to obtain the

impairment findings. The parties must notify the director when it is appropriate to schedule the medical arbiter examination and provide the necessary medical records when requested. Interim medical information that may be helpful to the director and the medical arbiter in assessing and describing the impairment due to the compensable condition(s) may be submitted at the time the parties notify the director that the medical arbiter exam can be scheduled. The director will determine whether the interim medical information is consistent with the provisions of ORS 656.268(6) and (7).

(b) If postponement is not appropriate, at the director's discretion either a medical arbiter examination or a medical arbiter record review may be obtained, or the director may issue an Order on Reconsideration based on the record available at claim closure and other evidence submitted in accordance with ORS 656.268(6).

(11) All costs related to record review, examinations, tests, and reports of the medical arbiter must be paid under OAR 436-009-0015, 436-009-0040, and 436-009-0070.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 11-1995(Temp), f. & cert. ef. 8-23-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 10-2001, f. 11-16-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0175
Fees and Penalties Within the Reconsideration Proceeding

(1) An insurer failing to provide information or documentation as set forth in OAR 436-030-0135, 0145 and 0165 may be assessed civil penalties under OAR 436-030-0580. Failure to comply with the requirements set forth in OAR 436-030-0135, 0145 and 0165 may also be grounds for extending the reconsideration proceeding under ORS 656.268(6).

(2) If upon reconsideration of a Notice of Closure there is an increase of 25 percent or more in the amount of permanent disability compensation from that awarded by the Notice of Closure, and the worker is found to be at least 20 percent permanently disabled, the insurer will be ordered to pay the worker a penalty equal to 25 percent of the increased amount of permanent disability compensation. If an increase in compensation results from the promulgation of a temporary emergency rule, penalties will not be assessed. For claims with medically stationary dates or statutory closure dates on or after June 7, 1995, if the increase in compensation results from new information obtained through a medical arbiter examination, the penalty will not be assessed.

(3) For the purpose of section (2) of this rule, a worker who receives a total sum of 64 degrees of scheduled or unscheduled disability or a combination thereof, will be found to be at least 20 percent disabled. As an illustration, a worker who receives 20 percent disability of a great toe (3.6 degrees) is not considered 20 percent permanently disabled because the great toe is only a portion of the whole person. A worker who is 100 percent permanently disabled is entitled to 320 degrees of disability. A worker who receives 64 degrees (20 percent of 320 degrees), whether scheduled, unscheduled or a combination thereof, will be considered the equivalent of at least 20 percent permanently disabled for the purposes of this rule.

(4) Attorney fees may only be authorized when a Request for Reconsideration is submitted by an attorney representing a worker or the attorney provides documentation of representation, and a valid signed retainer agreement has been filed with the director. The reconsideration order will order the insurer to pay the attorney 10 percent out of any additional compensation awarded but not more than the maximum attorney fee allowed in OAR 438-015-0040(1) and (2) and 438-015-0045, effective February 1, 1999. "Additional compensation" includes an increase in a permanent or temporary disability award.

Stat. Auth.: ORS 656.726
Stats. Implemented: ORS 656.268
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 11-1995(Temp), f. & cert. ef. 8-23-95; WCD 8-1996, f. 2-14-96, cert. ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 2-1999(Temp), f. 1-14-99, cert. ef. 2-1-99 thru 7-30-99; WCD 8-1999, f. & cert. ef. 4-28-99; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0185
Reconsideration: Settlements and Withdrawals

(1) Contested matters arising out of a claim closure may be resolved by mutual agreement of the parties at any time after the claim has been closed under ORS 656.268 but before that claim closure has become final by operation of law. If the parties have reached such an agreement prior to the completion of the reconsideration proceeding, the parties must submit the stipulation agreement to the director for approval as part of the reconsideration proceeding. The Stipulation for review at the reconsideration proceeding must:

(a) Address only issues that pertain to a claim closure and cannot include any issues of compensability;

(b) List the body part(s) for which any award is made and recite all disability awarded in both degrees and percent of loss when permanent partial disability is part of the stipulated agreement. In the event there is any inconsistency between the stated degrees and percent of loss awarded in any stipulated agreement, the stated percent of loss will controll.

(2) The director will review the Stipulation and issue an order within 18 working days from receipt of the Stipulation by the director. Stipulations approved by the director are not appealable.

(3) When the stipulated agreement does not expressly resolve all issues relating to the claim closure, the Order on Reconsideration will include the Stipulation as well as a substantial determination of all remaining issues. In these claims, the 18 working day time frame may be postponed in the same manner as any reconsideration proceeding.

(4) If the Stipulation is not approved, the reconsideration proceeding will be postponed to allow the parties to:

(a) Address the disapproval, and/or

(b) To request that the director issue an Order on Reconsideration addressing the substantive issues.

(5) When the parties desire to enter into a stipulated agreement to resolve disputed issues relating to the claim closure but are unable to reach an agreement, the parties may request the assistance of the director to mediate an agreement.

(6) When the parties desire to enter a stipulated agreement that addresses issues including all matters being reconsidered as well as issues not before the reconsideration proceeding, and the parties do not want a reconsideration on the merits of the claim closure, they may advise the director of their resolution and request the director enter an Order on Reconsideration affirming the Notice of Closure. The request for an affirming order must be made prior to the date an Order on Reconsideration is issued and in accordance with the following procedure:

(a) A written request for an affirming reconsideration order must be made by certified mail and be signed by both parties or their representatives. The written request must also state that the parties waive their right to an arbiter review, and that all matters subject to the mandatory reconsideration process have been resolved. A copy of the proposed stipulated agreement must accompany the request.

(b) After the affirming Order on Reconsideration has issued, the parties will submit their stipulation to a referee of the Hearings Division, Workers' Compensation Board, for approval in accordance with the provisions of ORS 656.289 and the Board's rules of practice and procedure.

(c) An Order on Reconsideration issued under this rule is final and is subject to review under ORS 656.283.

(d) This provision does not apply to Claims Disposition Agreements filed under ORS 656.236.

(7) A worker requesting a reconsideration may withdraw the request for reconsideration if no additional information has been submitted by the other party(ies), no medical arbiter exam has occurred, and the insurer has not requested reconsideration under OAR 436-030-0145. If additional information has been submitted by the other party(ies), a medical arbiter exam has occurred, or the insurer has requested reconsideration, the reconsideration request will not be dismissed unless all parties agree.

(8) If the insurer has requested reconsideration, either the worker or the insurer may initiate the withdrawal request but both must agree to the withdrawal.

(9) The director will issue an order dismissing the reconsideration under section (7) and (8) of this rule, when appropriate.

Stat. Auth.: ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268(6) & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0575
Audits

(1) Notices of Closure issued by insurers and supporting documentation including, but not limited to, the worksheet upon which the Notice of Closure is based, will be subject to periodic audit by the director. Supporting documentation and records must be maintained in accordance with OAR 436-050.

(2) The director reserves the right to visit the worksite to determine compliance with these rules.

Stat. Auth.: ORS 656.268, ORS 656.726 & 1999 OL Ch. 313
Stats. Implemented: ORS 656.268, 656.455, 656.726, 656.750 & 1999 OL Ch. 313
Hist.: WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-030-0580
Penalties and Sanctions

(1) Under ORS 656.745, the director or designee may assess a civil penalty against an employer or insurer who fails to comply with the rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(2) An insurer or medical service provider failing to meet the requirements set forth in these rules may be assessed a civil penalty.

(3) Under OAR 436-010-0340, the director may impose sanctions for any medical service provider where the insurer can provide sufficient documentation to substantiate lack of cooperation. The medical service provider will be sent a warning letter about possible penalties and the reporting requirements. Failure by the medical service provider to submit the requested information within the specified period may result in civil penalties.

(4) Sufficient documentation to substantiate lack of cooperation by the medical service provider includes:

(a) Copies of letters to the medical service provider;

(b) Memos to the claim file of follow-up phone calls and/or the lack of response;

(c) Letters from the medical service provider indicating a lack of cooperation; or

(d) Medical reports received by the insurer, after adequate instruction by the insurer or the director, which do not supply the requested information or which supply information that is not consistent with the Disability Rating Standards in OAR 436-035.

(5) In arriving at the amount of penalty, the director or designee may assess a penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations in any three-month period.

Stat. Auth.: ORS 656.268, 656.726, OL Ch. 332 1995 & Ch. 313 1999
Stats. Implemented: ORS 656.268, 656.726, 656.745, OL Ch. 332 1995 & Ch. 313 1999
Hist.: WCD 13-1987, f. 12-17-87, ef. 1-1-88; WCD 31-1990, f. 12-10-90, cert. ef. 12-26-90; WCD 5-1992, f. 1-17-92, cert. ef. 2-20-92; WCD 12-1994, f. 11-18-94, cert. ef. 1-1-95; WCD 8-1996, f. 2-14-96, cert.ef. 2-17-96; WCD 17-1997, f. 12-22-97, cert. ef. 1-15-98; WCD 9-2000, f. 11-13-00, cert. ef. 1-1-01; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

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 (§ 3, ch 811, OL 2003) and OAR 436-010.

(3) "Designated Paying Agent" means the insurer temporarily ordered responsible to pay compensation for a compensable injury pursuant to ORS 656.307.

(4) "Director" or "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" or "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

436-060-0008
Administrative Review

(1) Any party as defined by ORS 656.005, including an assigned claims agent as a designated processing agent pursuant to ORS 656.054, aggrieved by an action taken pursuant to these rules in which a worker's right to compensation or the amount thereof is directly in issue, may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS Chapter 656 and the Board's Rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law except where otherwise provided in ORS Chapter 656.

(2) Contested case hearings of Sanctions and Civil Penalties: Any party as described in section (1) aggrieved by a proposed order or proposed assessment of civil penalty of the director or division issued pursuant to ORS 656.254, 656.735, 656.745 or 656.750 may request a hearing by the Hearings Division of the Workers' Compensation Board in accordance with ORS 656.740 (section 9, chapter 170, Oregon Laws 2003).

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds upon which the person requesting the hearing contests the proposed order or assessment.

(b) The aggrieved person must file a hearing request with the Administrator of the Workers' Compensation Division within 60 days after the mailing of the proposed order or assessment. No hearing will be granted unless the request for hearing is mailed or delivered to the administrator within 60 days of the mailing date of the proposed order or assessment.

(3) Contested cases before the Office of Administrative Hearings: Any party as defined by ORS 656.005 aggrieved by an action or order of the director or division pursuant to these rules, other than as described in section (2), where such action or order qualifies for review as a contested case, may request review pursuant to ORS 183.310 through 183.550 as modified by these rules pursuant to ORS 183.315(1). When the matter qualifies for review as a contested case, the process for review will be as follows:

(a) The request for hearing must be sent in writing to the Administrator of the Workers' Compensation Division. No hearing will be granted unless the request specifies the grounds upon which the action or order is contested and is mailed or delivered to the administrator within 30 days of the action or from the date of mailing or other service of an order.

(b) The hearing will be conducted by an Administrative Law Judge of the Office of Administrative Hearings.

(c) Any proposed order issued by the administrative law judge is subject to revision by the director. The director may allow objections to the proposed order to be filed for the director's consideration within 30 days of issuance of the proposed order.

(4) Administrative review by the director or designee: Any party aggrieved by an action taken pursuant to these rules by another person except as described in sections (1) through (3) above may request administrative review by the division on behalf of the director. The process for administrative review of such matters will be as follows:

(a) The request for administrative review shall be made in writing to the Administrator of the Workers' Compensation Division within 90 days of the action. No administrative review will be granted unless the request

specifies the grounds upon which the action is contested and is mailed or delivered to the administrator within 90 days of the contested action unless the director or the director's designee determines that there was good cause for delay or that substantial injustice may otherwise result.

(b) In the course of the review, the division may request or allow such input or information from the parties deemed to be helpful.

(c) The division's determination will specify whether it is a final order or whether an aggrieved party may request a contested case hearing before the Office of Administrative Hearings pursuant to ORS 183.310.

(d) The hearing request must comply with the procedures provided in section (3) above.

Stat. Auth.: ORS 656.704, 656.726(4) & 656.745
Stats. Implemented: ORS 656.245, 656.260, 656.704, 656.726(4), 656.740(1)
Hist.: WCD 6-1978(Admin), f. & ef. 4-27-78, WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0998, 5-1-85; 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 12-2003, f. 12-4-03, cert. ef. 1-1-04; WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-060-0009
Access to Department of Consumer and Business Services Workers' Compensation Claim File Records

(1) Pursuant to 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 shall 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) Pursuant to ORS 192.502(19) 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(19) 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 shall be made in writing or in person and shall include:

(a) The name, address and telephone number of the requester;

(b) A specific identification of the public record(s) required and the format in which they are required;

(c) The number of copies required;

(d) 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 & ORS 656.726(4)
Stats. Implemented: ORS 656.704 & ORS 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

436-060-0010
Reporting Requirements

(1) A subject employer shall accept notice of a claim for workers' compensation benefits from an injured worker or the worker's representative. The employer shall provide a copy of the "Worker's and Employer's Report of Occupational Injury or Disease," Form 440-801 (Form 801) or, an optional short form, the "Worker's Notice of Claim for Occupational Injury or Disease," Form 440-801W (Form 801W), 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 or Form 801W. 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, pursuant to OAR 436-010-0240, necessary to process the claim.

(3) Employers, except self-insured employers, shall 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 shall provide the information requested on the Form 801, and shall 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 or Form 801W, 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 shall maintain records showing the name of the worker, the date, nature of the injury and first aid provided for one year. 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 pursuant to 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 shall 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 shall 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 shall 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 shall 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, shall be identified on all insurer generated workers' compensation forms, including insurer name, third party administrator name (if applicable), address, and phone number of the location responsible for processing the claim.

(10) The insurer shall 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 shall 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 an initial compensability decision Form 1502, the insurer shall 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.

(12) The insurer shall 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; or

(f) The date of any denial.

(13) A nondisabling claim shall 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.

(14) If the insurer voluntarily reopens a qualified claim pursuant to ORS 656.278, it shall file a Form 3501 with the director within 14 days of the date the insurer reopens the claim.

(15) The insurer shall 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.

(16) New condition claims that are ready to be closed within 14 days shall be reported on the "Insurer Notice of Closure Summary," Form 440-1503 (Form 1503) at the time the insurer closes the claim. The Form 1503 shall be accompanied by the "Modified Notice of Acceptance" and "Updated Notice of Acceptance at Closure" letter.

(17) 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 shall submit a Form 1502 with a copy of the worker's communication to the director, if the claim had previously been reported.

(18) 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 ten 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).

(19) Insurers shall make an annual report to the director reporting attorney fees, attorney salaries, and all other costs of legal services paid pursuant to ORS Chapter 656. The report shall be submitted on forms furnished by the director for that purpose. Reports for each calendar year shall be filed not later than March 1 of the following year.

(20) If an insurer elects to process and pay supplemental disability benefits, pursuant to ORS 656.210(5)(a), the insurer does not need to inform the director of their election. The insurer shall request reimbursement, pursuant to 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 shall submit Form 3530, "Supplemental Disability Election Notification," to the director by February 1 of each year. The election remains in effect for all supplemental disability claims the insurer receives during that calendar year. The election is made by the insurer and applies to all third party administrators an insurer may use for processing claims.

(21) 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 656.262, 656.264, 656.265, 656.704, 656.726(4) & sec. 3(5)(a), ch. 865, OL 2001

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

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 shall be given to the worker's attorney pursuant to 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 pursuant to 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 shall 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, "Understanding workers' compensation claims," Form 440-3283 (Form 3283) may be provided in lieu of Form 1138, unless the worker specifically requests Form 1138.

(4) The insurer shall provide Form 3283 to their insured employers for distribution to workers at the time a worker completes a Form 801 or Form 801W, for all claims filed.

(5) The insurer shall 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 pursuant to OAR 436-060-0140(6). For the purpose of this rule, an equivalent to the Form 3058 shall include all of the statutory and rule requirements.

(6) Additional notices the insurer shall 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, service companies, 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.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 656.331, 656.704, 656.726(4) & ORS 656.745
Stats. Implemented: ORS 656.331, 656.704 & ORS 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

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 shall date stamp each document upon receipt with the date it is received. The date stamp shall 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 shall 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 shall 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 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 shall be accompanied by a worker signed attorney retention agreement or a medical release signed by the worker. The signed medical release shall 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 shall provide such new documents to claimant's attorney every 30 days, unless specific documents are requested sooner by the attorney. Such documents shall 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 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 shall furnish copies of documents within the following time frames:

(a) The documents of open and closed files, and/or microfilmed files shall 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 shall so notify the requester in writing within 14 days of receiving the request for claim documents. The insurer shall 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 shall 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 shall 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 shall 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 shall respond in writing to the division. The response must be mailed or delivered to the director within 21 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, a civil penalty may be assessed pursuant to 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 in this rule are available from the agency.]
Stat. Auth.: ORS 656.360, 656.362, 656.704, 656.726(4) & ORS 656.745
Stats. Implemented: ORS 656.704 & ORS 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

436-060-0018
Nondisabling/Disabling Reclassification

(1) When the insurer changes the classification of an accepted claim, the insurer shall 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 shall be communicated by issuing a Modified Notice of Acceptance. This notice shall include an explanation of the change in status and shall 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 shall close the claim under ORS 656.268(5).

(2) The insurer shall reclassify a non-disabling 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) The insurer shall reclassify a non-disabling claim 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 less than one year 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 shall 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 shall 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 be accompanied by:

(a) A copy of the request for reclassification the worker sent to the insurer, and

(b) A copy of the insurer's Notice of Refusal to Reclassify that the worker received in response.

(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 shall 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 non-disabling. 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.

Stat. Auth.: ORS 656.268, 656.726, 1995 OL Ch 332 & 1999 OL Ch 313
Stats. Implemented: ORS 656.210, 656.212, 656.214, 656.262, 656.268, 656. 273, 656.277, 656.745, 656.726, 1999 OL Ch 313 & 2001 OL Ch 350
Hist.: WCD 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-060-0019
Determining and Paying the Three Day Waiting Period

(1) Pursuant to ORS 656.210 and 656.212, the three day waiting period is three consecutive calendar days beginning with the first day the worker loses time or wages from work as a result of the compensable injury, subject to the following:

(a) If the worker leaves work but returns and completes the work shift without loss of wages, that day shall not be considered the first day of the three day waiting period.

(b) If the worker leaves work but returns and completes the work shift and receives reduced wages, that day shall be considered the first day of the three day waiting period.

(c) If the worker does not complete the work shift, that day shall be considered the first day of the three day waiting period even if there is no loss of wages. For the purpose of this rule, an attending physician's or authorized nurse practitioner's authorization of temporary disability is not required to begin the waiting period; however, the waiting period would not be due and payable unless authorized.

(2) Pursuant to ORS 656.210(3), no disability payment is due the worker for temporary total disability suffered during the first three calendar days after the worker leaves work as a result of a compensable injury, unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. For the purpose of this rule, admittance as an inpatient to a hospital can be any time following the date of the injury, but must be within 14 days of the first onset of total disability to waive the three day waiting period.

(3) If compensation is due and payable for the three day waiting period, the worker shall be paid for one-half day for the initial work day lost if the worker leaves the job during the first half of the shift and does not return to complete the shift. No compensation is due for the initial day of the waiting period if the worker leaves the job during the second half of the shift.

(4) If a worker is employed with varying days off or cyclic work schedules, the three day waiting period shall be determined using the work schedule of the week the worker begins losing time or wages as a result of the injury. If the worker is no longer employed with the employer at injury or does not have an established schedule when the worker begins losing time/wages, the three day waiting period and scheduled days off shall be based on the work schedule of the week the worker was injured.

Stat. Auth.: ORS 656.210, 656.212, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210 & 656.212
Hist.: WCD 11-2001, f. 11-30-01, cert. ef. 1-1-02; 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

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 pursuant to 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 shall provide adequate payment documentation as the insurer may require to meet its responsibilities.

(2) Pursuant to 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 pursuant to 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 shall 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 shall document its file regarding those findings. The insurer shall 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, shall 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 shall 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 pursuant to ORS 656.262(4)(g).

(5) An insurer may suspend temporary disability benefits without authorization from the division pursuant to 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 rescheduled appointment. We notified you of the rescheduled appointment by certified mail and warned you that your benefits would be suspended if you failed to attend. Since you failed to attend the rescheduled appointment, your temporary disability benefits have been suspended. In order to resume your benefits, you must attend a rescheduled 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 shall:

(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 shall 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 pursuant to ORS 656.262 and also does not apply to benefits pursuant to ORS 656.214 and 656.245. Claims subject to the pro rata order approved by the division shall be closed pursuant to 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 shall receive compensation at the highest temporary disability rate of the claims involved.

(9) If a closure pursuant to 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 shall begin payments pursuant to 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 shall begin temporary disability payments pursuant to 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) & sec. 1(30), ch. 865, OL 2001

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

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, pursuant to ORS 656.018(6) the employer is not precluded from supplementing the amount of temporary total disability paid the worker. Employers shall separately identify workers' compensation benefits from other payments and shall not have payroll deductions withheld from such benefits.

(2) Notwithstanding section (1), pursuant to 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 shall 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 shall have their weekly wages determined pursuant to OAR 436-060-0025(5).

(b) For workers employed through union hall call board insurers shall 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) When the worker disagrees with the wage amount used, the insurer shall contact the employer to confirm the correct wage, or if a self-insured employer, the employer shall verify whether the correct wage amount was used. The insurer shall provide the worker an explanation of any wage change different from that reported on the claim Form 801.

(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. The insurer shall resolve disputes regarding wage calculations by contacting the employer and worker to determine a reasonable wage. If an agreement cannot be reached, the dispute may be referred to the division for resolution.

(a) For workers employed seasonally, on call, paid hourly, paid by piece work or with varying hours, shifts or wages:

(A) Insurers shall 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 pursuant to 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 shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury or all earnings, if the worker qualifies pursuant to 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 shall 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 shall 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 shall 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 shall 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 shall 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, shall 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 shall 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 shall 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 shall use the wages actually paid, plus the amount of tips required to be reported by the employer pursuant to 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 shall 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., shall 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 shall use the worker's average commission earnings for previous 52 weeks, if available. For workers without 52 weeks of earnings, insurers shall use the assumed wage on which premium is based. Any regular wage in addition to commission shall 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 shall use the assumed wage on which the employer's premium is based.

(l) For school teachers or workers paid in a like manner, insurers shall 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 shall 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 in this rule are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.210(2), 656.704 & ORS 656.726(4)

Stats. Implemented: ORS 656.210, 656.704, 656.726(4) & sec. 3(2)(a)-(c), ch. 865, OL 2001

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

436-060-0030

Payment of Temporary Partial Disability Compensation

(1) The amount of temporary partial disability compensation due a worker shall be determined by:

(a) Subtracting post-injury wage earnings by the worker from any kind of work from

(b) The wage used to compute the rate of compensation at the time of injury; then

(c) Dividing the difference by the wage earnings used in subsection (b) to arrive at the percentage of loss of wages; then

(d) Multiplying the current temporary total disability compensation rate by the percentage of loss of wages in subsection (c).

(2) Notwithstanding section (1), for workers whose rate of compensation is based on an assumed wage, "post-injury wage earnings" will be that proportion of the assumed wage which the hours worked during the period of temporary partial disability represent as a percentage of the hours worked prior to the injury.

(3) An insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) from the date an injured worker begins wage earning employment, prior to claim closure, unless the worker refuses modified work pursuant to ORS 656.268(4)(c)(A) through (F). If the worker is with a new employer and upon request of the insurer to provide wage information, it shall be the worker's responsibility to provide documented evidence of the amount of any wages being earned. Failure to do so shall be cause for the insurer to assume that post-injury wages are the same as or higher than the worker's wages at time of injury.

(4) For the purpose of section (5) of this rule:

(a) "Commute" means the lesser of the distance traveled from the worker's residence at the time of injury to the work site or the worker's residence at the time of the modified work offer to the work site;

(b) "Where the worker was injured" means the location where the worker customarily reported or worked at the time of injury; and

(c) "Temporary employees" has the same meaning as defined in OAR 436-050-0420.

(5) Pursuant to ORS 656.325(5)(a), an insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when an injured worker fails to begin wage earning employment, under the following conditions:

(a) The employer or insurer:

(A) notifies the attending physician or authorized nurse practitioner of the physical tasks to be performed by the injured worker;

(B) notifies the attending physician or authorized nurse practitioner of the location of the modified work offer; and

(C) asks the attending physician or authorized nurse practitioner if the worker can, as a result of the compensable injury, physically commute to and perform the job.

(b) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities and the commute is within the physical capacity of the worker; and

(c) The employer or insurer has confirmed the offer of employment in writing to the worker stating:

(A) The beginning time, date and place;

(B) The duration of the job, if known;

(C) The wages;

(D) An accurate description of the physical requirements of the job;

(E) That the attending physician or authorized nurse practitioner has found the job to be within the worker's capabilities and the commute within the worker's physical capacity;

(F) The worker's right to refuse the offer of employment without termination of temporary total disability if any of the following conditions apply:

(i) The offer is at a site more than 50 miles from where the worker was injured, unless the work site is less than 50 miles from the worker's residence, or the intent of the employer and worker at the time of hire or as

established by the employment pattern prior to the injury was that the job involved multiple or mobile work sites and the worker could be assigned to any such site. Examples of such sites include, but are not limited to logging, trucking, construction workers, and temporary employees;

(ii) The offer is not with the employer at injury;

(iii) The offer is not at a work site of the employer at injury;

(iv) The offer is not consistent with existing written shift change policy or common practice of the employer at injury or aggravation; or

(v) The offer is not consistent with an existing shift change provision of an applicable union contract; and

(G) The following notice, in prominent or bold face type:

"If you refuse this offer of work for any of the reasons listed in this notice, you should write to the insurer or employer and tell them your reason(s) for refusing the job. If the insurer reduces or stops your temporary total disability and you disagree with that action, you have the right to request a hearing. To request a hearing you must send a letter objecting to the insurer's action(s) to the Worker's Compensation Board, 2601 25th Street SE, Suite 150, Salem, Oregon 97302-1282."

(6) Pursuant to ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

(a) The employer has a written policy of offering modified work to injured workers;

(b) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1);

(c) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks to be performed by the injured worker; and

(d) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(7) Pursuant to ORS 656.325(5)(c), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (1) as if the worker had begun the employment when the attending physician or authorized nurse practitioner approves employment in a modified job whether or not such a job is available if the worker is a person present in the United States in violation of federal immigration laws, under the following conditions:

(a) The insurer has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (1);

(b) The attending physician or authorized nurse practitioner has been notified by the employer or insurer of the physical tasks that would have been performed by the injured worker; and

(c) The attending physician or authorized nurse practitioner agrees the employment appears to be within the worker's capabilities.

(8) Temporary partial disability shall be paid at the full temporary total disability rate as of the date a modified job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim shall be included in this section. For the purpose of this rule, when a worker who has been doing modified work quits the job or the employer terminates the worker for violation of work rules or other disciplinary reasons it is not a withdrawal of a job offer by the employer, but shall be considered the same as the worker refusing wage earning employment pursuant to ORS 656.325(5)(a). This section does not apply to those situations described in sections (5), (6), and (7) of this rule.

(9) When the worker's disability is partial only and temporary in character, temporary partial disability compensation pursuant to ORS 656.212 shall continue until:

(a) The attending physician or authorized nurse practitioner verifies that the worker can no longer perform the modified job and is again temporarily totally disabled;

(b) The compensation is terminated by order of the division or by claim closure by the insurer pursuant to ORS 656.268; or

(c) The compensation is lawfully suspended, withheld or terminated for any other reason.

(10) In determining failure on the part of the worker in section (5) and for purposes of subsection (1)(a), "post-injury wages" are the wages the worker could have earned by accepting a job offer, or actual wages earned, whichever is greater, and any unemployment, sick or vacation leave payments received.

(11) 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 shall:

(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.

(12) The insurer shall provide the injured worker and the worker's attorney a written notice of the reasons for changes in the compensation rate, and the method of computation, whenever a change is made.

Stat. Auth.: ORS 656.212, 656.704 & 656.726(4)

Stats. Implemented: ORS 656.212, 656.325(5), 656.704, 656.726(2) & ch 865(12) (4)(c) OL 2001

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 436-054-0222, 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 1-1994(Temp), f. & cert. ef. 3-1-94; 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 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

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 agent" is the company or business whom 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 check stubs or payroll records which include:

(A) Identification of the Oregon subject employer(s) and the time period of the date of injury to establish 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 pursuant to 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 a claim on which the temporary disability rate does not meet or exceed the maximum rate, the insurer shall send a worker who identifies employment in addition to the primary job on the Form 801 a notice informing the worker of the date the insurer received the claim and the final date by which the insurer or the assigned processing agent must receive verifiable documentation to determine the worker's eligibility for supplemental disability. If the insurer has elected not to process and pay these benefits, the insurer shall copy the assigned processing agent with the notice to the worker. The notice shall contain the name, address, and telephone number of the assigned processing agent, and

shall also clearly advise the worker that the verifiable documentation must be sent to the assigned processing agent.

(4) Within 14 days of receiving the worker's verifiable documentation, the insurer or the assigned processing agent shall determine the worker's eligibility for supplemental disability and shall communicate the decision to the worker and the worker's representative, if any, in writing. The written communication shall 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.

(5) 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,

(c) The worker provides verifiable documentation to the insurer or the assigned processing agent within 60 days of the date the insurer received the notification, and

(d) 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.

(6) The insurer or the assigned processing agent shall calculate supplemental disability for an eligible worker by adding all earnings the worker received from all subject employment, pursuant to 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.

(7) If the temporary disability rate from the primary employer does not meet or exceed the maximum rate, the insurer or the assigned processing agent shall combine the weekly wages, determined pursuant to 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.

(8) To establish the combined partial disability benefits when the worker has post injury wages from either job, the insurer or the assigned processing agent shall use all post injury wages from both primary and all secondary employers. The insurer or the assigned processing agent shall 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 agent shall 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.

(9) 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.

(10) If the worker returns to a job not held at the time of the injury, the insurer or the assigned processing agent shall process supplemental disability under the same terms, conditions and limitations as OAR 436-060-0030.

(11) Except as otherwise provided in sections (2), (7), (8), and (9) of this rule, supplemental disability shall be due, paid, and processed under the same provisions, conditions, and limitations as would be applicable to temporary disability for the job at injury. Supplemental disability may be due on a non-disabling claim even if temporary disability is not due from the primary job. The non-disabling claim will not change to disabling status due to payment of supplemental disability. When supplemental disability payments cease on a non-disabling claim, the insurer or the assigned processing agent shall 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.

(12) If the insurer has elected to process and pay supplemental disability pursuant to ORS 656.210(5)(a), the insurer shall determine the worker's on-going entitlement to supplemental disability and shall pay the worker supplemental disability simultaneously with any temporary disability due. Reimbursement for supplemental disability paid will be made pursuant to OAR 436-060-0500.

(13) If the insurer has elected not to process and pay supplemental disability, the assigned processing agent shall determine the worker's on-going entitlement to supplemental disability and shall pay the worker supplemental disability due once each 14 days.

(14) 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 agent, even if temporary disability is not due from the primary job.

(15) If the insurer has elected not to process and pay supplemental disability, the insurer and the assigned processing agent shall communicate and retain documentation of shared information, as necessary, to coordinate benefits due.

(16) 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.

(17) When an insurer elects to pay supplemental disability pursuant to ORS 656.210(5)(a) and OAR 436-060-0010(20) and receive reimbursement pursuant to OAR 436-060-0500, the insurer shall maintain a record of supplemental disability paid to the worker, separate from temporary disability paid as a result of the job at injury.

(18) If a worker disagrees with the insurer's or the assigned processing agent'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 agent's decision within 60 days of the notice in section (4) of this rule. Disputes that arise about the rate of supplemental disability may be resolved pursuant to OAR 436-060-0025(5) and may be submitted at any time. 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. By requesting resolution of the dispute under OAR 436-060-0025(5), the worker authorizes the Workers' Compensation Division to contact the secondary job employer to verify information provided by the worker to resolve the dispute.

(19) 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 agent and that delay causes a delay in the worker receiving supplemental disability benefits.

Stat. Auth.: ORS 656.210, 656.704 & 656.726(4)
Stats. Implemented: ORS 656.210, 656.325(5), 656.704, 656.726(4) & sec. 3(2)(a), ch. 865, OL 2001
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

436-060-0040
Payment of Permanent Partial Disability Compensation

(1) Permanent partial disability exceeding $6,000 may be paid monthly by the insurer. If it is paid monthly, it must be paid at 4.35 times the weekly temporary disability rate at the time of closure.

(2) If a claim is reopened as a result of a new medical condition or an aggravation of the worker's accepted condition(s) and temporary disability is due, any permanent partial disability benefits due shall continue to be paid concurrently with temporary disability benefits.

(3) The insurer shall stop temporary disability compensation payments and resume any award payments suspended pursuant to ORS 656.268(9) upon the worker's completion or ending of the training, unless the worker is not then medically stationary. If no award payment remains due, temporary disability compensation payments shall continue pending a subsequent claim closure.

Stat. Auth.: ORS 656.268(9), 656.704 & ORS 656.726(4)
Stats. Implemented: ORS 656.268(9), 656.704 & ORS 656.726(4)
Hist.: 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 436-054-0232, 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 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

436-060-0060
Lump Sum Payment of Permanent Partial Disability Awards

(1) Pursuant to ORS 656.230, in all cases where an award for permanent partial disability does not exceed $6,000, the insurer shall pay all of the award to the worker in a lump sum. When the award for permanent partial disability exceeds $6,000, the insurer or director may approve an application of the worker for lump sum payment when the order has become final by operation of law or the worker has waived their right to appeal the

adequacy of the award. The lump sum application shall be in the form and format provided by the director.

(2) When an insurer receives a request for a lump sum application from the worker or the worker's representative, the insurer shall send the lump sum application form 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 shall 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 submit the lump sum application with the reason for disagreement to the director within 14 days of receipt of the signed application. The insurer shall simultaneously copy the worker and the worker's attorney, if represented, of the disagreement and submission to the division.

(6) The insurer or the division shall not approve an application for lump sum payment of unscheduled permanent 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.

(7) The insurer or the division shall not approve an application for lump sum payment of scheduled or unscheduled permanent disability when the worker is involved in litigation affecting the permanent partial disability award.

(8) When the division approves a disputed application, the insurer shall pay the lump sum amount to the worker within 14 days after the mailing of the order.

(9) If any party disagrees with the decision of the division, the party may petition the director to reconsider the decision within 14 days after the mailing of the decision. Appeal of an order approving a lump sum payment stays payment of the lump sum until the director's review is complete and an order on the appeal is issued. The director's decision shall be final and not subject to review.

(10) A lump sum payment ordered in a litigation order or which is a part of a Claim Disposition Agreement pursuant to ORS 656.236 does not require further approval by the insurer or the division.

(11) When a partial payment is approved by the insurer or the division, it shall be in addition to the regularly scheduled monthly payment. The remaining balance shall be paid pursuant to ORS 656.216. Denial or partial approval of an application does not prevent another application 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 & ORS 656.726(4)

Stats. Implemented: ORS 656.230, 656.704 & ORS 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

436-060-0095

Medical Examinations; Suspension of Compensation; and Insurer Medical Examination Notice

(1) The division will suspend compensation by order under conditions set forth in this rule. The worker shall 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 when the worker refuses or fails to submit to, or otherwise obstructs, a medical examination reasonably requested by the insurer or the director pursuant to ORS 656.325(1). Compensation will be suspended until the examination has been completed. The conditions of the examination shall be consistent with conditions described in OAR 436-010-0265. Any action of a friend or family member which obstructs the examination shall be considered an obstruction of the examination by the worker for the purpose of this rule. The division may determine whether special circumstances exist that would not warrant suspension of compensation for failure to attend or obstruction of the examination.

(2) The division will consider requests to authorize suspension of benefits on accepted claims, deferred claims and on denied claims in which the worker has appealed the insurer's denial.

(3) A worker shall submit to medical examinations reasonably requested by the insurer or the director. No more than three separate medical examinations may be requested by the insurer for each open period of a claim, except as provided under OAR 436-010. Examinations after the worker's claim is closed are subject to limitations in ORS 656.268(7).

(4) The insurer may contract with a third party to schedule insurer requested medical examinations. If the third party notifies the worker of a scheduled examination on behalf of the insurer, the appointment notice is required to be sent on the insurer's stationery and must conform with the requirements of OAR 436-060-0095(5).

(5) If an examination is scheduled by the insurer or by another party at the request of the insurer, the worker and the worker's attorney shall be simultaneously notified in writing of the scheduled medical examination pursuant to ORS 656.331. The notice shall be sent at least 10 days prior to the examination. The notice sent for each appointment, including those which have been rescheduled, shall contain the following:

(a) The name of the examiner or facility;

(b) A statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(c) The date, time and place of the examination;

(d) The first and last name of the attending physician or authorized nurse practitioner and verification that the attending physician or authorized nurse practitioner was informed of the examination by, at least, a copy of the appointment notice, 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 examination;

(f) That the reasonable cost of public transportation or use of a private vehicle will be reimbursed and that, 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 these costs be necessary for attendance, a request for advancement shall be made in sufficient time to ensure a timely appearance;

(g) That an amount will be paid equivalent to net lost wages for the period during which it is necessary to be absent from work to attend the medical examination if benefits are not received under ORS 656.210(4) during the absence; and

(h) The following notice in prominent or bold face type:

"You must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. 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 656.325 and OAR 436-060."

(6) Child care costs reimbursed at the rate prescribed by the State of Oregon Department of Human Services, comply with this rule.

(7) The request for suspension shall be sent to the division. A copy of the request, including all attachments, shall 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 shall include the following information:

(a) That the insurer requests suspension of benefits pursuant to ORS 656.325 and OAR 436-060-0095;

(b) The claim status and any accepted or newly claimed conditions;

(c) What specific actions of the worker prompted the request;

(d) The dates of any prior insurer medical examinations the worker has attended in the current open period of the claim and the names of the examining physicians or facilities, or a statement that there have been no prior examinations, whichever is appropriate;

(e) A copy of any approvals given by the director, or a statement that no approval was necessary, whichever is appropriate;

(f) Any reasons given by the worker for failing to comply, whether or not the insurer considers the reasons invalid, or a statement that the worker has not given any reasons, whichever is appropriate;

(g) The date and with whom failure to comply was verified. Any written verification of the worker's refusal to attend the exam received by the insurer from the worker or the worker's representative will be sufficient documentation with which to request suspension;

(h) A copy of the letter required in section (5) and a copy of any written verification received under subsection (7)(g);

(i) Any other information which supports the request; and

(j) 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. If your claim has not yet been accepted, your future benefits, if any, will be jeopardized."

(8) If the division consents to suspend compensation, the suspension shall be effective from the date the worker fails to attend an examination or such other date the division deems appropriate until the date the worker undergoes an examination scheduled by the insurer or director. Any delay in requesting consent for suspension may result in authorization being denied or the date of authorization being modified.

(9) The insurer shall assist the worker in meeting requirements necessary for the resumption of compensation payments. When the worker has undergone the examination, the insurer shall verify the worker's participation and reinstate compensation effective the date of the worker's compliance.

(10) If the worker makes no effort to reinstate compensation in an accepted claim within 60 days of the date of the consent to suspend order, the insurer shall close the claim pursuant to OAR 436-030-0034(7).

(11) If the division denies the insurer's request for suspension of compensation, it shall promptly notify the insurer of the reason for denial. 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.

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 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; Renumbered from 436-060-0085(1),(2),(4); 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

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 shall 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 pursuant to 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 shall 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 shall contain the following information, and a copy shall be sent simultaneously to the worker's attorney:

(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 shall verify whether the worker complied with the request for cooperation on the date specified in section (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 shall be sent to the division. A copy of the request, including all attachments, shall 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 shall 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 shall monitor the claim to determine if and when the worker complies with the insurer's requests. When cooperation resumes, payment of compensation shall resume effective the date cooperation was resumed.

(9) The insurer shall 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 shall close the claim pursuant to 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 shall:

(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

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 pursuant to 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 shall have the opportunity to submit information disputing the insurer's request for suspension of compensation prior to issuance of the order.

(2) A worker shall 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 pursuant to 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 shall notify the worker in writing that an interview or deposition has been scheduled, or of other investigation requirements, and shall give the worker at least 14 days to cooperate. The notice shall be sent to the worker and copied to the worker's attorney, if represented, and shall 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 shall 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) Notwithstanding section (4) of this rule, for suspension of benefits to be granted under ORS 656.262(14) for noncooperation during an investigation of a claim resulting from a worker's failure to attend or cooperate in an insurer medical examination, the notification requirements in OAR 436-060-0095(5) must be met; however, the notice required by 436-060-0095(5)(h) must be replaced with the following notice, 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. Therefore, you must attend this examination. If there is any reason you cannot attend, you must tell the insurer as soon as possible before the date of the examination. If you fail to attend or fail to cooperate, and do not have a good reason for not attending, payment of your compensation benefits may be suspended and your claim may be denied in accordance with ORS 656.262 and OAR 436-060."

(6) The request for suspension shall be sent to the division after the 14 days in section (4) have expired. If the request is for failure to attend an insurer medical examination pursuant to section (5), the request shall be sent to the division after the date of the examination, or after the insurer receives written documentation from the worker or the worker's representative that the worker will not attend the examination. Any delay in requesting suspension may result in authorization being denied. A copy of the request, including all attachments, shall be sent simultaneously to the worker and the worker's attorney by registered or certified mail or by personal service. The request shall include the following information sufficient to show the worker's failure to cooperate:

(a) That the insurer requests suspension of benefits pursuant to 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. Any written verification the insurer receives from the worker or the worker's representative of the worker's refusal to cooperate or attend an exam will be sufficient documentation with which to request suspension;

(d) A copy of the notice required in section (4) or (5) of this rule; a copy of any written verification received under subsection (6)(c); and

(e) All other pertinent information.

(7) After receiving the insurer's request as required in section (6) 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.

(8) If the worker cooperates after the insurer has requested suspension, the insurer shall 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.

(9) 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.

(10) 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 (7) of this rule. The suspension of compensation shall remain in effect until 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).

(11) 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 shall have the opportunity to dispute the allegation prior to the issuance of a penalty. Notice under this section shall be sent to the division. A copy of the notice shall be sent simultaneously to the worker and the worker's attorney. Notice to the division by the insurer shall 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.

(12) Failure to comply with the requirements of this rule will be grounds for denial of the insurer's request.

Stat. Auth.: ORS 656.704 & ORS 656.726(4)

Stats. Implemented: ORS 656.262(14), 656.262(15), 656.704 ORS 656.726(4) & sec. 7(6)(a), ch. 865, OL 2001

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

436-060-0140
Acceptance or Denial of a Claim

(1) The insurer is required to conduct a "reasonable" investigation based on all available information in ascertaining whether to deny a claim. A reasonable investigation is whatever steps a reasonably prudent person with knowledge of the legal standards for determining compensability would take in a good faith effort to ascertain the facts underlying a claim, giving due consideration to the cost of the investigation and the likely value of the claim.

(2) In determining whether an investigation is reasonable, the director will only look at information contained in the insurer's claim record at the time of denial. The insurer may not rely on any fact not documented in the claim record at the time of denial to establish that an investigation was reasonable.

(3) The insurer shall give the claimant written notice of acceptance or denial of a claim within:

(a) 90 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of written notice of an aggravation claim or written notice of a new medical condition claim for claims with a date of injury prior to January 1, 2002; or

(b) 60 days after the employer's notice or knowledge of an initial claim or the insurer's receipt of written notice of an aggravation claim or written notice of a new medical or omitted condition claim for claims with a date of injury on or after January 1, 2002.

(4) The director may assess a penalty against any insurer delinquent in accepting or denying a claim beyond the days required in (3) in excess of 5 percent of their total volume of reported disabling claims during any quarter.

(5) A notice of acceptance shall comply with ORS 656.262(6)(b) and the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438. It shall include a current mailing date, be addressed to the worker, be copied to the worker's representative, if any, and the worker's attending physician, and specify to the worker:

(a) What conditions are compensable;

(b) Whether the claim is disabling or nondisabling;

(c) Of the Expedited Claim Service, of hearing and aggravation rights concerning nondisabling injuries including the right to object to a decision that the injury is nondisabling by requesting the insurer review the status;

(d) Of the employment reinstatement rights and responsibilities under ORS Chapter 659A;

(e) Of assistance available to employers from the Reemployment Assistance Program under ORS 656.622;

(f) That expenses personally paid for claim related expenses up to a maximum established rate shall be reimbursed by the insurer when requested in writing and accompanied by sales slips, receipts, or other reasonable written support, for meals, lodging, transportation, prescriptions and other related expenses;

(g) That if the worker believes a condition has been incorrectly omitted from the notice of acceptance, or the notice is otherwise deficient, the worker must first communicate the objection to the insurer in writing specifying either that the worker believes the condition has been incorrectly omitted or why the worker feels the notice is otherwise deficient; and

(h) That if the worker wants the insurer to accept a claim for a new medical condition, the worker must put the request in writing, clearly identify the condition as a new medical condition, and request formal written acceptance of the condition.

(6) On fatal claims, the notice shall be addressed "to the estate of" the worker and the requirements in (5)(a) through (h) shall not be included.

(7) The first acceptance issued on the claim shall contain the title "Initial Notice of Acceptance" near the top of the notice. Any notice of acceptance shall contain all accepted conditions at the time of the notice. Additionally, when reopening a claim, the notice of acceptance shall specify the condition(s) for which the claim is being reopened. Under ORS 656.262(6)(b)(F) the insurer must modify acceptance from time to time as medical or other information changes. An insurer shall issue a "Modified Notice of Acceptance" (MNOA) when they:

(a) Accept a new or omitted condition: on a nondisabling claim, while a disabling claim is open or after claim closure;

(b) Accept an aggravation claim;

(c) Change the disabling status of the claim; or

(d) Amend a notice of acceptance.

(8) Notwithstanding OAR 436-060-0140(7)(d), to correct an omission or error in an "Updated Notice of Acceptance at Closure" (UNOA), pursuant to OAR 436-030-0015(1)(e), the insurer shall add the word "Corrected" to the UNOA.

(9) When an insurer accepts a new or omitted condition on a closed claim, the insurer must reopen the claim and process it to closure under ORS 656.262 and 656.267.

(10) A notice of denial shall comply with the rules of Practice and Procedure for Contested Cases under the Workers' Compensation Law, OAR chapter 438, and shall:

(a) Specify the factual and legal reasons for the denial, including the worker's right to request a Worker Requested Medical Examination and a specific statement indicating if the denial was based in whole or part on an insurer medical examination, pursuant to ORS 656.325, and one of the following statements, as appropriate:

(A) "Your attending physician agreed with the insurer medical examination report"; or

(B) "Your attending physician did not agree with the insurer medical examination report"; or

(C) "Your attending physician has not commented on the insurer medical examination report"; and

(b) Inform the worker of the Expedited Claim Service and of the worker's right to a hearing under ORS 656.283.

(c) If the denial is pursuant to ORS 656.262(14), it must inform the worker that for an appeal to be considered, the worker must request an expedited hearing pursuant to ORS 656.291.

(11) The insurer shall send notice of the denial to each provider of medical services and health insurance when compensability of any portion of a claim for medical services is denied at the same time the denial is sent to the worker. If the insurer receives any billings from medical providers after claim denial, they shall send a copy of the denial to the medical provider and advise the medical provider of the status of the denial. When compensability of the claim has been finally determined or when disposition of the claim has been made, the insurer shall notify each affected service provider of the results of the compensability determination or disposition. The notification shall include the results of the proceedings under ORS 656.236 or 656.289(4) and the amount of any settlement.

(12) The insurer shall pay compensation due pursuant to ORS 656.262 and 656.273 until the claim is denied, except where there is an issue concerning the timely filing of a notice of accident as provided in ORS 656.265(4). The employer may elect to pay compensation under this section in lieu of the insurer doing so. The insurer shall report to the division payments of compensation made by the employer as if the insurer had made the payment.

(13) Compensation payable to a worker or the worker's beneficiaries while a claim is pending acceptance or denial does not include the costs of medical benefits or burial.

Stat. Auth.: ORS 656.704 & 656.726(4)
Stats. Implemented: ORS 656.262(6), 656.704, 656.726(4) & sec. 7(6)(a) & 1(1)(b), ch. 865, OL 2001
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 436-054-0305, 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 12-1992, f. 6-12-92, cert. ef. 7-1-92; 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 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

436-060-0147
Worker Requested Medical Examination (WRME)

(1) Pursuant to ORS 656.325(1)(b) the director shall establish and maintain a list of physicians in accordance with OAR 436-010-0330.

(2) The director shall determine the worker's eligibility for a Worker Requested Medical Examination (Exam). The worker is eligible for an exam pursuant to this rule if the worker

(a) 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

(b) The denial was based on one or more Insurer Medical Examination reports with which the attending physician disagreed.

(3) The worker shall submit a request for the exam to the director. A copy of the request shall be sent simultaneously to the insurer or self-insured employer. The request shall 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 did not concur with the Insurer Medical Examination report(s).

(4) The insurer shall, 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 who have:

(a) Acted as attending physician;

(b) Provided medical consultations and/or treatment to the worker;

(c) Examined the worker at an insurer medical examination; or

(d) Reviewed the worker's medical records on this claim. For the purpose of this rule, "Attending Physician" and "Insurer Medical Examination" have the meanings defined in OAR 436-010-0005 and 436-010-0265(1), respectively.

(5) Failure to provide the required documentation described in section (4) in a timely manner will subject the insurer to civil penalties under OAR 436-060-0200.

(6) The director will notify all 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 shall send the physician the worker's complete medical record on this claim and the original questions asked of the Insurer Medical Examination(s) physician(s) no later than 14 days prior to the date of 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 shall address the original Insurer Medical Examination(s) questions and the questions from the worker or the worker's representative pursuant to section (9) 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 shall pay the physician selected pursuant to 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 shall 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 shall reimburse the worker for all necessary related services pursuant to ORS 656.325(1).

Stat. Auth.: ORS 656.704, 656.726(4) & sec. 13(1)(b),ch. 865, OL 2001

Stats. Implemented:ORS 656.325(1), 656.704 & ORS 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

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 pursuant to 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 80% of payments are timely. The director may assess a penalty against an insurer falling below these norms during any quarter.

(4) Compensation withheld pursuant to ORS 656.268(12) and (13), and 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 pursuant to ORS 656.268(9), if the claim has previously been closed;

(d) The date the insurer has notice or knowledge of a medically verified inability to work due to an aggravation of the worker's condition under ORS 656.273. For the purpose of this subsection, compensation for authorized temporary disability is due and payable on a claim for aggravation, unless the claim is denied;

(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, pursuant to 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 shall 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 pursuant to ORS 656.029;

(j) The date the division refers a noncomplying employer claim to an assigned claims agent pursuant to ORS 656.054; or

(k) The date a claim disposition is disapproved by the Board, if temporary disability benefits are otherwise due;

(l) The date the division designates a paying agent pursuant to ORS 656.307;

(m) The date a claim is reclassified from non-disabling 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 shall 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 and fatal benefits shall 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 or fatal benefits. Permanent total or fatal benefits accruing from the date of the order shall 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 signature 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; or

(e) The date a claim disposition is disapproved by the Board, if permanent disability benefits are otherwise due.

(f) The date authorized training ends if the worker is medically stationary and any previous award remains unpaid, pursuant to ORS 656.268(9) and OAR 436-060-0040(2).

(8) Subsequent payments of permanent disability and fatal benefits are made in monthly sequence. The insurer may adjust monthly payment dates, but shall inform the beneficiary prior to making the adjustment. No payment period shall exceed one month without the division approval.

(9) The insurer shall notify the worker or beneficiary in writing when compensation is paid of the specific purpose of the payment, the time period for which the payment is made and the reimbursable expenses. The insurer shall maintain records of compensation paid for each claim where benefits are due and payable. If the worker submits a request for reimbursement of multiple items and full reimbursement is not made, the insurer shall provide specific reasons for non-payment or reduction of each item.

(10) Payment of a Claim Disposition Agreement shall be made no later than the 14th day after the Board mails notice of its approval of the agreement to the parties, unless otherwise stated in the agreement.

(11) Pursuant to 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 shall 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 & ORS 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

436-060-0180

Designation and Responsibility of a Paying Agent

(1) For the purpose of this rule:

(a) "Compensable injury" means an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

(b) "Exposure" means a specific incident or period during which a compensable injury may have occurred.

(c) "Responsibility" means liability under the law for the acceptance and processing of a compensable claim.

(2) The division shall designate by order which insurer shall pay a claim if the employers and insurers admit that the claim is otherwise compensable, and where there is an issue regarding:

(a) Which subject employer is the true employer of a worker;

(b) Which of more than one insurer of a certain employer is responsible for payment of compensation to a worker;

(c) Which of two or more employers or their insurers is responsible for paying compensation for one or more on-the-job injuries and/or occupational diseases; or

(d) Which of two or more employers is responsible when there is joint employment.

(3) With the consent of the Workers' Compensation Board, Own Motion claims are subject to the provisions of this rule.

(4) Upon learning of any of the situations described in section (2), the insurer shall expedite the processing of the claim by immediately investigating the claim to determine responsibility and whether the claim is otherwise compensable. For the purposes of this rule, insurers identified in a potential responsibility dispute pursuant to ORS 656.307 shall, upon request, share claim related medical reports and other information without charge pertinent to the injury in order to expedite claim processing. The act of the worker applying for compensation benefits from any employer identified as a party to a responsibility dispute shall constitute authorization for the involved insurers to share the pertinent information in accordance with the criteria and restrictions provided in OAR 436-060-0017 and 436-010-0240. No insurer who shares information in accordance with this rule shall bear any legal liability for disclosure of such information.

(5) Upon learning of any of the situations described in section (2), the insurer shall immediately notify any other affected insurers of the situation. Such notice shall identify the compensable injury and include a copy of all medical reports and other information pertinent to the injury. The notice shall identify each period of exposure which the insurer believes responsible for the compensable injury by the following:

(a) Name of employer;

(b) Name of insurer;

(c) Specific date of injury or period of exposure; and

(d) Claim number, if assigned.

(6) Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer shall request designation of a paying agent by writing to the division and sending a copy of the request to the worker and the worker's representative, if any. The request shall not be contained in or attached to any form or report the insurer is required to submit pursuant to OAR 436-060-0010 or in the denial letter to the worker required by OAR 436-060-0140. Such a request, or agreement to designation of a paying agent, is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer. The insurer's written request to the division shall contain the following information:

(a) Identification of the compensable injury(s);

(b) That the insurer is requesting designation of a paying agent pursuant to ORS 656.307;

(c) That the insurer acknowledges the injury is otherwise compensable;

(d) That responsibility is the only issue;

(e) Identification of the specific claims or exposures involved by

(A) Employer,

(B) Insurer,

(C) Date of injury or specific period of exposure, and

(D) Claim number, if assigned;

(f) Acknowledgment that medical reports and other material pertinent to the injury have been provided to the other parties; and

(g) Confirmation the worker has been advised of the actions being taken on the worker's claim.

(7) The division will not designate a paying agent where there remains an issue of whether the injury is compensable against a subject Oregon employer, or if the 60 day appeal period of a denial has expired without a request for hearing being received by the Board or the division receiving a request for a designation of paying agent order, or if an insurer included in the question of responsibility opposes designation of a paying agent because it has received no claim.

(8) When notified by the division that there is a reasonable doubt as to the status of the claim or intent of a denial, the insurer shall provide written clarification to the division, the worker, insurers involved and other interested parties within 21 days of the date of the notification. If an insurer fails to respond timely or provides an inadequate response (e.g. failing to answer specific questions or provide requested documents), a civil penalty will be assessed pursuant to OAR 436-060-0200.

(9) Insurers receiving notice from the division of a worker's request for designation of a paying agent shall immediately process the request in accordance with sections (4) through (6).

(10) Upon receipt of written acknowledgment from the insurers that the only issue is responsibility for an otherwise compensable injury claim, the division will issue an order designating a paying agent pursuant to ORS 656.307. The division will designate the insurer with the lowest compensation considering the following factors:

(a) The claim with the lowest temporary total disability rate.

(b) If the temporary total disability rates and the rates per degree of permanent disability are the same, the earliest claim.

(c) If there is no temporary disability or the temporary total disability rates are the same, but the rates per degree of permanent disability are different, the claim with the lowest rate per degree of permanent disability.

(d) If one or more claims have disposed of benefits in accordance with ORS 656.236(1), the claim providing the lowest compensation not released by the claim disposition agreement.

(e) If one claim is under "Own Motion" jurisdiction, the Own Motion claim even if not the claim with the lowest temporary total disability rate.

(f) If more than one claim is under "Own Motion" jurisdiction, the Own Motion claim with the lowest temporary total disability rate.

(11) By copy of its order, the division will refer the matter to the Workers' Compensation Board to set a proceeding pursuant to ORS 656.307 to determine which insurer is responsible for paying benefits to the worker.

(12) The designated paying agent shall process the claim as an accepted claim through claim closure pursuant to OAR 436-030-0015(9) unless relieved of the responsibility by an order of the Administrative Law Judge or resolution through mediation or arbitration pursuant to ORS 656.307(6). The parties to an order under this section shall not settle any part of a claim pursuant to ORS 656.236 or 656.289, except to resolve the issue of responsibility, unless prior approval and agreement is obtained from all potential responsible insurers. Resolution of a dispute by mediation or arbitration by a private party cannot obligate the Consumer and Business Services Fund without the prior approval of the director. The Consumer and Business Services Fund shall not be obligated when one party declines to participate in a legitimate settlement conference under an ORS 656.307 order. Compensation paid under the order shall include all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries. The payment of temporary disability due shall be for periods subsequent to periods of disability already paid by any insurer.

(13) After a paying agent is designated, if any of the insurers determine compensability is or will be an issue at hearing, they shall notify the division. Any insurer shall notify the division and all parties to the order of any change in claim acceptance status after the designation of a paying agent. When the division receives notification of a change in the acceptance of a claim or notification that compensability is an issue after designation of a paying agent, the division shall order termination of any further benefits due from the original order designating a paying agent.

Stat. Auth.: ORS 656.307, 656.704, 656.726(4) & ORS 656.745
Stats. Implemented: ORS 656.307, 656.308, 656.704 & ORS 656.726(4)
Hist.: WCD 1-1980(Admin), f & ef. 1-11-80; WCD 5-1980(Admin)(Temp), f & ef. 4-29-80; WCD 7-1980(Admin), f. 9-5-80, ef. 10-1-80; WCD 8-1983(Admin), f. 12-29-83, ef. 1-1-84; Renumbered from 436-054-0332, 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 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 2-2004, f. 2-19-04 cert. ef. 2-29-04

436-060-0190
Monetary Adjustments Among Parties and Department of Consumer and Business Services

(1) An order of the director pursuant to ORS 656.307 and OAR 436-060-0180 applies only to the period prior to the order of the Administrative Law Judge determining the responsible paying party. Payment of compensation made thereafter shall not be recovered from the Consumer and Business Services Fund, unless the director concludes payment was made before the Administrative Law Judge's order was received by the paying agent designated under OAR 436-060-0180. Any monetary adjustment necessary after the Administrative Law Judge's order shall be handled under 436-060-0195.

(2) When all litigation on the issue of responsibility is final, the insurer ultimately held to be responsible shall, prior to paying any compensation, contact any nonresponsible insurer to learn what compensation has already been paid. When contacted by the responsible insurer, the nonresponsible insurer shall provide the requested information necessary for the responsible insurer to make a timely payment to the worker, medical providers or others, but in any case no later than 20 days after the date of the notification. Failure to respond to the responsible insurer's inquiry in a timely manner may result in non-reimbursement otherwise due from the responsible insurer or from the Consumer and Business Services Fund.

(3) The responsible insurer shall reimburse any nonresponsible insurers for compensation the nonresponsible insurer paid which the responsible insurer is responsible for, but has not already paid within 30 days of receiving sufficient information to adequately determine the benefits paid and the relationship to the condition(s) involved. Any balance remaining due the worker, medical providers or others shall be paid in a timely manner pursuant to OAR 436-009 and 436-060-0150. Payment of compensation which results in duplicate payment to the worker, medical providers or others as a result of failing to contact the nonresponsible insurer shall not release the responsible insurer from the requirement to reimburse any nonresponsible insurers for its costs.

(4) The division shall direct any necessary monetary adjustment between the parties involved which is not otherwise ordered by the Administrative Law Judge or voluntarily resolved by the parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except in the situation described in section (3). Failure to make monetary adjustments within 30 days of an order by the division will subject the insurer to civil penalties under OAR 436-060-0200. Only compensation paid as a result of an order by the director pursuant to 436-060-0180 and consistent with this rule shall be recoverable from the Consumer and Business Services Fund when such compensation is not reimbursed to the nonresponsible insurer by the responsible insurer.

(5) When the division determines improper or untimely claim processing by the designated paying agent has resulted in unnecessary costs, the division may deny reimbursement from the responsible insurer and the Consumer and Business Services Fund.

Stat. Auth.: ORS 656.704 & ORS 656.726(4)
Stats. Implemented: ORS 656.307(3), 656.704 & ORS 656.726(4)
Hist.: WCB 5-1970, f. 6-3-70, ef. 6-25-70; WCD 1-1980(Admin), f. & ef. 1-11-80; WCD 5-1980(Admin)(Temp), f. & ef. 4-29-80; WCD 7-1980(Admin), f. 9-5-80, ef. 10-1-80; 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 436-054-0334, 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 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

436-060-0195
Miscellaneous Monetary Adjustments Among Insurers

(1) The director may order monetary adjustments between insurers under authority provided by ORS 656.726(4) and 656.202 where a claimant has a right to compensation, but there is a dispute between insurers that does not fall under the director's authority in ORS 656.307 and OAR 436-060-0190. Any failure to obtain reimbursement from an insurer under this rule shall not be recoverable from the Consumer and Business Services Fund. The purpose of this rule is to ensure the claimant properly receives all compensation due under the workers' compensation law, but is not unduly compensated for more than the law intended.

(2) When any litigation on issues in question is final, insurers shall make any necessary monetary adjustments among themselves consistent with the determination of coverage for compensation paid to the worker, medical providers and others for which they are responsible and payment has not already been made within 30 days of receiving sufficient information to adequately determine the benefits paid and the relationship to the condition(s) involved. Any balance due after making such adjustments shall be paid in a timely manner to the worker, medical providers and others pursuant to OAR 436-009 and 436-060-0150.

(3) The division may direct any necessary monetary adjustment between parties, but shall not order an insurer to pay compensation over and beyond that required by law, as it relates to the insurer's claim, except where an insurer unduly compensates a claimant while having knowledge such compensation has already been paid by another insurer. Notwithstanding, each insurer has its own independent obligation to process its claim and pay interim compensation due until the claim is either accepted or denied. When notified by the division that a dispute over monetary adjustment exists the insurer shall provide a written response to questions or issues raised, including supporting documentation, to the division, insurers involved and other interested parties within 21 days of the date of the notification.

(4) Failure to respond to the division's inquiries or make monetary adjustments within 30 days of an order by the division will subject the insurer to civil penalties under OAR 436-060-0200.

(5) When the division determines improper or untimely claim processing by an insurer resulted in unnecessary costs, the division may deny monetary adjustment between the insurers.

Stat. Auth.: ORS 656.704, 656.726(4) & ORS 656.745
Stats. Implemented: ORS 656.704 & ORS 656.726(4)
Hist.: 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 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

436-060-0200
Assessment of Civil Penalties

(1) The director through the division and pursuant to ORS 656.745 shall assess a civil penalty against an employer or insurer who intentionally or repeatedly induces claimants for compensation to fail to report accidental injuries, causes employees to collect accidental injury claims as off-the-job injury claims, persuades claimants to accept less than the compensation due or makes it necessary for claimants to resort to proceedings against the employer to secure compensation due.

(2) A penalty under section (1) will only be assessed after all litigation on the matter has become final by operation of the law. For the purpose of section (1):

(a) "Intentionally" means the employer or insurer acted with a conscious objective to cause any result described in ORS 656.745(1) or to engage in the conduct so described in that section; and

(b) "Repeatedly" means more than once in any twelve month period.

(3) Pursuant to ORS 656.745, the director may assess a civil penalty against an employer or insurer who fails to comply with rules and orders of the director regarding reports or other requirements necessary to carry out the purposes of the Workers' Compensation Law.

(4) An employer or insurer failing to meet the time frame requirements set forth in OAR 436-060-0010, 436-060-0017, 436-060-0030, 436-060-0060, 436-060-0147, 436-060-0155 and 436-060-0180 may be assessed a civil penalty up to $1,000.

(5) An insurer who willfully violates OAR 436-060-0160 shall be assessed a civil penalty of $1,000.

(6) An insurer that does not accurately report timeliness of first payment information to the division may be assessed a civil penalty of $500 for reporting inaccurate information plus $50 for each violation, or $10,000 in the aggregate for all violations within any three month period. For the purposes of this section, a violation consists of each situation where a first payment was reported to have been made timely, but was found upon audit to have actually been late.

(7) Notwithstanding section (3) of this rule, an employer or insurer who does not comply with the claims processing requirements of ORS Chapter 656, and rules and orders of the director relating thereto may be assessed a civil penalty of up to $2,000 for each violation or $10,000 in the aggregate for all violations within any three month period.

(8) Any employer or insurer which misrepresents themselves in any manner to obtain workers' compensation claims records from the director, or which uses such records in a manner contrary to these rules, is subject to a civil penalty of $1,000 for each occurrence. In addition, the director may suspend or revoke an employer's or insurer's access to workers' compensation claims records for such time as the director may determine. Any other person determined to have misrepresented themselves or who uses records in a manner contrary to these rules shall have access to these records suspended or revoked for such time as the director may determine.

(9) For the purpose of section (7), statutory claims processing requirements include but are not limited to, ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, and 656.335.

(10) In arriving at the amount of penalty, the division may consider, but is not limited to:

(a) The ratio of the volume of violations to the volume of claims reported, or

(b) The ratio of the volume of violations to the average volume of violations for all insurers or self-insured employers, and

(c) Prior performance in meeting the requirements outlined in this section.

(11) Insurer performance data is reviewed every quarter based on reports submitted by the insurer during the previous calendar quarter. Civil penalties will be issued for each of the performance areas where the percentages fall below the acceptable standards of performance as set forth in these rules. The standard for reporting claims to the division will allow insurers to report claims by filing a Form 1502 accompanied by a Form 827 where the Form 801 is not available. Penalties will be issued in accordance with the matrix set forth in Appendix "C."

(12) Pursuant to ORS 656.262(13), an injured worker's attorney that is not willing or available to participate in an interview at a time reasonably chosen by the insurer within 14 days of the request for interview may be assessed a civil penalty not to exceed $1,000 if the director finds the attorney's actions unreasonable.

[ED. NOTE: Appendices & Forms referenced are available from the agency.]

Stat. Auth.: ORS 656.704 & ORS 656.726(4)

Stats. Implemented: ORS 656.202, 656.210, 656.212, 656.228, 656.234, 656.236, 656.245, 656.262, 656.263, 656.264, 656.265, 656.268, 656.273, 656.307, 656.313, 656.325, 656.331, 656.335, 656.704, 656.726(4) & ORS 656.745

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 436-054-0981, 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 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 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

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 shall be submitted on Form 3504, "Supplemental Disability Benefits Quarterly Reimbursement Request," and shall 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 non-disabling;

(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(3).

(6) Claim Dispositions or Stipulated Settlements, pursuant to 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 shall 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) & sec. 3(5)(a), ch. 865, OL 2001

Stats. Implemented: ORS656.210, 656.704 & ORS 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

• • • • • • • • • •

Adm. Order No.: WCD 3-2004
Filed with Sec. of State: 3-5-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04

Rules Adopted: 436-001-0300
Rules Amended: 436-001-0000, 436-001-0001, 436-001-0003, 436-001-0004, 436-001-0005, 436-001-0007, 436-001-0008, 436-001-0030, 436-001-0110, 436-001-0150, 436-001-0155, 436-001-0160, 436-001-0170, 436-001-0185, 436-001-0201, 436-001-0210, 436-001-0225, 436-001-0226, 436-001-0240, 436-001-0260, 436-001-0265, 436-001-0275, 436-009-0003, 436-009-0004, 436-009-0005, 436-009-0008, 436-009-0010, 436-009-0015, 436-009-0020, 436-009-0022, 436-009-0025, 436-009-0030, 436-009-0040, 436-009-0050, 436-009-0060, 436-009-0070, 436-009-0080, 436-009-0090, 436-010-0003, 436-010-0005, 436-010-0008, 436-010-0210, 436-010-0220, 436-010-0230, 436-010-0240, 436-010-0250, 436-010-0265, 436-010-0270, 436-010-0275, 436-010-0280, 436-010-0340, 436-120-0003, 436-120-0004, 436-120-0008, 436-120-0320, 436-120-0340, 436-120-0350, 436-120-0360, 436-120-0410, 436-120-0500, 436-120-0710, 436-120-0720, 436-120-0830, 436-120-0840
Rules Repealed: 436-001-0025, 436-001-0045, 436-001-0055, 436-001-0065, 436-001-0090, 436-001-0105, 436-001-0120, 436-001-0135, 436-001-0140, 436-001-0171, 436-001-0175, 436-001-0191, 436-001-0195, 436-001-0205, 436-001-0231, 436-001-0255, 436-001-0285, 436-001-0295, 436-010-0350, 436-120-0920
Subject: These rules have been amended to replace temporary rules issued to implement changes in the law due to legislation passed by the 2003 Oregon Legislature:

• Senate Bill 233 changed the time frame for appeal of a proposed order or proposed assessment of civil penalty from 60 days following the party's receipt of notice to 60 days from the date the order is mailed by the department. OAR 436-010 and 436-120 have been amended accordingly.

• Senate Bill 620 modified ORS 656.385 to require payment of fees to workers' attorneys when a worker prevails in certain medical and vocational disputes. An attorney fee matrix has been added to OAR 436-001, 010, and 120, and the maximums apply to all work the worker's attorney has done relative to the proceeding at all levels before the department, absent a showing of extraordinary circumstances.

• House Bill 2305 addresses how medical records may be released, consistent with the federal Health Insurance Portability and Accountability Act, and related changes have been made to OAR 436-010.

• House Bill 3669 gave additional authority to nurse practitioners to treat injured workers and authorize temporary disability payments. This bill was a result of legislative action after development of the legislative concepts by nurse practitioners and the Management Labor Advisory Committee. OAR 436-009, 436-010, and 436-120 have been amended accordingly.

In addition, these rules - 436-001:

• Update the rulemaking notice rule.

• Update the contested case rules to establish consistency with the Attorney General's Model Rules of Procedure applicable to hearings before the Office of Administrative Hearings, OAR 137-003. Because the model rules control, duplicative or inconsistent rules are repealed. Remaining supplementary rules have been updated. Significant changes address the filing of hearing requests; delegation of authority to the ALJ; clarifications regarding scope of review; and a new process for alternative dispute resolution.

436-009: • Adopt updated medical resources.

• Incorporate data reporting requirements currently published in Bulletin 220.

• Add group nine to the fee schedule for ambulatory surgical centers.

• Require insurers and self-insured employers to keep track of dates of receipt of medical bills.

• Provide that if a provider's usual and customary fee is unreasonable, the director may determine a different fee based on criteria.

• Increase the dollar amount of each conversion factor by 2.33%, based on the annual increase in the physicians' component of the consumer price index.

• Require electronic billings to include a "zz" modifier for services that use an Oregon Specific Code.

• Modify the definitions of first and second level physical capacity evaluations and of work capacity evaluation.

• Provide that pharmacy fees shall be paid at 88% of the Average Wholesale Price (AWP) – a reduction from 95% in the current rules — with an $8.70 dispensing fee – an increase from $6.70 in the current rules.

• Provide that a brand name drug that has a generic equivalent will be paid at the lesser of 88% of the AWP for the brand name or 88% of the average AWP for the class of generic drug, plus dispensing fee, unless the prescribing medical provider writes "Do not substitute" or similar phrase on the prescription.

• Provide that payment for Oxycontin, Vioxx, Celebrex and Bextra is limited to an initial 5-day supply unless the prescriber writes a clinical justification for the drug.

• Define "clinical justification" and provide that insurers and self-insured employers cannot challenge the adequacy of the justification.

436-010: • Provide that a dispute may be resolved by agreement between the parties, and that the director may then issue a letter of agreement in lieu of an administrative order.

• Require that ancillary medical service providers send a copy of the treatment plan to the referring medical service provider and the insurer within seven days of starting treatment; the responsibility to sign and send a copy of the treatment plan to the insurer rests with the referring medical service provider; failure of the referring provider to do so may subject the provider to sanctions.

• Provide that, except in an emergency, drugs and medicine for oral consumption supplied by a physician's office are compensable for a maximum supply of 10 days.

• Require insurers to forward requested medical information to new attending physicians or authorized nurse practitioners within 14 days of a request.

• Require that the insurer forward a copy of the insurer medical examination report to the attending physician or authorized nurse practitioner within 72 hours of the insurer's receipt of the report.

• Require that the insurer notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim.

436-120: • Require the insurer to notify the worker in writing, within 14 days of a request for vocational assistance when the insurer is not required to determine eligibility.

• Refer vocational professionals to the Oregon Wage Information (OWI) publication in lieu of the Oregon Automated Reporting System (OARS) Job Order Wage Report, both published by the Oregon Employment Department. The OARS publication will no longer provide job/wage data effective 4/1/04. When using the OWI wage information data, the presumed standard shall be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate.

• Eliminate the requirement that vocational counselors sign statements that their eligibility determinations were based on substantial handicap assessments.

• Specify the conditions under which training may be terminated for failure to attend.

• State additional circumstances that require vocational eligibility to be redetermined.

• Provide that for workers found to have an exceptional disability or exceptional loss of earning capacity, certain fee schedule spending limits are increased by 30%.

• Increase the direct worker purchase training category fee schedule maximum by 10% due to state-wide tuition increases.

• Provide that to conduct only labor market research and/or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

Direct questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; or e-mail fred.h.bruyns@state.or.us. Rules are available on the internet: http://www.oregonwcd.org/policy/rules/rules.html#permrules

For a copy of the rules, contact Publications at 503-947-7627, Fax 503-947-7630.

Rules Coordinator: Fred Bruyns—(503) 947-7717

436-001-0000
Notice of Agency Action Concerning Rules

(1) Except when adopting a temporary rule, the division will give prior notice of the adoption, amendment, or repeal of any rule(s), as provided in ORS 183.335 and this rule.

(2) The division will publish notice of a proposed action in the Secretary of State's Oregon Bulletin at least 21 days prior to the effective date of the action.

(3) The division will notify interested persons and organizations on the division's notification lists of proposed rulemaking actions under ORS 183.335.

(4) A person or organization may be included on the division's notification list as follows:

(a) To receive electronic notification through the division's e-mail notification service, by subscribing through the division's web board at www.oregonwcd.org. The on-line subscription form requires a first name, last name, password, e-mail address, and phone number.

(b) To receive hard-copy notification, by submitting a written request, including the person or organization's full name and address.

(5) The division's notification list includes persons and organizations receiving electronic and hard-copy notification of proposed actions. The list complies with the requirements of the mailing list as required by ORS 183.335(8), and the Uniform Electronic Transactions Act, ORS 84.001 to 84.061.

Stat. Auth.: ORS 656.704(2) & ORS 656.726(4)
Stats. Implemented: ORS 183.335 & 84.022
Hist.: WCB 16-1975, f. & ef. 10-20-75; WCD 4-1977(Admin)(Temp), f. & ef. 11-7-77; WCD 4-1978(Admin), f. & ef. 3-6-78; Renumbered from 436-090-0505, 5-1-85; WCD 3-1986, f. & ef. 5-15-86; WCD 9-1992, f. & cert. ef. 5-22-92; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0001
Authority

The director adopts these rules under the general rulemaking authority in ORS 656.726, and the director's specific authority and responsibility under ORS Chapters 183 and 656.

Stat. Auth.: ORS 656.704(2) & 656.726(4)
Stats. Implemented: ORS 183, 656.245, 656.248, 656.260, 656.262, 656.268, 656.283, 656.327, 656.385, 656.388 & 656.447
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0003
Applicability and Purpose

(1) This rule division establishes supplemental procedures governing rulemaking and contested case hearings, and carries out the provisions of ORS Chapters 183 and 656.

(2) These rules apply to all contested case hearings and rulemaking on or after the effective date .

(3) Unless otherwise obligated by statute, the director may waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704(2) & ORS 183.310-183.550
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0004
Definitions

The following definitions apply to these rules, unless the context requires otherwise.

(1) "Administrative Law Judge" or "ALJ" means an Administrative Law Judge assigned by the Office of Administrative Hearings.

(2) "Administrator" means the administrator of the Workers' Compensation Division or the administrator's designee.

(3) "Delivered" means physical delivery to the division's Salem office.

(4) "Department" means the Department of Consumer and Business Services.

(5) "Director" means the director of the Department of Consumer and Business Services or the director's designee.

(6) "Division" means the department's Workers' Compensation Division.

(7) "Filed" means mailed, electronically transmitted by telephonic facsimile or e-mail, or delivered to the division.

(8) "Final order" means a final action by the director, expressed in writing.

(9) "Good cause" includes, but is not limited to, mistake, inadvertence, surprise, or excusable neglect.

(10) "Mailed" means correctly addressed, with sufficient postage and placed in the custody of the U. S. Postal Service.

(11) "Party" includes, but is not limited to, a worker, an employer, an insurer, a self-insured employer, a managed care organization, or a medical provider.

(12) "Proposed and final order" means an order subject to revision by the director which becomes final unless exceptions are timely filed, or the director issues a notice of intent to review the proposed and final order.

(13) Other words and phrases have the same meaning as given in ORS 183.310, where applicable.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704(2) & ORS 183.310-183.550
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0005
Model Rules of Procedure Governing Rulemaking

The director adopts the Attorney General's Model Rules for Rulemaking, OAR 137-001-0005 to 137-001-0085, by reference.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.325 - ORS 183.410 & ORS 656.704 (2)
Hist.: WCD 5-1977(Admin)(Temp), f. & ef. 11-7-77; WCD 3-1978(Admin), f. & ef. 3-6-78; WCD 2-1982(Admin), f. 1-20-82, ef. 1-21-82; Renumbered from 436-090-0110 thru 436-090-0180, 5-1-85; WCD 3-1986, f. & ef. 5-15-86; WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0007
Designation of Preliminary or Final Order

(1) Unless provided otherwise by statute or administrative rule, an order issued by an administrative law judge is a proposed and final order subject to revision by the director.

(2) An order suspending or revoking the insurer's authority to issue guaranty contracts under ORS 656.447 is a proposed and final order subject to revision by the director.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.704(2) & ORS 656.447
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0008
Model Rules of Procedure in Contested Cases

These rules supplement the Attorney General's Model Rules of Procedure for Contested Cases, OAR 137-003-0501 to 137-003-0700, which govern the procedures for a contested-case hearing before the Office of Administrative Hearings. If there is a conflict between these rules and the model rules, the provisions of the model rules will control.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the agency.]
Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.310-183.550 & 656.704(2) (& §7, ch. 75, OL 2003)
Hist.: WCD 8-1991(Temp), f. & cert. ef. 12-2-91; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0030
Role of the Workers' Compensation Division

(1) In any contested-case proceeding, the director, may request to:

(a) Receive notice of all matters;

(b) Receive copies of all documents; and

(c) Present evidence, testimony, and argument.

(2) The director may appear by providing the administrative law judge and parties with an entry of appearance in the contested-case hearing. The director may be represented by a contested-case representative, assistant attorney general, or special assistant attorney general as authorized by the Department of Justice. If the director enters an appearance, all notices and documents in the dispute must be provided to the director's representative.

(3) In every contested-case proceeding the administrative law judge must copy the director with all:

(a) Notices and reset notices of hearing;

(b) Substitution of Counsel notices;

(c) Addition of a party notices; and

(d) All orders.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 180.220(2), 180.235 & 656.704(2)

Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98 ; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0110

Consolidation or Separation

(1) The administrative law judge may consolidate cases in which there are common parties or common issues of law and fact.

(2) The administrative law judge may separate cases which will promote efficient disposition of the matters.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 183.310 - ORS 183.508 & ORS 656.704(2)

Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0150

Change of Administrative Law Judge

The director adopts OAR 471-060-0005, by reference.

Stat. Auth.: ORS 656.726(3)

Stats. Implemented: ORS 183.310 - ORS 183.550 & ORS 656.704(2)

Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0155

Manner of Filing a Contested-Case Hearing Request

(1) A request for hearing must be mailed to the division no later than the filing deadline. The date and time of receipt for electronic filings is determined under ORS 84.043. Parties are responsible for submitting a request timely, which will not be extended except as provided in section (6) of this rule. The request should be copied to all known parties and their legal representatives, if any.

(2) A contested case hearing request must be in writing. A party may use the division's Form 2839. If filing by electronic mail and attaching a word processing document, the document must be in Microsoft Word 97 format. A request for hearing must include:

(a) The identity, name, address, and phone number of the party making the request;

(b) The division's administrative order number;

(c) The worker's name, address, and phone number;

(d) The name, address, and phone number of the worker's attorney, if any;

(e) The date of injury;

(f) The insurer or self-insured employer claim number;

(g) The division's file number;

(h) The reason for requesting review; and

(i) If applicable, the justification for holding an in-person hearing.

(3) A request for hearing may be mailed or delivered to the division.

(4) A request for hearing may be electronically transmitted to "wcd.hearings@state.or.us", the division's contested-case hearing electronic mail address. The division will acknowledge receipt of the transmission by electronic response. A party submitting a request for hearing under this section consents and agrees to conduct the transaction electronically. The party's electronic mailing address qualifies as its electronic signature.

(5) A telephonic facsimile request for hearing will be accepted provided the document transmitted indicates that it has been delivered by FAX, uses the division's facsimile transmission number, and the original signed document is simultaneously mailed to the division. The complete facsimile copy must be received by the filing deadline. When reception of a document begins after 5 p.m., the receipt date will be the date of the next regular workday.

(6) The director will deny requests for hearing if the request is submitted or received after the filing deadline. The party may request a show-cause hearing within 30 days after the date of the denial notice. The administrative law judge may only consider whether:

(a) The request for contested case hearing was filed timely; or

(b) If good cause existed that prevented the party from timely requesting a hearing on the merits.

Stat. Auth.: ORS 656.726(4) & ORS 84.013

Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)

Hist.: WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0160

Extension of Time for Filing

Requests for extension of time for filing documents other than a request for hearing must be received by the director, or the administrative law judge if the contested case has been referred to the Office of Administrative Hearings, on or before the document's filing deadline.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)

Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0170

Duties and Powers of the Administrative Law Judge

(1) The administrative law judge may remand a dispute to the director for further administrative action.

(2) Unless otherwise provided in writing, the director delegates to an administrative law judge conducting a contested case hearing on the director's behalf the authority to:

(a) Rule on a petition to participate as a party or as a limited party under OAR 137-003-0535;

(b) Issue subpoenas in support of a discovery order, and manage discovery motions, under OAR 137-003-0572(10) when a motion for an order requiring discovery has been filed with the administrative law judge under OAR 137-003-0520(2);

(c) Issue a written order granting or denying a deposition, or issue a subpoena to compel a deposition, of persons other than department employees under OAR 137-003-0572;

(d) Determine whether a party is unable to pay for a qualified interpreter under OAR 137-003-0590;

(e) Execute and issue final orders of dismissal when the requesting party has withdrawn the request, and no cross-request for hearing was filed; and

(f) Execute and issue final orders by default under OAR 137-003-0670.

(3) If necessary, the administrative law judge shall continue a hearing to allow the presentation of oral or written legal argument by the Department of Justice.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)

Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0185

Hearings

(1) At the discretion of the administrative law judge, hearings may be conducted either by telephone or in-person.

(2) In-person contested case hearings are held in Salem, Oregon except when the administrative law judge authorizes a hearing outside of Salem.

(3) Upon prior arrangement and approval of the administrative law judge, a party or witness for an in-person hearing may appear by telephone.

(4) The administrative law judge shall make an audio recording of all hearings.

(5) Prior to the hearing, each party and the division must provide copies of documentary evidence that it will seek to introduce into the record to all other parties, the director's representative under OAR 436-001-0030(2), and the administrative law judge.

(6) Nothing in this rule precludes any party or the division from seeking to introduce documentary evidence in addition to evidence described in section (5) during the hearing. The administrative law judge may receive such evidence, subject to the applicable rules of evidence, if inclusion of the evidence in the record is necessary to conduct a full and fair hearing. When new evidence is introduced, the other parties may request an opportunity to submit rebuttal evidence. The administrative law judge may allow the admission of rebuttal evidence. If any evidence introduced during the hearing has not previously been provided to the administrative law judge, the director's representative, and to the other parties, the hearing may be continued for sufficient time to allow the party or the division to obtain and review the evidence.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)

Hist.: WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0201
Failure to Appear

(1) If the petitioner fails to appear at the hearing, the administrative law judge may issue an order of dismissal or an order to show cause. An order to show cause shall allow the petitioner ten days to present argument establishing good cause reason for the failure to appear.

(2) If the respondent does not appear, the administrative law judge has the discretion to proceed with the hearing.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.415 & ORS 656.704(2)
Hist.: WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0210
Record and Transcript of Hearing

(1) A verbatim record shall be made of all hearings, including all motions, rulings and testimony. The record shall be made by audio tape or reporter, at the discretion of the administrative law judge.

(2) At any time before the decision becomes final, the administrative law judge or director may order a full or partial transcript of the record.

(3) At any time before the reporter's notes or recordings of the hearing are destroyed, any party may order a transcript at that party's expense.

(4) Audio tapes, reporters' notes or records of a hearing may be destroyed six months after final disposition of the case.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0225
Scope of Review/Limitations on the Record

(1) Review of medical service (ORS 656.245 and 656.247(3)(a)) and treatment (ORS 656.327 and 656.260) disputes is for substantial evidence or error of law. New medical evidence or issues may not be considered at the contested-case hearing.

(2) In vocational assistance (ORS 656.340) disputes, new evidence may be admitted. The standard of review is to determine whether the director's order:

(a) Violates a statute or rule;

(b) Exceeds the statutory authority of the agency;

(c) Was made upon unlawful procedure; or

(d) Was characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(3) The scope of review for medical fee (ORS 656.248 and 656.247(3)(b)) disputes is de novo.

(4) The scope of review in all other contested-case hearing disputes is de novo, unless otherwise prescribed by statute or administrative rule.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.260, 656.283, 656.327 & ORS 656.704(2)
Hist.: WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0226
Notice of Expert Testimony

At least 14 days before the hearing, a party shall provide written notice to the administrative law judge, all other parties, and the director's representative identifying each expert witness the party will call to testify at hearing. If a party fails to provide 14 days notice, the contested-case hearing will be continued to allow sufficient time for the parties to prepare.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.415 & ORS 656.704(2)
Hist.: WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0240
Exhibits and Exchange of Exhibits

(1) The division will provide the parties and the administrative law judge legible copies of all documents that were relied upon in the underlying administrative review, together with an index. The index will include a description of each document, author, number of pages, and date of the document. The documents will be arranged in chronological order and designated by numbers in the lower right corner of each page, beginning with the document of earliest date. Pagination of multiple-page documents will be designated by the document number, followed by the page number. For example, page two of document five may be marked as "Exhibit 5, page 2" or "Ex. 5-2," etc.

(2) Not less than 14 days before the hearing, or within seven days of receipt of the division's document index and documents, which ever is later, the petitioner(s) must provide the other parties, the director's representative, and the administrative law judge legible copies of any additional documents to be relied upon at hearing. The additional documents must be marked and accompanied by a supplemental document index, numbered to coincide in chronological order with the division's exhibits and exhibit list. For example, a document which is chronologically between documents 5 and 6 of the division's exhibit list may be marked as "Exhibit 5a," "Ex. 5a," etc.

(3) Not less than seven days before the hearing, the respondent(s)/cross-petitioner(s) must provide to the other parties, the director's representative, and the administrative law judge legible copies of any additional documents that they will offer at hearing in the same manner as provided by the petitioner(s).

(4) Any party using photographs as exhibits must provide each party, the director's representative, and the administrative law judge with a set of the photographs.

(5) All exhibits offered, whether or not admitted into evidence, unless withdrawn, will be part of the record in the case.

(6) At the discretion of the administrative law judge, an accurate description or photograph of an object or real evidence may be substituted for such object or real evidence. The party offering such evidence shall be responsible for providing the description or photograph, and for retaining custody of the object until the case is closed.

(7) If any party, in the regular course of the party's business or activity, had kept or recorded any memorandum, writing, entry, print, reproduction, or a combination thereof, of any act, transaction, occurrence, or event, and in the regular course of the party's business or activity has caused any or all of the same to be recorded, copied, or reproduced by any photographic, photostatic, microfilm, micro-card, miniature photographic, optical imaging, or other process that accurately reproduces or forms a durable medium for so reproducing the original, the original may be destroyed in the regular course of business. Such reproduction, when satisfactorily identified, is as admissible in evidence as the original itself whether the original is in existence or not at the time a party introduces into evidence such reproduction. The introduction of a reproduced record, enlargement, or facsimile does not preclude admission of the original.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.310-550, 656.260, 656.327, 656.283 & 656.704(2)
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0260
Unacceptable Conduct

(1) Contested case hearings are not public meetings and are not open to the public, except with the consent of the parties and as authorized by the administrative law judge.

(2) The administrative law judge may expel a person from a contested case hearing if that person disrupts the proceeding.

(3) The administrative law judge may prohibit broadcasting, television, sound or video recording, and the taking of photographs of proceedings in the hearing room. These prohibitions, in the administrative law judge's discretion, may be applied to areas immediately adjacent to the hearing room where the activities may interrupt or interfere with entry or exit from the hearing room and distract or disturb the proceedings or interfere with the conduct of the hearing.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)
Hist.: WCD 9-1992, f. & cert. ef. 5-22-92; WCD 6-1995(Temp), f. & cert. ef. 7-14-95; Suspended by WCD 17-1995(Temp), f. & cert. ef. 11-2-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0265
Attorney Fees

(1) In cases where the director is required to assess an attorney fee under ORS 656.385(1) (§2, ch. 756, OL 2003):

(a) The fee must be based on the factors listed in ORS 656.385(1) (§2, ch. 756, OL 2003).

(b) Absent a showing of extraordinary circumstances or unless otherwise agreed by the parties, the fee may not exceed $2,000 nor fall outside the ranges provided in the following matrix:

Estimated Results Achieved — Attorney Time Devoted
1-2 hours — 2.1-4 hours — 4.1-6 hours — 6.1-8 hours — 8.1-12 hours
$1-$2000 — $100-400 — $200-700 — $300-750 — $600-1000 — $800-1250
$2001-$4000 — $200-500 — $400-800 — $600-900 — $800-1300 — $1050-1500
$4001-$6000 — $300-700 — $600-1000 — $800-1250 — $1000-1450 — $1300-1750
$6001-$10000 — $400-900 — $800-1300 — $1050-1600 — $1350-1800 — $1550-2000

(c) In cases under ORS 656.245, 656.260, or 656.327, the factors listed in OAR 436-010-0008(13) may also be considered.

(d) In cases under ORS 656.340, the factors listed in OAR 436-120-0008(2) may also be considered.

(2) Except as provided in section (3), in cases where the administrative law judge or director assesses an attorney fee , the following factors may also be considered:

(a) The complexity of the issue(s) involved;

(b) The quality of the legal representation;

(c) The value of the interest involved;

(d) The nature of the proceedings;

(e) The risk in a particular case that an attorney's efforts may go uncompensated;

(f) The assertion of frivolous issues or defenses;

(g) A statement of services, if submitted within seven days of the hearing date, unless the administrative law judge instructs otherwise; and

(h) Any other relevant consideration deemed appropriate by the administrative law judge or director.

(3) In cases under ORS 656.262(11) (§1, ch. 756, OL 2003) where the issue is solely the assessment and payment of a penalty and attorney fee, OAR 438-015-0110 applies.

(4) If an attorney fee has been assessed by an administrative law judge in a proposed order, the opposing parties may file written exceptions to the fee under OAR 436-001-0275.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.262, 656.385, 656.388 & 656.704(2) (& ch. 756, OL 2003)
Hist.: WCD 6-1995(Temp), f. & cert. ef. 7-14-95; WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; 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

436-001-0275
Proposed and Final Orders, Filing Exceptions

(1) When the administrative law judge serves a proposed and final order on the parties, the Office of Administrative Hearings shall notify the parties that written exceptions must be filed within 30 days of the date of service of the proposed and final order.

(2) Written responses to exceptions must be filed within 20 days of service of the exceptions and a reply, if any, must be filed within 10 days of service of the responses.

(3) If no exceptions are filed, the proposed and final order becomes final 30 days after the date of service of the order.

(4) Notwithstanding section (3) of this rule, the administrator may revise the proposed and final order under OAR 137-003-0501 to 137-003-0700, or these rules.

(5) "Date of service" means the date mailed or delivered.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.310-183.550 & ORS 656.704(2)
Hist.: WCD 7-1996, f. & cert. ef. 2-12-96; WCD 8-1998, f. 8-10-98, cert. ef. 9-15-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-001-0300
Alternative Dispute Resolution

(1) The director may contact the parties to a contested case dispute for the purposes of offering a resolution alternative to a contested-case hearing.

(2) If consent to attempt alternative dispute resolution is received prior to referral of the dispute to the Office of Administrative Hearings, the director will stay the referral. Once the dispute is settled, or it becomes clear that no resolution can be reached, the director will refer it.

(3) If consent to attempt alternative dispute resolution is received after referral of the dispute to the Office of Administrative Hearings, the director will notify the administrative law judge that the parties have agreed to use an alternative dispute resolution process, and that the hearing should be suspended until the process is complete. Once the dispute is settled, or it becomes clear that no resolution can be reached, the director will notify the administrative law judge to resume the hearing.

(4) If the parties resolve only the issues under the director's jurisdiction related to the contested case notice, then the director will incorporate the agreement into a final order under OAR 137-003-0665.

(5) If the parties resolve any or all matters regarding the claim under ORS 656.236, or issues resolving disputes over compensability of a claim under ORS 656.289(4), the disposition must be submitted to the Workers' Compensation Board for approval.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 183.415, 183.502 (§16, ch. 75, OL 2003)
Hist.: WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-009-0003
Applicability of Rules

(1) These rules apply to all services rendered on or after the effective date of these rules.

(2) Applicable to these rules, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.248
Hist.: WCD 12-1996, f. 5-6-96, cert. ef. 6-1-96; WCD 5-1998, f. 4-3-98, cert. ef. 7-1-98; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-009-0004
Adoption of Standards

(1) The director adopts, by reference, the Centers for Medicare & Medicaid Services (CMS) 2004 Medicare Resource-Based Relative Value Scale (RBRVS) Addendum B "Relative Value Units (RVUs) and Related Information" except the "status indicators," and Addendum C "Codes with Interim RVUs," 68 Federal Register No. 216, November 7, 2003 as the fee schedule for payment of medical service providers except as otherwise provided in these rules.

(2) The director adopts, by reference, the *American Society of Anesthesiologists* (ASA), *Relative Value Guide 2004* as a supplementary fee schedule for payment of anesthesia service providers except as otherwise provided in these rules for those anesthesia codes not found in the Federal Register.

(3) The director adopts *Current Procedural Terminology (CPT® 2004), Fourth Edition Revised*, 2003 for billing by medical providers except as otherwise provided in these rules. The guidelines are adopted as the basis for determining level of service.

(4) Specific provisions contained in OAR 436, divisions 009, 010, and 015 shall control over any conflicting provision in Addenda B and C, 68 Federal Register No. 216, November 7, 2003, ASA Relative Value Guide 2004, or CPT® 2004.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.248 & 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

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.

(a) Durable medical equipment (DME) is equipment which is primarily and customarily used to serve a medical purpose, can withstand repeated use, appropriate for use in the home, and not generally useful to a person in the absence of an illness or injury.

(b) Medical supplies are expendable materials including, but not limited to, incontinent pads, catheters, bandages, elastic stockings, irrigating kits, sheets, and bags.

(c) 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. Any ambulatory surgical center outside of Oregon must meet similar licensing requirements, or be certified by Medicare or a nationally recognized agency.

(2) Abbreviations used in these rules are defined as follows:

(a) ASA means American Society of Anesthesiologists

(b) ASC means ambulatory surgical center

(c) CARF means Commission on Accreditation of Rehabilitation Facilities

(d) CMS means Centers for Medicare & Medicaid Services (formerly HCFA, Health Care Financing Administration)

(e) CPT® means Current Procedural Terminology

(f) DME means Durable Medical Equipment

(g) DMSO means Dimethyl sulfoxide

(h) EDI means Electronic Data Interchange

(i) HCFA means Health Care Financing Administration (former name of CMS)

(j) HCPCS means Healthcare Common Procedure Coding System

(k) ICD-9-CM means International Classification of Diseases, Ninth Revision, Clinical Modification, Vol. 1, 2 & 3

(l) JCAHO means Joint Commission on Accreditation of Healthcare Organizations

(m) MCO means Managed Care Organization

(n) NCPDP means National Council for Prescription Drug Programs

(o) OSC means Oregon specific code

(p) PCE means physical capacity evaluation

(q) RBRVS means Medicare Resource-Based Relative Value Scale

(r) RVU means relative value unit

(s) 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

436-009-0008

Administrative Review and Contested Cases

Administrative review before the director:

(1)(a) The director has exclusive jurisdiction to resolve all disputes concerning medical fees and non-payment of compensable medical bills. A party need not be represented to participate in the administrative review before the director except as provided in ORS Chapter 183 and OAR chapter 436, division 001.

(b) Any party may request the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. If the dispute does not resolve through mediation, a director's order shall be issued.

(2) The medical provider, injured worker, or insurer may request review by the director in the event of a dispute about either the amount of a fee or non-payment 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 receipt 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. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due pursuant to 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) The director may, on the director's own motion, initiate a medical services review at any time.

(d) 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 must first be decided by the Hearings Division of the Workers' Compensation Board.

(3) Parties shall submit requests for administrative review to the director in the form and format prescribed by the director. The requesting party shall 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.

(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 HCFA/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 the involved parties have been provided a copy of the request for review and attached supporting documentation and, if known, that there is no issue of causation or compensability of the underlying claim or condition.

(4) The division shall investigate the matter upon which review was requested.

(a) The investigation may include, but shall 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 shall have 14 days to respond.

(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.

(d) Pursuant to section (6) of this rule, within 30 days of the administrative order, any party may appeal to a contested case before the director.

(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) Contested cases before the director: Pursuant to 183.310 through 183.550, as modified by OAR chapter 436, division 001 and ORS 656.704(2), any party that disagrees with an action or order of the director pursuant to these rules, may request a contested case before the director. For purposes of these rules, "contested case" has the meaning prescribed in ORS 183.310(2) and OAR 436 division 001. A party may appeal to the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested and include a copy of the order being appealed.

(b) The appeal must be mailed within 30 days of the mailing date of the order or notice of action being appealed.

(7) Contested case hearings of sanction and civil penalties: Under ORS 656.740 (§9, ch. 170, OL 2003), any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to 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(15).

(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, pursuant to these rules, may request administrative review by the director. Any party may request administrative review 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.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (6) of this rule.

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

436-009-0010
General Requirements for Medical Billings

(1) Only treatment that falls within the scope and field of the practitioner's license to practice will be paid under a worker's compensation claim.

(2) All medical providers shall submit bills to the insurer or managed care organization, as provided by their contract for medical services, on a current UB92 or HCFA/CMS 1500 form, except for:

(a) Dental billings which shall be submitted on American Dental Association dental claim forms;

(b) Pharmacy billings, which shall be submitted on the most current NCPDP form;

(c) EDI transmissions of medical bills pursuant to OAR 436-009-0030(3)(c). Computer-generated reproductions of these forms may also be used. Billings shall include the worker's full name, date of injury, the employer's name and, if available, the insurer's claim number.

(3)(a) All original medical provider billings shall be accompanied by legible chart notes documenting services which have been billed, and identifying the person performing the service and license number of person providing the service. Medical doctors are not required to provide their medical license number if they are already providing other identification such as a federal tax reporting identification number, or Unique Provider Identification Number (UPIN).

(b) When processing billings via EDI, the insurer may waive the requirement that billings be accompanied by chart notes. The insurer remains responsible for payment of only compensable medical services. The medical provider may submit their chart notes separately or at regular intervals as agreed with the insurer.

(4) Codes listed in CPT® 2004 or Oregon Specific Codes (OSC) shall be used when billing medical services. All billings shall be fully itemized and include ICD-9-CM codes. Services shall be identified by the code numbers and descriptions provided in these rules. A "zz" modifier shall be used when billing electronically for services that use Oregon Specific Codes.

(a) If there is no specific code for the medical service, the medical provider shall use the appropriate unlisted code at the end of each medical service section of CPT® 2004 and provide a description of the service provided.

(b) Any service not identifiable with a code number shall be adequately described by report.

(5) Billings for treatment shall be rendered at reasonable intervals not to exceed 60 days following treatment. Late billings may be subject to discounts, not to exceed 10 percent for each 30 day period or fraction thereof, beyond 60 days, provided the medical provider has notice or knowledge of the responsible workers' compensation insurer or processing agent.

(6) Rebillings shall indicate that the charges have been previously billed.

(7) The medical provider shall bill their usual and customary fee charged to the general public. The submission of the bill by the medical provider shall serve as a warrant that the fee submitted is the usual fee of the medical provider for the services rendered. The department shall have the right to require documentation from the medical provider establishing that the fee under question is the medical provider's usual fee charged to the general public. For purposes of this rule, "general public" means any person who receives medical services, except those persons who receive medical services subject to specific billing arrangements allowed under the law which require providers to bill other than their usual fee.

(8) Medical providers shall not submit false or fraudulent billings. As used in this section, "false or fraudulent" shall mean an intentional deception or misrepresentation issued with the knowledge that the deception could result in unauthorized benefit to the provider or some other person. The medical provider shall not bill for services not provided.

(9) When a worker with two or more separate compensable claims receives treatment for more than one injury or illness costs shall be divided among the injuries or illnesses, irrespective of whether there is more than one insurer.

(10) Workers may make a written request to a medical provider to receive copies of medical billings. Upon receipt of a request, the provider may furnish the worker a copy during the next billing cycle, but in no event later than 30 days following receipt of the request. Thereafter, worker copies shall be furnished during the regular billing cycle.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 656.245, 656.252 & ORS 656.254
Stats. Implemented: ORS 656.245, 656.252 & ORS 656.254
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 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 8-2001, f. 9-13-01, cert. ef. 9-17-01; 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

436-009-0015
Limitations on Medical Billings

(1) An injured worker shall not be liable to pay for any medical service related to an accepted compensable injury or illness or any amount reduced by the insurer pursuant to OAR chapter 436. A medical provider shall not attempt to collect payment for any medical service from an injured worker, except as follows:

(a) When the injured worker seeks treatment for conditions not related to the accepted compensable injury or illness;

(b) When the injured worker seeks treatment that has not been prescribed by the attending physician or authorized nurse practitioner, or a specialist physician upon referral of the attending physician or authorized nurse practitioner. This would include, but not be limited to, ongoing treatment by non-attending physicians in excess of the 30 day/12 visit period or by nurse practitioners in excess of the 90 day period, as set forth in ORS 656.245 (§3, ch. 811, OL 2003) and OAR 436-010-0210;

(c) When the injured worker seeks palliative care that is either not compensable or not authorized by the insurer or the director pursuant to OAR 436-010-0290, after the worker has been provided notice that the worker is medically stationary;

(d) When the injured worker seeks treatment outside the provisions of a governing MCO contract after insurer notification in accordance with OAR 436-010-0275; or

(e) When the injured worker seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental.

(2) A medical provider may not charge any fee for completing a medical report form required by the director under this chapter or for providing chart notes required by OAR 436-009-0010(3) of this rule.

(3) The preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service.

(4) No fee shall be paid for the completion of a work release form or completion of a PCE form where no tests are performed.

(5) No fee is payable for a missed appointment except a closing examination or an appointment arranged by the insurer or the department or for a Worker Requested Medical Examination. Except as provided in OAR 436-009-0070(10)(d), when the worker fails to appear without providing the medical provider at least 24 hours notice, the medical provider shall be paid at 50 percent of the examination or testing fee. A medical arbiter may also receive payment for a file review as determined by the director.

(6) Pursuant to ORS 656.245(3), the director has excluded from compensability the following medical treatment. While these services may be provided, medical providers shall not be paid for the services or for treatment of side effects.

(a) DMSO, except for treatment of compensable interstitial cystitis,
(b) Intradiscal electrothermal therapy (IDET),
(c) Surface EMG (electromylography) tests,
(d) Rolfing,
(e) Prolotherapy, and
(f) Thermography.

(7) Only one office visit code may be used for each visit except for those code numbers relating specifically to additional time.

(8) Mechanical muscle testing may be paid a maximum of three times during a treatment program when prescribed and approved by the attending physician or authorized nurse practitioner: once near the beginning, once near the middle, and once near the end of the treatment program. Additional mechanical muscle testing shall be paid for only when authorized in writing by the insurer prior to the testing. The fee for mechanical muscle testing includes a copy of the computer printout from the machine, written interpretation of the results, and documentation of time spent with the patient.

(9)(a) When a physician or authorized nurse practitioner provides services in hospital emergency or outpatient departments which are similar to services that could have been provided in the physician's or authorized nurse practitioner's office, such services shall be identified by CPT® codes and paid according to the fee schedule.

(b) When a worker is seen initially in an emergency department and is then admitted to the hospital for inpatient treatment, the services provided immediately prior to admission shall be considered part of the inpatient treatment. Diagnostic testing done prior to inpatient treatment shall be considered part of the hospital services subject to the hospital fee schedule.

(10) Physician assistant or nurse practitioner fees shall be paid at the rate of 80 percent of a physician's allowable fee for a comparable service.

The bills for services by these providers shall be marked with modifier "81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(11) Except as otherwise provided in OAR 436-009-0070, when a medical provider is asked to prepare a report, or review records or reports prepared by another medical provider, insurance carrier or their representative, the medical provider should bill for their report or review of the records utilizing CPT® Codes such as 99080. Refer to specific code definitions in the CPT® for other applicable codes. The billing should include the actual time spent reviewing the records or reports.

[Publications: Publications referenced are available from the agency.
Stat. Auth.: ORS 656.245, 656.252 & 656.254
Stats. Implemented: ORS 656.245, 656.252 & 656.254
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 8-2001, f. 9-13-01, cert. ef. 9-17-01; 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

436-009-0020
Hospital Fees

(1) Hospital inpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes. Unless otherwise provided for by a governing MCO contract, insurers shall pay hospitals for inpatient services using the current adjusted cost/charge ratio (see Bulletin 290). 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 UB92 billing form. The audited bill shall be multiplied by the hospital's adjusted cost/charge ratio to determine the allowable payment.

(2) Hospital outpatient charges billed to insurers shall include ICD-9-CM diagnostic and procedural codes, CPT® codes, HCPCS codes, and National Drug Codes (NDC), where applicable. Unless otherwise provided for by a governing MCO contract, insurers shall pay hospitals for outpatient services according to the following: the insurer shall first separate out and pay charges for services covered under the CPT® and RBRVS. These charges should be subtracted from the total bill and the adjusted cost/charge ratio should be applied only to the balance. For all outpatient therapy services (physical therapy, occupational therapy, and speech language pathology), use the non-facility total column. All other charges billed using both the hospital name and tax identification number will be paid as if provided by the hospital.

(3) Each hospital's HCFA/CMS 2552 form and financial statement shall be the basis for determining its adjusted cost/charge ratio. If a current 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 (1) the hospital's last published cost/charge ratio or, (2) 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 (3)(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 HCFA/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 (3)(c) and (3)(d) of this rule will be added to the ratio calculated in subsection (3)(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 shall submit a copy of their HCFA/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, to be effective for the six-month period beginning April 1, and to be effective for the six-month period beginning October 1.

(g) For those newly formed or established hospitals for which no HCFA/CMS 2552 has been filed, or for those hospitals that do not file Worksheet G-2 with the submission of their HCFA/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 and/or geographic location.

(h) If the financial circumstances of a hospital unexpectedly and/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 HCFA/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 cost/charge ratio shall be 1.000 for out-of-state hospitals, unless a lower rate is negotiated between the insurer and the hospital.

(k) Notwithstanding section (1) and (2) 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), 656.012, 656.236(5), 656.327(2)
Stats. Implemented: ORS 656.248, 656.252, 656.256 & OL 1991, Ch. 771, Sect. 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

436-009-0022
Ambulatory Surgical Center Fees

(1) Bills from an ASC shall be submitted on HCFA/CMS 1500 form. The modifier "SG" shall be used to identify facility charges.

(2) Fees shall be paid at the usual and customary fee, or in accordance with the fee schedule, whichever is less. For all MCO enrolled claims, payment of fees shall be as provided by the MCO contract, at the provider's usual and customary fee, or according to 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) Procedures not listed in the Medicare ASC groups shall be paid at the provider's usual and customary 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; and

(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, and anesthetists' services.

(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

436-009-0025
Reimbursement of Related Services Costs

(1) The insurer shall notify the worker at the time of claim acceptance that actual and reasonable costs for travel, prescriptions and other claim-related services paid by the worker will be reimbursed by the insurer upon request. The insurer may require reasonable documentation to support the request. Insurers shall date stamp requests for reimbursement upon receipt and shall reimburse the costs within 30 days of receiving the worker's written request and supporting documentation, if the request clearly shows the costs are related to the accepted compensable injury or disease. If the insurer cannot determine if the costs are related to the accepted compensable injury or disease, the insurer shall inform the worker what information is needed before the request for reimbursement can be processed. On deferred claims, requests which are at least 30 days old at the time of claim acceptance become due immediately upon claim acceptance and shall be paid within 14 days. If there is a claim for aggravation or a new medical condition on an accepted claim, reimbursement of related services is not due and payable until the aggravation or new medical condition is accepted. If the claim is denied, requests for reimbursement shall be returned to the worker within 14 days.

(2) Reimbursement of the costs of meals, lodging, public transportation and use of a private vehicle reimbursed at the rate of reimbursement for State of Oregon classified employees, as published in Bulletin 112, complies with this section. Reimbursement may exceed these rates where special transportation or lodging is needed.

(3) Requests for reimbursement of related services costs must be received by the insurer within two years of the date the costs were incurred or within two years of the date the claim or medical condition is finally determined compensable, whichever date is later. The insurer may disapprove requests for reimbursement received beyond the two year period as being untimely requested.

(4) Requests for reimbursement denied as unreasonable or not related to the accepted compensable injury or disease shall be returned to the worker within 30 days of the date of receipt by the insurer. The insurer shall provide the worker an explanation of the reason for nonpayment and advise the worker of the right to appeal the insurer's decision by requesting administrative review before the director, pursuant to OAR 436-009-0008.

(5) Pursuant to ORS 656.325(1)(c) and OAR 436-060-0095(5)(f), the insurer shall reimburse the worker for costs related to the worker's attendance at an insurer medical examination regardless of the acceptance, deferral, or denial of the claim.

Stat. Auth.: ORS 656.245, 656.704 & ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.704 & ORS 656.726(4)
Hist.: WCB 6-1969, f. 10-23-69, ef. 10-29-69; 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 436-054-0270, 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 1-1992, f. 1-3-92, cert. ef. 2-1-92; WCD 5-1996, f. 2-6-96, cert. ef. 2-12-96; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02, Renumbered from 436-060-0070; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-009-0030
Insurer's Duties and Responsibilities

(1) The insurer shall 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 shall furnish a reasonable work-site for the records to be reviewed at no cost. These records shall be provided or made available for review within 14 days of a request.

(3) Insurers shall 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 or 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 shall retain a copy of each medical provider's bill received by the insurer or shall 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 fee reduction other than a fee schedule 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 renders a bill via EDI, it shall be considered "mailed" in accordance with OAR 436-010-0005.

(4) 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.

(5) Failure to pay for medical services timely may render 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.

(6) When there is a dispute over the amount of a bill or the appropriateness of services rendered, the insurer shall, 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 shall be made in accordance with OAR 436-009-0008, 436-010-0008 and 436-015.

(7) 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.

(8) The insurer shall 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 shall provide upon request documentation establishing that the insurer is conducting a continuous audit of medical bills. This documentation shall include, but not be limited to, medical bills, internal audit forms, and any medical charge summaries prepared by private medical audit companies.

(9) 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 service billing 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 insurer may apply for exemption from the reporting requirement. The reporting requirements are as follows:

(a) The director will notify the affected insurers when they reach the minimum. The transmission data and format requirements are included in Appendix A;

(b) The data shall include all payments made during each calendar quarter for medical services that are covered by the department's fee schedules. The following apply:

(A) Hospital Inpatient: Each hospital inpatient stay should be reported as one record summarizing all services related to the inpatient stay using provider type "HI." Report ICD-9-CM procedure code in the service code field.

(B) Hospital Outpatient: Report at the individual service-code level using provider type "HO." A service code, whether CPT, HCPCS or other, is required on all "HO" records in addition to the ICD-9-CM diagnostic code.

(C) Adjustments to payments must be associated with specific services.

(c) The affected insurers shall submit the medical data within 45 days of the end of each calendar quarter. A grace period of two calendar quarters may be granted for revised requirements and also for insurers which are newly affected by these requirements. The calendar quarter due dates are as outlined in the table below:

QUARTERLY DUE DATES Table
QUARTER — MONTH OF PAYMENT — DUE NEXT
First — January, February & March — May 15th
Second — April, May & June — August 14th
Third — July, August & September — November 14th
Fourth — October, November & December — February 14th

(d) Technical Requirements: Data for each quarter calendar year must be transmitted as an individual file. Insurers transmitting data for more than one insurer may batch multiple insurer data files in one transmission. Data must be transmitted in electronic text files either on a 3.5 inch diskette, CD, or by file transfer protocol (FTP). Contact the Information Management Division (IMD) to arrange submission by FTP files or other electronic transmission methods. The record length must be fixed, 129 bytes, no packed fields, and in conformance with the records layout in Appendix A. Diskettes must be ASCII format, high density. Diskettes and CDs must have a physical label that indicates "Medical Data," the name of the group submitting, the quarter reported, and the date the file was created. Include a cover letter in the same package with each diskette or CD. Contact IMD for e-mail cover letter instructions. The cover letter must include the label information and the following: a list of all insurance companies' data included in the transmission; number of records; a contact person's name, address, and telephone number; and any known problems with the data.

(e) Data Quality: The director will conduct electronic edits for blank or invalid data. Affected insurers are responsible for pre-screening the data they submit to check that all the required information is reported. Files which have more than five percent missing or invalid data in any field, based on initial computerized edits, will be returned to the insurer for correction and must be resubmitted within three weeks (21 days) from the date it was returned by the department.

(f) Audit Quality: The director may also conduct field audits of actual payments reported for individual claims. When an audit occurs, in order to be in compliance with this rule and OAR 436-009-0025, audited data must have no more than 15 percent inaccurate data in any field.

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

436-009-0040
Calculating Medical Provider Fees

(1) Medical fees shall be paid at the provider's usual and customary fee or in accordance with the fee schedule whichever is less. For all MCO enrolled claims, payment of medical fees shall be at the provider's usual and customary fee or according to the fee schedule, whichever is less, unless otherwise provided by MCO contract. Where 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, but not limited to, the following: reasonableness, the usual and customary fees of similar providers, the services provided in the specific case, fees for similar services in similar geographic regions, and any extenuating circumstances.

(2)(a) When using RBRVS, the RVU is determined by reference to the appropriate CPT® code. Where the procedure is performed inside the medical service provider's office, use Year 2004 non-facility total column. Where the procedure is performed outside the medical service provider's office, use Year 2004 facility total 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 Year 2004 non-facility total column. No other column applies.

(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 OAR 436-009-0070(13).

(c) When using the ASA Relative Value Guide, a basic unit value is determined by reference to the appropriate Anesthesia code. The basic unit value includes unit value, time units, and modifying units.

(3) Payment according to the fee schedule shall 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, it shall be paid at the provider's usual and customary rate.

(4) The table below lists the conversion factors to be applied to services, assigned an RVU, rendered by all medical professionals.

Service Categories — Conversion Factors
Evaluation / Management — $68.40
Anesthesiology — $53.45
Surgery — $93.66
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

436-009-0050
CPT® Sections

Each CPT® section has its own schedule of relative values, completely independent of and unrelated to any of the other sections. The definitions, descriptions, and guidelines found in CPT® shall be used as guides governing the descriptions of services, except as otherwise provided in these rules. The following provisions are in addition to those provided in each section of CPT®

(1) Evaluation and Management services.

(2) Anesthesia services.

(a) In calculating the units of time, use 15 minutes per unit. If a medical provider bills for a portion of 15 minutes, round the time up to the next 15 minutes and pay one unit for the portion of time.

(b) Anesthesia basic unit values are to be used only when the anesthesia is personally administered by either a licensed physician or nurse anesthetist who remains in constant attendance during the procedure for the sole purpose of rendering such anesthesia service.

(c) When a regional anesthesia is administered by the attending surgeon, the value shall be the "basic" anesthesia value only without added value for time.

(d) When the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the modifier "NT" (no time) shall be noted on the bill.

(e) Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the relative value unit for the surgical procedure.

(3) Surgery services.

(a) When a worker is scheduled for elective surgery, the immediate pre-operative visit, in the hospital or elsewhere, necessary to examine the patient, complete the hospital records, and initiate the treatment program is included in the listed global value of the surgical procedure. If the procedure is not elective, the physician is entitled to payment for the initial evaluation of the worker in addition to the global fee for the surgical procedure(s) performed.

(b) When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.

(c) Multiple surgical procedures performed at the same session shall be paid as follows:

(A) When multiple surgical procedures are performed by one surgeon, the principal procedure is paid at 100 percent of the maximum allowable fee, the secondary and all subsequent procedures are paid at 50 percent of the maximum allowable fee. A diagnostic arthroscopic procedure per-

formed preliminary to an open operation, is considered a secondary procedure and paid accordingly.

(B) When multiple arthroscopic procedures are performed, the major procedure shall be paid at no more than 100 percent of the value listed in these rules and the subsequent procedures paid at 50 percent of the value listed.

(C) When more than one surgeon performs surgery, each procedure shall be billed separately. The maximum allowable fee for each procedure, as listed in these rules, shall be reduced by 25 percent. When the surgeons assist each other throughout the operation, each is entitled to an additional fee of 20 percent of the other surgeon's allowable fee as an assistant's fee. When the surgeons do not assist each other, and a third physician assists the surgeons, the third physician is entitled to the assistant's fee of 20 percent of the surgeons' allowable fees.

(D) When a surgeon performs surgery following severe trauma that requires considerable time, and the surgeon does not think the fees should be reduced under the multiple surgery rule, the surgeon may request special consideration by the insurer. Such a request must be accompanied by written documentation and justification. Based on the documentation, the insurer may pay for each procedure at 100 percent.

(E) When a surgical procedure is performed bilaterally, the modifier "-50" shall be noted on the bill for the second side, and paid at 50% of the fee allowed for the first side.

(d) Physician assistants or nurse practitioners shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The bills for services by these providers shall be marked with a modifier "-81." Chart notes shall document when medical services have been provided by a physician assistant or nurse practitioner.

(e) Other surgical assistants who are self-employed and work under the direct control and supervision of a physician shall be paid at the rate of 10 percent of the surgeon's allowable fee for the surgical procedure(s). The operation report shall document who assisted.

(4) Radiology services.

(a) In order to be paid, x-ray films must be of diagnostic quality. Billings for 14" x 36" lateral views shall not be paid. Billings for X-rays shall not be paid without a report of the findings.

(b) When multiple areas are examined by computerized axial tomography (CAT) scan, magnetic resonance angiography (MRA) or magnetic resonance imaging (MRI), the first area examined shall be paid at 100 percent, the second area at 50 percent, and the third and all subsequent areas at 25 percent of these rules.

(5) Pathology and Laboratory services.

(a) The laboratory and pathology conversion factor applies only when there is direct physician involvement.

(b) Laboratory fees shall be billed in accordance with ORS 676.310. If any physician submits a bill for laboratory services that were performed in an independent laboratory, the bill shall show the amount charged by the laboratory and any service fee that the physician charges.

(6) Medicine services.

(7) Physical Medicine and Rehabilitation services.

(a) Increments of time for a time-based CPT® code shall not be prorated.

(b) Payment for modalities and therapeutic procedures shall be limited to a total of three separate CPT®-coded services per day. CPT® codes 97001, 97002, 97003, or 97004 are not subject to this limit. An additional unit of time (15 minute increment) for the same CPT® code is not counted as a separate code.

(c) All modality codes requiring constant attendance (97032, 97033, 97034, 97035, 97036, and 97039) are time-based. Chart notes must clearly indicate the time treatment begins and the time treatment ends for the day.

(d) CPT® codes 97010 through 97028 shall not be paid unless they are performed in conjunction with other procedures or modalities which require constant attendance or knowledge and skill of the licensed medical provider.

(e) When multiple treatments are provided simultaneously by a machine, device or table there shall be a notation on the bill that treatments were provided simultaneously by a machine, device or table and there shall be one charge.

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

436-009-0060
Oregon Specific Code, Multidisciplinary Services

(1) Services provided by multidisciplinary programs not otherwise described by CPT® codes shall be billed under Oregon-Specific Codes. Electronic billings shall include a "zz" modifier as provided in OAR 436-009-0010.

(2) Treatment in a chronic pain management program, physical rehabilitation program, work hardening program, or a substance abuse program shall not be paid unless the program is accredited for that purpose by the CARF or the JCAHO.

(a) Organizations which have applied for CARF accreditation, but have not yet received such accreditation, may receive payment for multidisciplinary programs upon providing evidence to the insurer that an application for accreditation has been filed with and acknowledged by CARF. Such organizations may provide multidisciplinary services under this section for a period of up to 6 months from the date CARF provided notice to the organization that the accreditation process has been initiated, or until such time as CARF accreditation has been received or denied, whichever occurs first.

(b) Notwithstanding OAR 436-009-0010(4), program fees for services within a multidisciplinary program may be used based upon written preauthorization from the insurer. Programs must identify the extent, frequency, and duration of services to be provided.

(c) All job site visits and ergonomic consultations must be preauthorized by the insurer.

(3) When an attending physician or authorized nurse practitioner approves a multidisciplinary treatment program for an injured worker, he or she must provide the insurer with a copy of the approved treatment program within 14 days of the beginning of the treatment program.

(4) Billings using the multidisciplinary codes must include copies of the treatment record which specifies the type of service rendered, the medical provider who provided the service, whether treatment was individualized or provided in a group session, and the amount of time treatment was rendered for each service billed.

(5) The table below lists the Oregon Specific Codes for Multidisciplinary Services. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables 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 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

436-009-0070
Oregon Specific Code, Other Services

(1) 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) The fee for a deposition shall be billed under OSC-D0002. This code should include time for preparation, travel and deposition. Payment of the hourly rate may be limited to a customary fee charged by similar providers.

(7) When an insurer obtains an Insurer Medical Examination (IME), the medical service provider shall bill under OSC-D0003. This code shall be used for a report, file review or examination.

(8) The fee for interpretive services shall be billed under OSC-D0004.

(9) 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-A0001 Exam
Level 2 — OSC-A0002 Exam
Level 3 — OSC-A0003 Exam
Limited — OSC-A0004 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-A0011 Report
Level 2 — OSC-A0012 Report
Level 3 — OSC-A0013 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-A0021 File Review
Level 2 — OSC-A0022 File Review
Level 3 — OSC-A0023 File Review
Level 4 — OSC-A0024 File Review
Level 5 — OSC-A0025 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 shall notify the medical arbiter and the insurer of the approved code for each component to establish the total fee for the medical arbiter review.

(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-A0031
Complex — OSC-A0032

(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.

(a) 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.

(10) A single physician selected pursuant to 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 pursuant to 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) 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.

(e) 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.

(11) 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.

(12) The table below lists the Oregon Specific Codes for Other Services. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables 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

436-009-0080
Durable Medical Equipment and Medical Supplies

(1) Fees for durable medical equipment shall be paid as follows:

(a) The insurer shall pay for the purchase of all compensable DME and other devices that are ordered and approved by the physician, at 85% of the manufacturer's suggested retail price (MSR).

(b) The DME provider shall be 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. Labor shall be paid at the provider's usual and customary rate.

(c) The provider may offer a service agreement at an additional cost.

(d) Rental of all compensable DME and other devices shall be billed at the provider's usual and customary rate. Within 90 days of the beginning of the rental, the insurer shall be entitled to purchase the DME or device at the fee provided in this rule, with a credit for rental paid up to 2 months.

(2) Fees for all prosthetics as defined in OAR 436-010-0230(12), orthotics, and other medical supplies shall be listed as 0.00.

(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 $5000.00 for a pair of hearing aids, or $2500.00 for a single hearing aid.

(3) The worker shall have the right to select the service provider, except for claims enrolled in a managed care organization (MCO) where service providers are specified by the MCO contract.

(4) Except as provided in subsection (2)(c) of this rule, this rule shall not apply to a worker's direct purchase of DME and medical supplies, and shall not limit a worker's right to reimbursement for actual out-of-pocket expenses pursuant to OAR 436-009-0025.

(5) DME, medical supplies and other devices dispensed by a hospital (inpatient or outpatient) shall be billed pursuant 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

436-009-0090
Pharmacy Fees

(1) Except for in-patient hospital charges, pharmacy fees shall be paid at the provider's usual and customary rate or the maximum allowable fee established by this rule, whichever is the lower.

(a) The Average Wholesale Price (AWP) effective on the day the drug was dispensed shall be used to determine the maximum allowable fee.

(b) The maximum allowable fee is determined as follows:

(A) For generic drugs and for brand name drugs without a generic equivalent, 88% of the AWP for the dispensed drug plus $8.70 dispensing fee.

(B) For brand name drugs with a generic equivalent, if the prescribing medical service provider writes "Do not substitute" or a similar notation on the prescription, 88% of the AWP for the dispensed drug plus $8.70 dispensing fee.

(C) For brand name drugs with a generic equivalent, if the prescribing medical service provider did not write "Do not substitute" or a similar notation on the prescription, the lower of 88% of the AWP for the dispensed drug plus $8.70 dispensing fee, or 88% of the average AWP for the class of generic drugs plus $8.70 dispensing fee, or, in the event that the pricing guides have not established an average AWP, 88% of the calculated average AWP of the generic drugs listed in the pricing guide plus $8.70 dispensing fee.

(c) All providers who are licensed to dispense medications in accordance with their practice must be paid similarly regardless of profession.

(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, Vioxx, Celebrex, and Bextra 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 shall have the right to 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 shall not apply to a worker's direct purchase of prescription medications, and shall not limit a worker's right to reimbursement for actual out-of-pocket expenses pursuant to OAR 436-009-0025.

(8) The insurer shall be required to pay the retail-based fee for over-the-counter medications.

(9) Drugs dispensed by a hospital (inpatient or outpatient) shall to be billed pursuant 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 6-2003, f. 5-28-03, cert. ef. 7-1-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-010-0003
Applicability of Rules

(1) These rules shall be applicable on or after the effective date to carry out the provisions of ORS 656.245, 656.247, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331, 656.704, and 656.794, and govern all providers of medical services licensed or authorized to provide a product or service pursuant to ORS chapter 656

(2) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive any procedural rules as justice so requires.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.245, 656.248, 656.250, 656.252, 656.254, 656.256, 656.260, 656.268, 656.273, 656.313, 656.325, 656.327, 656.331, 656.704 & 656.794
Hist.: WCD 7-1978(Admin), f. & ef. 6-5-78; WCD 2-1980(Admin), f. 1-28-80, ef. 2-1-80; 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 436-069-0004, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; WCD 3-1990(Temp), f. 1-24-90, cert. ef. 2-1-90; WCD 4-1990(Temp), f. 4-20-90, cert. ef. 5-1-90; 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; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-010-0005
Definitions

For the purpose of these rules, OAR 436-009, and 436-015, unless the context otherwise requires:

(1) "Administrative Review" means any decision making process of the director requested by a party aggrieved with an action taken pursuant to these rules except the contested case process described in OAR 436-001.

(2) "Attending Physician" means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury or illness and who is:

(a) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Board of Medical Examiners for the State of Oregon or an oral surgeon licensed by the Oregon Board of Dentistry;

(b) A medical doctor, doctor of osteopathy, or oral surgeon practicing in and licensed under the laws of another state;

(c) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits, during that 30 day period, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon;

(d) For a period of 30 days from the date of first chiropractic visit on the initial claim or for 12 chiropractic visits during that 30 day period, whichever first occurs, a doctor or physician of chiropractic practicing and licensed under the laws of another state; or

(e) Any medical service provider authorized to be an attending physician in accordance with a managed care organization contract.

(3) "Authorized nurse practitioner" means a nurse practitioner authorized pursuant to ORS 656.245 (§3, ch. 811, OL 2003) to provide compensable medical services to an injured worker for a period of 90 days from the date of the first nurse practitioner visit on the initial claim, during that 90 day period. The authorized nurse practitioner may also authorize temporary disability benefits for a period of up to 60 days from the first nurse practitioner visit on the initial claim. Effective October 1, 2004, to be an authorized nurse practitioner, the nurse practitioner must certify to the director that the nurse practitioner has reviewed informational materials about the workers' compensation system provided by the director.

(4) "Chart note" means a notation made in chronological order in a medical record in which the medical service provider records such things as subjective and objective findings, diagnosis, treatment rendered, treatment objectives, and return to work goals and status.

(5) "Contested Case" means a proceeding as defined in ORS 183.310(2) pursuant to OAR 436-001.

(6) "Coordinated Health Care Program" means an employer program providing for the coordination of a separate policy of group health insurance coverage with the medical portion of workers' compensation coverage, for some or all of the employer's workers, which provides the worker with health care benefits even if a worker's compensation claim is denied.

(7) "Current Procedural Terminology" or "CPT" means the Current Procedural Terminology codes and terminology most recently published by the American Medical Association unless otherwise specified in these rules.

(8) "Customary Fee" means a fee that falls within the range of fees normally charged for a given service.

(9) "Days" means calendar days.

(10) "Direct control and supervision" means the physician is on the same premises, at the same time, as the person providing a medical service ordered by the physician. The physician can modify, terminate, extend, or take over the medical service at any time.

(11) "Division" means the Workers' Compensation Division of the Department of Consumer and Business Services.

(12) "Eligible" means an injured worker who has filed a claim and is employed by an employer who is located in an MCO's authorized geographical service area, covered by an insurer who has a contract with that MCO. "Eligible" also includes a worker with an accepted claim having a date of injury prior to contract when that worker's employer later becomes covered by an MCO contract.

(13) "Enrolled" means an eligible injured worker has received notification from the insurer that the worker is being required to treat under the auspices of the MCO. However, a worker may not be enrolled who would otherwise be subject to an MCO contract if the worker's primary residence is more than 100 miles outside the managed care organization's certified geographical service area.

(14) "First Chiropractic Visit" means a worker's first visit to a chiropractic physician on the initial claim.

(15) "Health Care Practitioner" has the same meaning as a "medical service provider."

(16) "HCFA form 2552" (Hospital Care Complex Cost Report) means the annual report a hospital makes to Medicare.

(17) "Hearings Division" means the Hearings Division of the Workers' Compensation Board.

(18) "Home Health Care" means medically necessary medical and medically related services provided in the injured worker's home environment. These services might include, but are not limited to, nursing care, medication administration, personal hygiene, or assistance with mobility and transportation.

(19) "Hospital" means an institution licensed by the State of Oregon as a hospital.

(20) "Initial Claim" means the first open period on the claim immediately following the original filing of the occupational injury or disease claim until the worker is first declared to be medically stationary by an attending physician or authorized nurse practitioner. For nondisabling claims, the "initial claim" means the first period of medical treatment immediately following the original filing of the occupational injury or disease claim ending when the attending physician or authorized nurse practitioner does not anticipate further improvement or need for medical treatment, or there is an absence of treatment for an extended period.

(21) "Inpatient" means an injured worker who is admitted to a hospital prior to and extending past midnight for treatment and lodging.

(22) "Insurer" means the State Accident Insurance Fund Corporation; an insurer authorized under ORS Chapter 731 to transact workers' compensation insurance in the state; 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.

(23) "Interim Medical Benefits" means those services provided pursuant to ORS 656.247 on initial claims with dates of injury on or after January 1, 2002 that are not denied within 14 days of the employer's notice of the claim.

(24) "Mailed or Mailing Date," for the purposes of determining timeliness pursuant to these rules, means the date a document is postmarked. Requests submitted by facsimile or "fax" are considered mailed as of the date printed on the banner automatically produced by the transmitting fax machine. Hand-delivered requests shall be considered mailed as of the date stamped or punched in by the Workers' Compensation Division. Phone or in-person requests, where allowed under these rules, shall be considered mailed as of the date of the request.

(25) "Managed Care Organization" or "MCO" means an organization formed to provide medical services and certified in accordance with OAR chapter 436, division 015.

(26) "Medical Evidence" includes, but is not limited to: expert written testimony; written statements; written opinions, sworn affidavits, and testimony of medical professionals; records, reports, documents, laboratory, x-ray and test results authored, produced, generated, or verified by medical professionals; and medical research and reference material utilized, produced, or verified by medical professionals who are physicians or medical record reviewers in the particular case under consideration.

(27) "Medical Service" means any medical, surgical, diagnostic, chiropractic, dental, hospital, nursing, ambulances, and other related services, and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services.

(28) "Medical Service Provider" means a person duly licensed to practice one or more of the healing arts.

(29) "Medical Provider" means a medical service provider, a hospital, medical clinic, or vendor of medical services.

(30) "Medical Treatment" means the management and care of a patient for the purpose of combating disease, injury, or disorder. Restrictions on activities are not considered treatment unless the primary purpose of the restrictions is to improve the worker's condition through conservative care.

(31) "Non-attending Physician" means a medical service provider who is not qualified to be an attending physician, or a chiropractor who no longer qualifies as an attending physician pursuant to ORS 656.005 and subsections (2)(c) and (2)(d) of this rule.

(32) "Outpatient" means a worker not admitted to a hospital prior to and extending past midnight for treatment and lodging. Medical services provided by a health care provider such as emergency room services, observation room, or short stay surgical treatments which do not result in admission are also outpatient services.

(33) "Parties" mean the worker, insurer, MCO, attending physician, and other medical provider, unless a specific limitation or exception is expressly provided for in the statute.

(34) "Physical Capacity Evaluation" or "PCE" means an objective, directly observed, measurement of a worker's ability to perform a variety of physical tasks combined with subjective analyses of abilities by worker and evaluator. Physical tolerance screening, Blankenship's Functional Evaluation, and Functional Capacity Assessment shall be considered to have the same meaning as Physical Capacity Evaluation.

(35) "Physical Restorative Services" means those services prescribed by the attending physician or authorized nurse practitioner to address permanent loss of physical function due to hemiplegia, a spinal cord injury, or to address residuals of a severe head injury. Services are designed to restore and maintain the injured worker to the highest functional ability consistent with the worker's condition. Physical restorative services are not services to replace medical services usually prescribed during the course of recovery.

(36) "Report" means medical information transmitted in written form containing relevant subjective and/or objective findings. Reports may take the form of brief or complete narrative reports, a treatment plan, a closing examination report, or any forms as prescribed by the director.

(37) "Residual Functional Capacity" means an individual's remaining ability to perform work-related activities despite medically determinable impairment resulting from the accepted compensable condition. A residual functional capacity evaluation includes, but is not limited to, capability for lifting, carrying, pushing, pulling, standing, walking, sitting, climbing, balancing, bending/stooping, twisting, kneeling, crouching, crawling, and reaching, and the number of hours per day the worker can perform each activity.

(38) "Specialist Physician" means a licensed physician who qualifies as an attending physician and who examines a worker at the request of the attending physician or authorized nurse practitioner to aid in evaluation of disability, diagnosis, and/or provide temporary specialized treatment. A specialist physician may provide specialized treatment for the compensable injury or illness and give advice and/or an opinion regarding the treatment being rendered, or considered, for a workers' compensable injury.

(39) "Usual Fee" means the fee charged the general public for a given service.

(40) "Work Capacity Evaluation" or "WCE" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening shall be considered to have the same meaning as Work Capacity Evaluation.

(41) "Work Hardening" means an individualized, medically prescribed and monitored, work oriented treatment process. The process involves the worker participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the worker to a specific job.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.000 et seq. & 656.005

Hist.: WCB 4-1976, f. 10-20-76, ef. 11-1-76; WCD 7-1978(Admin), f. & ef. 6-5-78; WCD 2-1980(Admin), f. 1-28-80, ef. 2-1-80; 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 436-069-0005, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 4-

1986(Admin), f. 6-26-86, ef. 7-1-86; 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 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 14-1990(Temp), f. & cert. ef. 7-20-91; WCD 16-1990(Temp), f. & cert. ef. 8-17-90; 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; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; 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

436-010-0008
Administrative Review and Contested Cases

(1) Administrative review before the director:

(a) Except as otherwise provided in ORS 656.704, the director has exclusive jurisdiction to resolve all matters concerning medical services arising under ORS 656.245, 656.247, 656.260, and 656.327.

(b) A party need not be represented to participate in the administrative review before the director except as provided in ORS Chapter 183 and OAR 436, division 001.

(c) Any party may request that the director provide voluntary mediation after a request for administrative review or contested case hearing is filed. The request must be in writing. When a dispute is resolved by agreement of the parties to the satisfaction of the director, any agreement shall be reduced to writing and approved by the director. Any mediated agreement may include an agreement on attorney fees, if any, to be paid to the claimant or claimant's attorney. If the dispute does not resolve through mediation, a director's order shall be issued.

(2) Administrative review and contested case processes for change of attending physician or authorized nurse practitioner issues are in OAR 436-010-0220; additional insurer medical examination (IMEs) matters are in OAR 436-010-0265; and fees and non-payment of compensable medical billings are described in OAR 436-009-0008.

(3) Except for disputes regarding interim medical benefits, when there is a formal denial of the compensability of the underlying claim, the parties must first apply to the Hearings Division of the Workers' Compensation Board to resolve the compensability issues. After the compensability of the underlying claim is finally decided, any party may request director's review of appropriate medical issues within 30 days after the date the decision becomes final by operation of law.

(4) When there is a denial of the causal relationship between the medical service and the accepted condition or the underlying condition, the issue must first be decided by the Hearings Division of the Workers' Compensation Board.

(5) All issues pertaining to disagreement about medical services within a Managed Care Organization (MCO), including disputes under ORS 656.245(4)(a) about whether a change of provider will be medically detrimental to the injured worker, are subject to the provisions of ORS 656.260. A party dissatisfied with an action or decision of the MCO must first apply for and complete the internal dispute resolution process within the MCO before requesting an administrative review of the matter by the director.

(6) The following time frames and conditions apply to requests for administrative review before the director under this rule:

(a) For all disputes subject to dispute resolution within a Managed Care Organization, upon completion of the MCO process, the aggrieved party must request administrative review by the director within 60 days of the date the MCO issues its final decision. If a party has been denied access to an MCO internal 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 the particular type of dispute, 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, 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. This time frame only applies if the aggrieved party other than the insurer is given written notice that they have 90 days in which to request administrative review by the director. When the aggrieved party is a represented worker, and the worker's attorney has given written notice of representation, the 90 day time frame begins when the attorney receives written notice or has actual knowledge of the dispute. For purposes of this rule, the date the insurer should have known of the dispute is the date action on the bill was due. For disputes regarding interim medical benefits on denied claims, the date the insurer should have known of the dispute is no later than one year from the claim denial, or 45 days after the bill is perfected, which ever occurs last. Filing a request for administrative review under this rule may also be accomplished in the manner prescribed in OAR 438, division 005.

(c) Disputes regarding elective surgery shall be processed in accordance with OAR 436-010-0250.

(d) The director may, on the director's own motion, initiate a medical services review at any time.

(e) Medical provider bills for treatment or services which are subject to director's review shall not be deemed payable pending the outcome of the review.

(7) Parties shall submit requests for administrative review to the director in the form and format provided in Bulletin 293. Unrepresented workers may seek help from the director in meeting the filing requirements. The requesting party shall 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 what issues are in dispute and specify with particularity the relief sought;

(c) Provide the specific dates of the unpaid disputed treatment.

(8) In addition to medical evidence relating to the medical services dispute, all parties may submit other relevant information, including but not limited to, written factual information, sworn affidavits, and legal argument for incorporation into the record. Such information may also include timely written responses and other evidence to rebut the documentation and arguments of an opposing party. The director may take or obtain addition evidence consistent with statute.

(9) When a request for administrative review is filed pursuant to ORS 656.247, 656.260, or 656.327, the insurer shall provide a record packet, without cost, to the director and all other parties or their representatives as follows:

(a) Except for disputes regarding interim medical benefits, the packet shall include certification that there is no issue of compensability of the underlying claim or condition. If there is a denial which has been reversed by the Hearings Division, the Board, or the Court of Appeals, a statement from the insurer regarding its intention, if known, to accept or appeal the decision.

(b) The packet shall include a complete, indexed copy of the worker's medical record and other documents that are arguably related to the medical service in dispute, arranged in chronological order, with oldest documents on top, and numbered in Arabic numerals in the lower right corner of each page. The number shall be preceded by the designation "Ex." and pagination of the multiple page documents shall be designated by a hyphen followed by the page number. For example, page two of document ten shall be designated "Ex. 10-2." The index shall include the document numbers, description of each document, author, number of pages, and date of the document. The packet shall include the following notice in bold type:

As required by OAR 436-010-0008, we hereby notify you that the director is being asked to review the medical care of this worker. The director may issue an order which could affect reimbursement for the disputed medical service(s).

(c) If the insurer requests review, the packet must accompany the request, with copies sent simultaneously to the other parties.

(d) If the requesting party is other than the insurer, or if the director has initiated the review, the director will request the record from the insurer. The insurer shall provide the record within 14 days of the director's request in the form and format described in this rule.

(e) If the insurer fails to submit the record in the time and format specified in this rule, the director may penalize or sanction the insurer under OAR 436-010-0340.

(10) If the director determines a review by a physician is indicated to resolve the dispute, the director, in accordance with OAR 436-010-0330, may appoint an appropriate medical service provider or panel of providers to review the medical records and, if necessary, examine the worker and perform any necessary and reasonable medical tests, other than invasive tests. Notwithstanding ORS 656.325(1), if the worker is required by the director to submit to a medical examination as a step in the administrative review process, the worker may refuse an invasive test without sanction.

(a) A single physician selected to conduct a review shall be a practitioner of the same healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

(b) When a panel of physicians is selected, at least one panel member shall be a practitioner of the healing art and specialty, if practicable, of the medical service provider whose treatment is being reviewed.

(c) When such an examination of the worker is required, the director shall notify the appropriate parties of the date, time, and location of the examination. The physician or panel shall not be contacted directly by any party except as it relates to the examination date, time, location, and attendance. If the parties wish to have special questions addressed by the physician or panel, these questions must be submitted to the director for screen-

ing as to the appropriateness of the questions. Matters not related to the issues before the director are inappropriate for medical review and will not be submitted to the reviewing physician(s). The examination may include, but is not limited to:

(A) a review of all medical records and diagnostic tests submitted,

(B) an examination of the worker, and

(C) any necessary and reasonable medical tests.

(11) The director shall review the relevant information submitted by all parties and the observations and opinions of the reviewing physician(s).

(a) 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 of the dispute.

(b) If the dispute is not resolved by agreement and if the director determines that no bona fide dispute exists in a claim not enrolled in an MCO, the director will issue an order pursuant to ORS 656.327(1). If any party disagrees with an order of the director that no bona fide medical services dispute exists, the party may appeal the order to the Workers' Compensation Board within 30 days of the mailing date of the order. Upon review, the order of the director may be modified only if it is not supported by substantial evidence in the record developed by the director.

(c) When a bona fide dispute exists, the director will issue an administrative order and provide notice of the record used in the review.

(A) A request for contested case hearing must be mailed to the director within 30 days from the issuance of an order pursuant to ORS 656.245, 656.260, or 656.327, or 60 days from the issuance of an order pursuant to ORS 656.247.

(B) 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 also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence 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 before the administrative order becomes final.

(C) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this subsection and may respond to such evidence submitted by others.

(D) Any party requesting reconsideration or responding to a reconsideration request shall simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(12) If the director issues an order declaring an already rendered medical service inappropriate, or otherwise in violation of the statute or medical services rules, the worker is not obligated to pay for such medical service.

(13) In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director shall award an attorney fee to be paid by the insurer or self-insured employer, as provided in ORS 656.385 (§2, ch. 756, OL 2003). The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration shall be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed $2000, nor fall outside the ranges for fees as provided in the following matrix:

Estimated Benefit Achieved — Professional Hours Devoted
1-2 hours — 2.1-4 hours — 4.1-6 hours — 6.1-8 hours — 8.1-12 hours
$1-$2000 — $100-400 — $200-700 — $300-750 — $600-1000 — $800-1250
$2001-$4000 — $200-500 — $400-800 — $600-900 — $800-1300 — $1050-1500
$4001-$6000 — $300-700 — $600-1000 — $800-1250 — $1000-1450 — $1300-1750
$6001-$10000 — $400-900 — $800-1300 — $1050-1600 — $1350-1800 — $1550-2000

(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the case if greater than two hours. In the absence of such a statement, the director shall assume the time spent on the case was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to, the following:

(A) The fee allowed by the fee schedule provided in OAR 436-009;

(B) The overall cost of the medical treatment or service; or

(C) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above $2000, they may submit a written or faxed statement of the extraordinary circumstances to the director.

(d) In order to provide parties an opportunity to inform the director of agreements, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any information or statements provided to the director must simultaneously be provided to all other parties to the dispute.

(e) An assessed attorney fee shall be paid within 30 days of the date the order authorizing the fee becomes final.

(14) Contested cases before the director: Any party that disagrees with an action or order pursuant to this rule, may request a contested case hearing before the director as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested, and include a copy of the administrative order being appealed.

(b) The appeal must be mailed within 30 days of the mailing date of the order or notice of action being appealed.

(c) The hearing shall be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(d) In the review of orders issued pursuant to ORS 656.327(2), 656.260(14) and (16), and 656.247, no new medical evidence or issues shall be admitted at the contested case hearing. In these reviews, an administrative order may be modified at hearing only if it is not supported by substantial evidence in the record or if it reflects an error of law.

(e) For claims not enrolled in an MCO, disputes about whether a medical service after a worker is medically stationary is compensable within the meaning of ORS 656.245(1)(c) and whether a medical treatment is unscientific, unproven, outmoded, or experimental under ORS 656.245(3), are subject to administrative review by the director. If appealed, review at contested case hearing is not subject to the "no new medical evidence or issues rule" in subsection (13)(d) of this rule. However, if the disputed medical service is determined compensable under ORS 656.245(1)(c) or 656.245(3) all disputes and assertions about whether the compensable medical services are excessive, inappropriate, ineffectual, or in violation of the director's rules regarding the performance of medical services are subject to the substantial evidence rule at contested case hearing.

(15) Contested case hearings of sanction and civil penalties: Under ORS 656.740 (§9, ch. 170, OL 2003), any party that disagrees with a proposed order or proposed assessment of a civil penalty issued by the director pursuant to ORS 656.254 or 656.745 may request a hearing by the Hearings Division of the Workers' Compensation Board as follows:

(a) A written request for a hearing must be mailed to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The request must be mailed to the division within 60 days after the mailing date of the order or notice of assessment.

(c) The division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(16) 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 (15) of this rule, pursuant to these rules, may request administrative review by the director. Any party may request administrative review as follows:

(a) A written request for review must be sent to the administrator of the Workers' Compensation Division within ninety (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.

(c) A director's order may be issued and will specify if the order is final or if it may be appealed in accordance with section (14) of this rule.

Stat. Auth.: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.254, 656.256, 656.260, 656.268, 656.313, 656.325, 656.327, 656.331 & 656.704

Hist.: 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 30-1990, f. 12-10-90, cert. ef. 12-26-90; 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; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-00; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; 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

436-010-0210
Who May Provide Medical Services and Authorize Timeloss

(1) Attending physicians and authorized nurse practitioners may authorize time loss and manage medical services subject to the limitations of these rules. However, an MCO may designate any medical service provider as an attending physician who may provide medical services to an enrolled worker in accordance with ORS 656.260.

(2) Authorized primary care physicians and authorized nurse practitioners may provide medical services to injured workers subject to the terms and conditions of the governing MCO.

(3) Attending physicians and authorized nurse practitioners may prescribe treatment to be carried out by persons licensed to provide a medical service. Attending physicians may prescribe treatment to be carried out by persons not licensed to provide a medical service or treat independently only when such treatment is rendered under the physician's direct control and supervision. Reimbursement to a worker for home health care provided by a worker's family member is not required to be provided under the direct control and supervision of the attending physician if the family member demonstrates competency to the satisfaction of the attending physician.

(4) Physician assistants may provide compensable medical services for a period of 30 days from the date of injury or 12 visits on the initial claim, whichever occurs first. Thereafter, medical services provided are not compensable without authorization of an attending physician. Additionally, those physician assistants practicing in Type A, Type B, and Type C rural hospital areas as specified in ORS 656.245, may authorize the payment of temporary disability compensation for a period not to exceed 30 days from the date of first visit on the initial claim. Definitions of Type A, Type B, and Type C rural hospitals are contained in ORS 442.470.

(5) Nurse practitioners and physician assistants working within the scope of their license and as directed by the attending physician, need not be working under a written treatment plan as prescribed in OAR 436-010-0230(4)(a), nor under the direct control and supervision of the attending physician.

(6) A physician assistant, licensed under ORS 677.515, may provide services when the physician assistant is approved for practice by the Board of Medical Examiners.

(7) Effective October 1, 2004, in order to qualify as an authorized nurse practitioner, a nurse practitioner must certify in a form provided by the director that the nurse practitioner has reviewed a packet of materials which the director will provide upon request to any nurse practitioner after April 1, 2004.

(8) In accordance with ORS 656.245(2)(a), with the approval of the insurer, the worker may choose an attending physician outside the state of Oregon. Upon receipt of the worker's request, or the insurer's knowledge of the worker's request to treat with an out-of-state physician, the insurer shall give the worker written notice of approval or denial of the worker's choice of attending physician within 14 days.

(a) If the insurer does not approve the worker's out-of-state physician, notice to the worker shall clearly state the reason(s) for the denial which may include, but are not limited to, the out-of-state physician's refusal to comply with OAR 436-009 and 436-010, and identify at least two other physicians of the same healing art and specialty whom it would approve . The notice shall also inform the worker that if the worker disagrees with the denial, the worker may refer the matter to the director for review under the provisions of OAR 436-010-0220.

(b) If the insurer approves the worker's choice of out-of-state attending physician, the insurer shall immediately notify the worker and the medical service provider in writing of the following:

(A) The Oregon fee schedule requirements;

(B) The manner in which the out-of-state physician may provide compensable medical services to Oregon injured workers; and

(C) Billings for compensable services in excess of the maximum allowed under the fee schedule may not be paid by the insurer.

(9) After giving prior approval, if the out-of-state physician does not comply with these rules, the insurer may object to the worker's choice of physician and shall notify the worker and the physician in writing of the reason for the objection, that payment for services rendered by that physician after notification shall not be reimbursable, and that the worker may be liable for payment of services rendered after the date of notification.

(10) If the worker is aggrieved by an insurer decision to object to an out-of-state attending physician, the worker or the worker's representative may refer the matter to the director for review under the provisions of OAR 436-010-0220.

Stat. Auth.:ORS 656.726(4)
Stats. Implemented: ORS 656.005(12), 656.245 & 656.260
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 5-1984(Admin), f. & ef. 8-20-84; Renumbered from 436-069-0301, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 6-1988, f. 9-6-88, cert. ef. 9-15-88; 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 436-010-0050; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-000; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; 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

436-010-0220
Choosing and Changing Medical Providers

(1) A newly selected attending physician, authorized nurse practitioner, or a specialist physician who becomes primarily responsible for the worker's care, shall notify the insurer not later than five days after the date of change or first treatment, using Form 827. An attending physician or authorized nurse practitioner:

(a) Is primarily responsible for the worker's care,

(b) Authorizes time loss,

(c) Monitors ancillary care and specialized care, and

(d) Is determined by the facts of the case and the actions of the physician, not whether a Form 827 is filed.

(2) The worker may have only one attending physician or authorized nurse practitioner at a time. Simultaneous or concurrent treatment by other medical service providers shall be based upon a written request of the attending physician or authorized nurse practitioner, with a copy of the request sent to the insurer. Except for emergency services, or otherwise provided for by statute or these rules, all treatments and medical services must be authorized by the injured worker's attending physician or authorized nurse practitioner to be reimbursable. Fees for treatment by more than one physician at the same time are payable only when treatment is sufficiently different that separate medical skills are needed for proper treatment.

(3) The worker is allowed to change his or her attending physician or authorized nurse practitioner by choice two times after the initial choice. Referral by the attending physician or authorized nurse practitioner to another attending physician or authorized nurse practitioner, initiated by the worker, shall count in this calculation. The limitations of the worker's right to choose physicians or authorized nurse practitioners pursuant to this section begin with the date of injury and extend through the life of the claim. For purposes of this rule, the following are not considered changes by choice of the worker:

(a) Emergency services by a physician;

(b) Examinations at the request of the insurer;

(c) Consultations or referrals for specialized treatment initiated by the attending physician or authorized nurse practitioner;

(d) Referrals to radiologists and pathologists for diagnostic studies;

(e) When workers are required to change medical service providers to receive compensable medical services, palliative care, or time loss authorization because their medical service provider is no longer qualified as an attending physician or authorized to continue providing compensable medical services.

(f) Changes of attending physician or authorized nurse practitioner required due to conditions beyond the worker's control. This could include, but not be limited to:

(A) When the physician terminates practice or leaves the area;

(B) When a physician is no longer willing to treat an injured worker;

(C) When the worker moves out of the area requiring more than a 50 mile commute to the physician;

(D) When the 90 day period for treatment by an authorized nurse practitioner has expired;

(E) When the nurse practitioner is required to refer the worker to an attending physician for a closing examination or because of a possible worsening of the worker's condition following claim closure; and

(F) When a worker is subject to managed care and compelled to be treated inside an MCO;

(g) A Worker Requested Medical Examination;

(h) Whether a worker has an attending physician or authorized nurse practitioner who works in a group setting/facility and the worker sees another group member due to team practice, coverage, or on-call routines; or

(i) When a worker's attending physician or authorized nurse practitioner is not available and the worker sees a medical provider who is covering for that provider in their absence.

(4) When a worker has made an initial choice of attending physician or authorized nurse practitioner and subsequently changed two times by choice or reaches the maximum number of changes established by the MCO, the insurer shall inform the worker by certified mail that any subsequent changes by choice must have the approval of the insurer or the director. If the insurer fails to provide such notice and the worker subsequently chooses another attending physician or authorized nurse practitioner, the insurer shall pay for compensable services rendered prior to notice to the worker. If an attending physician or authorized nurse practitioner begins treatment without being informed that the worker has been given the required notification, the insurer shall pay for appropriate services rendered prior to the time the insurer notifies the medical service provider that further payment will not be made and informs the worker of the right to seek approval of the director.

(5)(a) If a worker not enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the limit established in section (3) of this rule, the worker must request approval from the insurer. Within 14 days of receipt of a request for a change of medical service provider or a Form 827 indicating the worker is choosing to change his or her attending physician or authorized nurse practitioner, the insurer shall notify the worker in writing whether the change is approved. If the insurer objects to the change, the insurer shall advise the worker of the reasons, advise that the worker may request director approval, and provide the worker with Form 2332 (Worker's Request to Change Attending Physician or Authorized Nurse Practitioner) to complete and submit to the director if the worker wishes to make the requested change.

(b) If a worker enrolled in an MCO wishes to change his or her attending physician or authorized nurse practitioner beyond the changes allowed in the MCO contract or certified plan, the worker must request approval from the insurer. Within 14 days of receiving the request, the insurer shall notify the worker in writing whether the change is approved. If the insurer denies the change, the insurer shall provide the reasons and give notification that the worker may request dispute resolution through the MCO. If the MCO does not have a dispute resolution process for change of attending physician or authorized nurse practitioner issues, the insurer shall give notification that the worker may request director approval and provide the worker with a copy of Form 2332.

(6) Upon receipt of a worker's request for an additional change of attending physician or authorized nurse practitioner, the director may notify the parties and request additional information. Upon receipt of a written request from the director for additional information, the parties shall have 14 days to respond in writing.

(7) After receipt and review, the director will issue an order advising whether the change is approved. The change of attending physician or authorized nurse practitioner shall be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

(a) Whether there is medical justification for a change, including whether the attending physician or authorized nurse practitioner can provide the type of treatment that is appropriate for the worker's condition.

(b) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

(c) Whether such a change will cause unnecessary travel costs and/or lost time from work.

(8) Any party that disagrees with the director's order may request a contested case hearing before the director, pursuant to ORS 183.310(2) and OAR 436-001, as follows:

(a) The party must send a written request to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the order or other action of the director is contested and must include a copy of the order appealed.

(b) The appeal must be mailed within 30 days of the mailing date of the order.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth: ORS 656.276(4)

Stats. Implemented: ORS 656.245, 656.252 & 656.260

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 436-069-0401, 5-1-85; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; 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 436-010-0060; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; 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

436-010-0230

Medical Services and Treatment Guidelines

(1) Medical services provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. Services which are unnecessary or inappropriate according to accepted professional standards are not reimbursable.

(2) An employer or insurer representative may not attend a worker's medical appointment without written consent of the worker. The consent form must state that the worker's benefits cannot be suspended if the worker refuses to have a representative present. The worker has the right to refuse such attendance. The insurer shall retain a copy of a signed consent form in the claim file.

(3) Insurers have the right to require evidence of the frequency, extent, and efficacy of treatment. Unless otherwise provided for by statute, or within utilization and treatment standards under an MCO contract, treatment typically does not exceed 15 office visits by any and all attending physicians or authorized nurse practitioners in the first 60 days from first date of treatment, and two visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment.

(4) (a) Except as otherwise provided by an MCO, ancillary services including but not limited to physical therapy or occupational therapy, by a medical service provider other than the attending physician, authorized nurse practitioner, or specialist physician shall not be reimbursed unless prescribed by the attending physician, authorized nurse practitioner, or specialist physician and carried out under a treatment plan prepared prior to the commencement of treatment and sent by the ancillary medical service provider to the attending physician, authorized nurse practitioner, or specialist physician, and the insurer within seven days of beginning treatment. The treatment plan shall include objectives, modalities, frequency of treatment, and duration. The treatment plan may be recorded in any legible format including, but not limited to, signed chart notes. Treatment plans required under this subsection do not apply to services provided pursuant to ORS 656.245(2)(b)(A).

(b) The attending physician, authorized nurse practitioner, or specialist physician shall sign a copy of the treatment plan within 30 days of the commencement of treatment and send it to the insurer. Failure of the physician or nurse practitioner to sign or mail the treatment plan may subject the attending physician or authorized nurse practitioner to sanctions under OAR 436-010-0340, but shall not affect payment to the ancillary medical service provider.

(c) Medical services prescribed by an attending physician, specialist physician, or authorized nurse practitioner and provided by a chiropractor, naturopath, acupuncturist, or podiatrist shall be subject to the treatment plan requirements set forth in subsection (4)(a) and (b) of this rule.

(d) Unless otherwise provided for within utilization and treatment standards under an MCO contract, the usual range for therapy visits does not exceed 20 visits in the first 60 days, and 4 visits a month thereafter. This rule does not constitute authority for an arbitrary provision of or limitation of services, but is a guideline for reviewing treatment. The attending physician or authorized nurse practitioner shall document the need for services in excess of these guidelines when submitting a written treatment plan. The process outlined in OAR 436-010-0008 should be followed when an insurer believes the treatment plan is inappropriate.

(5) The attending physician or authorized nurse practitioner, when requested by the insurer or the director through the insurer to complete a physical capacity or work capacity evaluation, shall complete the evaluation within 20 days, or refer the worker for such evaluation within seven days. The attending physician or authorized nurse practitioner shall notify the insurer and the worker in writing if the worker is incapable of participating in such evaluation.

(6) Prescription medications are required medical services under the provisions of ORS 656.245(1)(a), (1)(b), and (1)(c) and do not require prior approval under the palliative care provisions of OAR 436-010-0290. A pharmacist, dispensing physician, or authorized nurse practitioner shall dispense generic drugs to injured workers in accordance with and pursuant to ORS 689.515. For the purposes of this rule, the worker shall be deemed the "purchaser" and may object to the substitution of a generic drug. However, payment for brand name drugs are subject to the limitations provided in OAR 436-009-0090. Workers may have prescriptions filled by a provider of their choice, unless otherwise provided for in accordance with an MCO contract. Except in an emergency, drugs and medicine for oral consumption supplied by a physician's or authorized nurse practitioner's office are compensable only for the initial supply to treat the worker with the medication up to a maximum of 10 days, subject to the provisions of this rule and OAR

436-009-0090. Compensation for certain drugs are limited as provided in OAR 436-009-0090.

(7) Dietary supplements including, but not limited to, minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured worker or they are provided in accordance with a utilization and treatment standard adopted by the director. Vitamin B-12 injections are not reimbursable unless necessary because of a specific dietary deficiency of malabsorption resulting from a compensable gastrointestinal condition.

(8) X-ray films must be of diagnostic quality and accompanied by a report. 14" x 36" lateral views are not reimbursable.

(9) Upon request of either the director or the insurer, original diagnostic studies shall be forwarded to the director or the insurer. Films shall be returned to the medical provider. A reasonable charge may be made for the costs of delivery of films. If a medical provider refuses to forward the films to the director or the insurer within 14 days of receipt of a written request, civil penalties may be imposed.

(10) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis, and gravity traction devices are not compensable unless a need is clearly justified by a report which establishes that the "nature of the injury or the process of recovery requires" the item be furnished. The report must specifically set forth why the worker requires an item not usually considered necessary in the great majority of workers with similar impairments. Trips to spas, to resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist.

(11) Physical restorative services may include but are not limited to a regular exercise program or swim therapy. Such services are not compensable unless the nature of the worker's limitations requires specialized services to allow the worker a reasonable level of social and/or functional activity. The attending physician or authorized nurse practitioner shall justify by report why the worker requires services not usually considered necessary for the majority of injured workers.

(12) The cost of repair or replacement of prosthetic appliances damaged when in use at the time of and in the course of a compensable injury, is a compensable medical expense, including when the worker received no physical injury. For purposes of this rule, a prosthetic appliance is an artificial substitute for a missing body part or any device by which performance of a natural function is aided, including but not limited to hearing aids and eye glasses.

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248 & 656.252

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; WCD 5-1984(Admin), f. & ef. 8-20-84; WCD 2-1985(Admin), f. 4-29-85, ef. 6-3-85; Renumbered from 436-069-0201, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; 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 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 436-010-0040; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-1999(Temp), f. & cert. ef. 2-11-99 thru 8-10-99; WCD 7-1999, f. & cert. ef. 4-28-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; 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

436-010-0240

Reporting Requirements for Medical Providers

(1) The act of the worker in applying for workers' compensation benefits constitutes authorization for any medical provider and other custodians of claims records to release relevant medical records under ORS 656.252. Medical information relevant to a claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. The authorization is valid for the duration of the work related injury or illness and is not subject to revocation by the worker or the worker's representative. However, this authorization does not authorize the release of information regarding:

(a) Federally funded drug and alcohol abuse treatment programs governed by Federal Regulation 42, CFR 2, which may only be obtained in compliance with this federal regulation, or

(b) The release of HIV related information otherwise protected by ORS 433.045(3). HIV related information should only be released when a claim is made for HIV or AIDS or when such information is directly relevant to the claimed condition(s).

(2) Any physician, hospital, clinic, or other medical service provider, shall provide all relevant information to the director, the insurer or their representative upon presentation of a signed Form 801, 827, or 2476 (Release of Information). "Signature on file," printed on the worker's signature line of any authorized Release of Information prescribed by the director, is a valid medical release, provided the insurer maintains the signed original in accordance with OAR 436-010-0270. However, nothing in this rule shall prevent a medical provider from requiring a signed authorized Release of Information.

(3) When the worker has initiated a claim or wishes to initiate a claim, the worker and the first medical service provider on the initial claim shall complete the first medical report (Form 827) in every detail, to include the worker's name, address, and social security number (SSN), and information required by ORS 656.252 and 656.254. The medical service provider shall mail it to the proper insurer no later than 72 hours after the worker's first visit (Saturdays, Sundays, and holidays will not be counted in the 72-hour period).

(a) Diagnoses stated on Form 827 and all subsequent reports shall conform to terminology found in the International Classification of Disease-9-Clinical Manifestations (ICD-9-CM) or taught in accredited institutions of the licentiate's profession.

(b) The worker's SSN will be used by the director to carry out its duties under ORS Chapter 656. The worker may voluntarily authorize additional use of the worker's SSN by various government agencies to carry out their statutory duties.

(4) All medical service providers shall notify the worker at the time of the first visit of the manner in which they can provide compensable medical services and authorize time loss. The worker shall also be notified that they may be personally liable for noncompensable medical services. Such notification should be made in writing or documented in the worker's chart notes.

(5) Attending physicians or authorized nurse practitioners shall, upon request from the insurer, submit verification of the worker's medical limitations related to the worker's ability to work, resulting from an occupational injury or disease. If the insurer requires the attending physician or authorized nurse practitioner to complete a release to return to work form, the insurer shall use Form 3245.

(6) Medical providers shall maintain records necessary to document the extent of services provided to injured workers.

(7) Progress reports are essential. When time loss is authorized by the attending physician or authorized nurse practitioner, the insurer may require progress reports every 15 days through the use of the physician's report, Form 827. Chart notes may be sufficient to satisfy this requirement. If more information is required, the insurer may request a brief or complete narrative report. Fees for such narrative reports shall be in accordance with OAR 436-009-0015(11), 436-009-0070(2) or (3), whichever applies

(8) Reports may be handwritten and include all relevant or requested information.

(9) All records shall be legible and cannot be kept in a coded or semi-coded manner unless a legend is provided with each set of records.

(10) The medical provider shall respond within 14 days to the request for relevant medical records as specified in section (1) of this rule, progress reports, narrative reports, and any or all necessary records needed to review the efficacy of treatment, frequency, and necessity of care. The medical provider shall be reimbursed for copying documents in accordance with OAR 436-009-0070(1). If the medical provider fails to provide such information within fourteen (14) days of receiving a request sent by certified mail, penalties under OAR 436-010-0340 or 436-015-0120 may be imposed.

(11) The attending physician or authorized nurse practitioner shall inform the insurer and the worker of the anticipated date of release to work, the anticipated date the worker will become medically stationary, the next appointment date, and the worker's medical limitations. To the extent any medical provider can determine these matters they must be included in each progress report. The insurer shall not consider the anticipated date of becoming medically stationary as a release to return to work.

(12) At the time the attending physician or authorized nurse practitioner declares the worker medically stationary, the attending physician or authorized nurse practitioner shall notify the worker, the insurer, and all other medical providers who are providing services to the worker. For disabling claims, if the worker has been under the care of an authorized nurse practitioner, the authorized nurse practitioner must refer the worker to a qualified attending physician to complete a closing examination. The attending physician shall send a closing report to the insurer within 14 days of the examination in which the worker is declared medically stationary, except where a consulting physician examines the worker. The procedures and time frames for a consulting physician to perform the closing exam are provided in OAR 436-010-0280.

(13) The attending physician or authorized nurse practitioner shall advise the worker, and within five days provide the insurer with written notice, of the date the injured worker is released to return to regular or mod-

ified work. The physician or nurse shall not notify the insurer or employer of the worker's release to return to regular or modified work without first advising the worker.

(14) An injured worker's claim for aggravation must be filed on Form 827 and must be accompanied by a medical report from the attending physician supported by objective findings that can be used to determine whether the worker has suffered a worsened condition attributable to the compensable injury under the criteria contained in ORS 656.273. The attending physician, on the worker's behalf, shall submit within five days the claim for aggravation and the medical report directly to the insurer

(15) The attending physician, authorized nurse practitioner, or the MCO may request consultation regarding conditions related to an accepted claim. The attending physician, authorized nurse practitioner, or the MCO shall promptly notify the insurer of the request for consultation. This requirement does not apply to diagnostic studies performed by radiologists and pathologists. The attending physician, authorized nurse practitioner, or MCO shall provide the consultant with all relevant clinical information. The consultant shall submit a copy of the consultation report to the attending physician, authorized nurse practitioner, the MCO, and the insurer within 10 days of the date of the examination or chart review. No additional fee beyond the consultation fee is allowed for this report. MCO requested consultations that are initiated by the insurer, which include examination of the worker, shall be considered insurer medical examinations subject to the provisions of 436-010-0265.

(16) A medical service provider shall not unreasonably interfere with the right of the insurer, pursuant to OAR 436-010-0265(1), to obtain a medical examination of the worker by a physician of the insurer's choice.

(17) Any time an injured worker changes his or her attending physician or authorized nurse practitioner:

(a) The new provider is responsible for:

(A) Submitting Form 827 to the insurer not later than five days after the change or the date of first treatment; and

(B) Requesting all available medical information, including information concerning previous temporary disability periods, from the previous attending physician, authorized nurse practitioner, or from the insurer.

(b) The requirements of paragraphs (A) and (B) also apply anytime a worker is referred to a new physician qualified to be an attending physician or to a new authorized nurse practitioner primarily responsible for the worker's care.

(c) Anyone failing to forward requested information within 14 days to the new physician or nurse will be subject to penalties under OAR 436-010-0340.

(18) Injured workers, or their representatives, are entitled to copies of all protected health information in the medical records. These records should ordinarily be available from the insurers, but may also be obtained from medical providers under the following conditions:

(a) A medical provider may charge the worker for copies in accordance with OAR 436-009-0070(1), but a patient may not be denied summaries or copies of his/her medical records because of inability to pay.

(b) For the purpose of this rule, "protected health information in the medical record" means any oral or written information in any form or medium that is created or received and relates to:

(A) The past, present, or future physical or mental health of the patient;

(B) The provision of health care to the patient; and

(C) The past, present, or future payment for the provision of health care to the patient.

(c) A worker or the worker's representative may request all or part of the record. A summary may substitute for the actual record only if the patient agrees to the substitution. Upon request, the entire health information record in the possession of the medical provider will be provided to the worker or the worker's representative. This includes records from other 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 administrative action or proceeding; and

(D) Other reasons specified by federal regulation.

[ED. NOTE: Forms referenced are available from the agency.]

[Publications: Publications referenced are available from the agency.]

Stat. Auth: ORS 656.276(4)

Stats. Implemented: ORS 656.245, 656.252, 656.254 & 656.273

Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0101, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1988, f. 1-20-88, cert. ef. 2-1-88; 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 14-1990(Temp), f. & cert. ef. 7-20-91; 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 12-1996, f. 5-6-96, cert. ef. 6-1-96; Renumbered from 436-010-0030; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; 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

436-010-0250

Elective Surgery

(1) "Elective Surgery" is surgery which may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

(2) Except as otherwise provided by the MCO, when the attending physician or surgeon upon referral by the attending physician or authorized nurse practitioner, believes elective surgery is needed to treat a compensable injury or illness, the attending physician, authorized nurse practitioner, or the surgeon shall give the insurer actual notice at least seven days prior to the date of the proposed surgery. Notification shall give the medical information that substantiates the need for surgery, and the approximate surgical date and place if known.

(3) When elective surgery is recommended, the insurer may require an independent consultation with a physician of the insurer's choice. The insurer shall notify the recommending physician, the worker and the worker's representative, within seven days of receipt of the notice of intent to perform surgery, whether or not a consultation is desired by submitting Form 440-3228 (Elective Surgery Notification) to the recommending physician. When requested, the consultation shall be completed within 28 days after notice to the physician.

(4)(a) Within seven days of the consultation, the insurer shall notify the recommending physician of the insurer's consultant's findings.

(b) When the insurer's consultant disagrees with the proposed surgery, the recommending physician and insurer shall endeavor to resolve any issues raised by the insurer's consultant's report. Where medically appropriate, the recommending physician, with the insurer's agreement to pay, shall obtain additional diagnostic testing, clarification reports or other information designed to assist them in their attempt to reach an agreement regarding the proposed surgery.

(c) The recommending physician shall provide written notice to the insurer, the worker and the worker's representative when further attempts to resolve the matter would be futile by signing Form 440-3228.

(5) If the insurer believes the proposed surgery is excessive, inappropriate, or ineffectual and cannot resolve the dispute with the recommending physician, the insurer shall request an administrative review by the director within 21 days of the notice provided in subsection(4)(c) of this rule. Failure of the insurer to timely respond to the physician's elective surgery request by submitting Form 440-3228, or to timely request administrative review pursuant to this rule shall bar the insurer from later disputing whether the surgery is or was excessive, inappropriate, or ineffectual.

(6) If the recommending physician and consultant disagree about the need for surgery, the insurer may inform the worker of the consultant's opinion. The decision whether to proceed with surgery remains with the attending physician and the worker.

(7) A recommending physician who prescribes or proceeds to perform elective surgery and fails to comply with the notification requirements in section (2) of this rule, may be subject to civil penalties as provided in ORS 656.254(3)(a) and OAR 436-010-0340.

(8) Surgery which must be performed promptly, i.e., before seven days, because the condition is life threatening or there is rapidly progressing deterioration or acute pain not manageable without surgical intervention, is not considered elective surgery. In such cases the attending physician or authorized nurse practitioner should endeavor to notify the insurer of the need for emergency surgery.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth: ORS 656.726(4)

Stats. Implemented: ORS 656.245, 656.248, 656.252, 656.260 & 656.327

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 436-069-0501, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; WCD 1-1990, f. 1-5-90, cert. ef. 2-1-90; 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 436-010-0070; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; 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

436-010-0265

Insurer Medical Examinations (IME)

(1) The insurer may obtain three medical examinations of the worker by physicians of their choice for each opening of the claim. These examinations may be obtained prior to or after claim closure. A claim for aggravation, Board's Own Motion, or reopening of a claim where the worker

becomes enrolled or actively engaged in training according to rules adopted pursuant to ORS 656.340 and 656.726 permits a new series of three medical examinations. For purposes of this rule, "insurer medical examination" (IME) means any medical examination including a physical capacity or work capacity evaluation or consultation that includes an examination, except as provided in section (5) of this rule, that is requested by the insurer and completed by any medical service provider, other than the worker's attending physician. The examination may be conducted by one or more medical providers with different specialty qualifications, generally done at one location and completed within a 72-hour period. If the medical providers are not at one location, the examination is to be completed within a 72-hour period and at locations reasonably convenient to the worker.

(2) When the insurer has obtained the three medical examinations allowed under this rule and wishes to require the worker to attend an additional examination, the insurer shall first notify and request authorization from the director. Insurers that fail to first notify and request authorization from the director, may be assessed a civil penalty. The process for requesting such authorization shall be as follows:

(a) The insurer shall submit a request for such authorization to the director in a form and format as prescribed by the director in Bulletin 252 including, but not limited to, the reasons for an additional IME, the conditions to be evaluated, dates, times, places, and purposes of previous examinations, copies of previous IME notification letters to the worker, and any other information requested by the director. A copy of the request shall be provided to the worker and the worker's attorney; and

(b) The director will review the request and determine if additional information is necessary prior to issuing an order approving or disapproving the request. Upon receipt of a written request for additional information from the director, the parties shall have 14 days to respond. If the parties do not provide the requested information, the director will issue an order approving or disapproving the request based on available information.

(3) In determining whether to approve or deny the request for an additional IME, the director may give consideration, but is not limited, to the following:

(a) Whether an IME involving the same discipline(s) and/or review of the same condition has been completed within the past six months.

(b) Whether there has been a significant change in the worker's condition.

(c) Whether there is a new condition or compensable aspect introduced to the claim.

(d) Whether there is a conflict of medical opinion about a worker's treatment, impairment, stationary status, or other issue critical to claim processing/benefits.

(e) Whether the IME is requested to establish a preponderance for medically stationary status.

(f) Whether the IME is medically harmful to the worker.

(g) Whether the IME requested is for a condition for which the worker has sought treatment or the condition has been included in the compensable claim.

(4) Any party aggrieved by the director's order may request a hearing by the Hearings Division of the Workers' Compensation Board pursuant to ORS 656.283 and OAR chapter 438.

(5) For purposes of determining the number of insurer required examinations, any examinations scheduled but not completed are not counted as a statutory IME. The following examinations shall not be considered IMEs and do not require approval as outlined in section (2) of this rule:

(a) An examination conducted by or at the request or direction of the worker's attending physician or authorized nurse practitioner;

(b) An examination obtained at the request of the director;

(c) A consultation obtained in accordance with OAR 436-010-0250(3);

(d) An examination of a permanently totally disabled worker required under ORS 656.206(5); and

(e) An examination by a consulting physician that has been arranged by the worker's attending physician or authorized nurse practitioner in accordance with OAR 436-010-0280.

(6) Examinations shall be at times and intervals reasonably convenient to the worker and shall not delay or interrupt proper treatment of the worker.

(7) When a worker is required to attend an examination by a physician of the insurer's choice, the insurer shall comply with the notification and reimbursement requirements contained in OAR 436-009-0025 and 436-060-0095.

(8) When scheduling an IME, the insurer shall provide Form 440-3227 (Invasive Medical Procedure Authorization) to the medical service provider.

(9) If a medical service provider intends to perform an invasive procedure as part of an IME, the worker shall sign Form 440-3227 and may refuse the procedure. For the purposes of this rule, an invasive procedure is a procedure in which the body is entered by a needle, tube, scope, or scalpel.

(10) The person conducting the examination shall determine the conditions under which the examination will be conducted. Subject to the physician's approval, the worker may use a video camera or tape recorder to record the examination. Also subject to the physician's approval, the worker may be accompanied by a family member or friend during the examination. If the physician does not approve a worker's request to record an examination or allow the worker to be so accompanied, the physician must document the reasons.

(11) Upon completion of the examination, the examining physician(s) shall send a copy of the report to the insurer within seven days. The insurer shall forward a copy of the report to the attending physician or authorized nurse practitioner within 72 hours of its receipt of the report.

Stat. Auth: ORS 656.726(4)
Stats. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260 & 656.264
Hist.: WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 3-1999(Temp), f. & cert. ef. 2-11-99 thru 8-10-99; WCD 7-1999, f. & cert. ef. 4-28-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 9-2002, f. 9-27-02, cert. ef. 11-1-02; 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

436-010-0270
Insurer's Rights and Duties

(1) Insurers shall notify the injured worker in writing, immediately following receipt of notice or knowledge of a claim, of the manner in which they may receive medical services for compensable injuries.

(2) Insurers may obtain relevant medical records, using a computer-generated equivalent of Form 2476 (Release of Information), with "signature on file" printed on the worker's signature line, provided the insurer maintains a worker-signed original of the release form.

(3) The insurer shall notify the attending physician or authorized nurse practitioner, if known, and the MCO, if any, when it denies or partially denies a previously accepted claim. In claims which have been denied, the insurer shall notify the medical service provider and MCO, if any, within ten days of any change of status of the claim.

(4) Upon request, the insurer shall forward all relevant medical information to return-to-work specialists, vocational rehabilitation organizations, or new attending physician or authorized nurse practitioner within 14 days.

(5) In disabling and non-disabling claims, immediately following notice or knowledge that the worker is medically stationary, insurers shall notify the injured worker and the attending physician or authorized nurse practitioner in writing which medical services remain compensable under the system. This notice must list all benefits the worker is entitled to receive under ORS 656.245(1)(c).

(6) When a medically stationary date is established by the insurer and is not based on the findings of an attending physician or authorized nurse practitioner, the insurer shall notify all medical service providers of the worker's medically stationary status. Applicable to all injuries occurring on or after October 23, 1999, the insurer shall be responsible for reimbursement to all medical service providers for services rendered until the insurer provides the notice to the attending physician or authorized nurse practitioner.

(7) Insurers shall reimburse workers for actual and reasonable costs for travel, prescriptions, and other claim related services paid by a worker in accordance with ORS 656.245(1)(e), 656.325, and 656.327.

(a) Reimbursement by the insurer to the worker for transportation costs to visit his or her attending physician may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate attending physician of the same specialty who is in a geographically closer medical community in relationship to the worker's home. If a worker seeks treatment from an authorized nurse practitioner, reimbursement by the insurer to the worker for transportation costs to visit his or her authorized nurse practitioner may be limited to the theoretical distance required to realistically seek out and receive care from an appropriate nurse practitioner of the same specialty who is in a geographically closer medical community in relationship to the worker's home. All medical practitioners within a metropolitan area are considered part of the same medical community and therefore are not considered geographically closer than any other physician in that metropolitan medical community for purposes of travel reimbursement.

(b) A worker who relocates within the State of Oregon may continue treating with the established attending physician or authorized nurse practitioner and be reimbursed transportation costs.

(c) Prior to limiting reimbursement under subsection (7)(a) of this rule, the insurer shall provide the worker a written explanation and a list of providers who can timely provide similar services within a reasonable traveling distance for the worker. The insurer shall inform the worker that treatment may continue with the established attending physician or authorized nurse practitioner; however, reimbursement of transportation costs may be limited as described.

(d) When the director decides travel reimbursement disputes at administrative review or contested case level, the determination will be based on principles of reasonableness and fairness within the context of the specific case circumstances as well as the spirit and intent of the law.

[ED. NOTE: Forms 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 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0801, 5-1-85; WCD 6-1985(Admin), f. 12-10-85, ef. 1-1-86; 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 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 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 436-010-0100; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-1999(Temp), f. & cert. ef. 10-25-99 thru 4-21-000; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; 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

436-010-0275
Insurer's Duties Under MCO Contracts

(1) Insurers who enter into an MCO contract in accordance with OAR 436-015, shall notify the affected insured employers of the following:

(a) The names and addresses of the complete panel of MCO medical providers within the employer's geographical service area(s);

(b) The manner in which injured workers can receive compensable medical services within the MCO;

(c) The manner in which injured workers can receive compensable medical services by medical providers outside the MCO; and

(d) The geographical service area governed by the MCO.

(2) Insurers under contract with an MCO shall notify all newly insured employers in accordance with section (1) of this rule, prior to or on the effective date of coverage.

(3) At least 30 days prior to any significant changes to an MCO contract affecting injured worker benefits, the insurer shall notify in accordance with OAR 436-015-0035 all affected insured employers and injured workers of the manner in which injured workers will receive medical services.

(4) When the insurer is enrolling a worker in an MCO, the insurer shall simultaneously provide written notice to the worker, all medical service providers, and the MCO of enrollment. The notice shall:

(a) Notify the worker of the eligible attending physicians within the relevant MCO geographic service area and describe how the worker may obtain the names and addresses of the complete panel of MCO medical providers;

(b) Advise the worker of the manner in which the worker may receive medical services for compensable injuries within the MCO;

(c) Describe how the worker can receive compensable medical treatment from a primary care physician or authorized nurse practitioner qualified to provide services as described in OAR 436-015-0070, who is not a member of the MCO, including how to request qualification of their primary care physician or authorized nurse practitioner;

(d) Advise the worker of the right to choose the MCO when more than one MCO contract covers the worker's employer except when the employer provides a coordinated health care program as defined in OAR 436-010-0005(5);

(e) Provide the worker with the title, address and telephone number of the contact person at the MCO responsible for ensuring the timely resolution of complaints or disputes;

(f) Advise the worker of the time lines for appealing disputes beginning with the MCO's internal dispute resolution process through administrative review before the director, that disputes to the MCO must be in writing and filed within 30 days of the disputed action and with whom the dispute is to be filed, and that failure to request review to the MCO precludes further appeal; and

(g) Notify the MCO of any request by the worker for qualification of a primary care physician or authorized nurse practitioner.

(5) Insurers under contract with MCOs who enroll workers prior to claim acceptance shall inform the worker in writing that the insurer will pay as provided in ORS 656.248 for all reasonable and necessary medical services received by the worker that are not otherwise covered by health insurance, even if the claim is denied, until the worker receives actual notice of the denial or until three days after the denial is mailed, whichever occurs first.

(6) Insurers enrolling a worker who is not yet medically stationary and is required to change medical providers, shall notify the worker of the right to request review by the MCO if the worker believes the change would be medically detrimental.

(7) If, at the time of MCO enrollment, the worker's medical service provider is not a member of the MCO and does not qualify as a primary care physician or authorized nurse practitioner, the insurer shall notify the worker and medical service provider regarding provision of care under the MCO contract, including the provisions for continuity of care.

(8) When an insurer under contract with an MCO receives a dispute regarding a matter that is to be resolved through the MCO dispute resolution process and that dispute has not been simultaneously provided to the MCO, the insurer shall within 14 days:

(a) Send a copy of the dispute to the MCO; or

(b) If the MCO does not have a dispute resolution process for that issue, the insurer shall notify the parties in writing to seek administrative review before the director.

(9) The insurer must also notify the MCO of the name, address, and telephone number of the worker and, if represented, the name of the worker's attorney, and must keep the MCO informed of any changes.

(10) Insurers under contract with MCOs shall maintain records as requested including, but not limited to, a listing of all employer's covered by MCO contracts, their WCD employer numbers, the estimated number of employees governed by each MCO contract, a list of all injured workers enrolled in the MCO, and the effective dates of such enrollments.

Stat. Auth: ORS 656.726(4)

Stat. Implemented: ORS 656.252, 656.325, 656.245, 656.248, 656.260 & 656.264

Hist.: WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; 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

436-010-0280
Determination of Impairment

(1) The attending physician or authorized nurse practitioner shall notify the insurer of the date on which the worker became medically stationary from the compensable injury or illness and whether or not the worker is released to any form of work. The medically stationary date should not be a projected date and should relate to an examination. On disabling claims, when finding or notification that the worker is medically stationary, an authorized nurse practitioner shall refer the worker to a qualified attending physician to complete a closing examination.

(2) The attending physician shall perform a closing examination pursuant to OAR 436-030-0020(2) and submit the closing report within 14 days of the examination in which the worker was determined medically stationary, or shall arrange or request the insurer to arrange for the worker to be examined by a consulting physician for all or any part of the closing examination within five days of the examination in which the worker is declared medically stationary.

(3) A closing examination shall be performed when the attending physician is notified by the insurer that the worker's accepted injury is no longer the major contributing cause of the worker's condition and a denial has been issued. The attending physician shall submit a closing report within 14 days of the examination. If the attending physician refers the worker to a consulting physician for all or any part of the closing examination, the examination shall be scheduled within five days of the denial notification. Upon notification that the worker's accepted condition in a disabling claim is no longer the major contributing cause of the worker's condition, an authorized nurse practitioner shall refer the worker to a qualified attending physician to complete a closing examination.

(4) Closing reports for examinations performed by a specialist physician pursuant to this rule shall be submitted to the attending physician within seven days of the examination. The attending physician must review the report and, within seven days of receipt of the report, concur in writing or provide a report to the insurer describing any finding/conclusion with which the attending physician disagrees.

(5) The physician conducting the examination shall provide all objective findings of impairment pursuant to these rules and in accordance with OAR 436-035-0007.

(6) The closing examination report does not include any rating of impairment or disability, but describes impairment findings to be rated by either the insurer or the director. Physicians shall provide comments regard-

ing the validity of the examination findings as they pertain to the accepted compensable conditions.

(7) The director may prescribe by bulletin what comprises a complete closing report, including, but not limited to, those specific clinical findings related to the specific body part or system affected. The bulletin may also include the impairment reporting format or form to be used as a supplement to the narrative report.

(8) The attending physician shall specify the worker's residual functional capacity or refer the worker for completion of a second level PCE or WCE (as described in OAR 436-009-0070(4) pursuant to the following:

(a) A PCE when the worker has not been released to return to regular work, has not returned to regular work, has returned to modified work, or has refused an offer of modified work.

(b) A WCE when there is question of the worker's ability to return to suitable and gainful employment. It may also be required to specify the worker's ability to perform specific job tasks.

(9) When the worker's condition is not medically stationary and a denial has been issued because the worker's accepted injury is no longer the major contributing cause of the worker's condition, the physician shall estimate the worker's future impairment and residual functional capacity pursuant to OAR 436-035-0007(5).

Stat. Auth: ORS 656.726(4) & 656.245(2)(b)(B)
Stats. Implemented: ORS 656.245 & 656.252
Hist.: WCD 5-1982(Admin), f. 2-23-82, ef. 3-1-82; WCD 1-1984(Admin), f. & ef. 1-16-84; Renumbered from 436-069-0601, 5-1-85; 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 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 436-010-0080; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-99; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-010-0340
Sanctions and Civil Penalties

(1) If the director finds any medical provider in violation of the medical reporting requirements established pursuant to ORS 656.245, 656.252, and 656.254(1), as found in OAR 436-009 and 436-010, the director may impose one or more of the following sanctions:

(a) Reprimand by the director;

(b) Non-payment, reduction or recovery of fees in part, or whole, for services rendered;

(c) Referral to the appropriate licensing board; or

(d) Civil penalty not to exceed $1,000 for each occurrence. In determining the amount of penalty to be assessed, the director shall consider:

(A) The degree of harm inflicted on the worker or the insurer;

(B) Whether there have been previous violations; and

(C) Whether there is evidence of willful violations.

(2) The director may impose a penalty of forfeiture of fees and a fine not to exceed $1,000 for each occurrence on any health care practitioner who, pursuant to ORS 656.254 and 656.327, has been found to:

(a) Fail to comply with the medical rules;

(b) Provide medical treatment that is excessive, inappropriate or ineffectual; or

(c) Engage in any conduct demonstrated to be dangerous to the health or safety of a worker.

(3) If the conduct as described in section (2) is found to be repeated and willful, the director may declare the practitioner ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years.

(4) A health care practitioner whose license has been suspended or revoked by the licensing board for violations of professional ethical standards may be declared ineligible for reimbursement for treating workers' compensation claimants for a period not to exceed three years. A certified copy of the revocation or suspension order shall be prima facie justification for the director's order.

(5) If a financial penalty is imposed on the attending physician or authorized nurse practitioner for violation of these rules, no recovery of penalty fees may be sought from the worker.

(6) If an insurer or worker believes sanctions under sections (1) or (2) of this rule are appropriate, either may submit a complaint in writing to the director.

(7) If the director finds an insurer in violation of the notification provisions of OAR 436-010 limiting medical treatment, the director may order the insurer to reimburse any affected medical service providers for services rendered until the insurer complies with the notification requirement. Any penalty shall be limited to the amounts listed in section (8) of this rule.

(8) If the director finds any insurer in violation of OAR 436-009 or 436-010, or an order of the director, the insurer may be subject to penalties pursuant to ORS 656.745 of not more than $2000 for each violation or $10,000 in the aggregate for all violations within any three month period. Each violation, or each day a violation continues, shall be considered a separate violation.

Stat. Auth: ORS 656726(4)
Stats. Implemented: ORS 656.245, 656.254 & ORS 656.745
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. 2-1-90; Renumbered from 436-010-0110(3)(4) & (7); 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 436-010-0130; WCD 11-1998, f. 12-16-98, cert. ef. 1-1-990; WCD 3-2000, f. 4-3-00, cert. ef. 4-21-00; WCD 13-2001, f. 12-17-01, cert. ef. 1-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0003
Applicability of Rules

(1) These rules govern vocational assistance pursuant to the Workers' Compensation Law on or after the effective date of these rules except as OAR 436-120 otherwise provides.

(2) The director's decisions under OAR 436-120-0008 regarding eligibility will be based on the rules in effect on the date the insurer issued the notice. The director's decisions regarding the nature and extent of assistance will be based on the rules in effect at the time the assistance was provided. If the director orders future assistance, such assistance shall be provided in accordance with the rules in effect at the time assistance is provided.

(3) Under these rules a claim for aggravation or reopening a claim to process a newly accepted condition will be considered a new claim for purposes of vocational assistance eligibility and vocational assistance, except as otherwise provided in these rules.

(4) The requirement for the director's advance approval of services eligible for claims cost reimbursement pursuant to OAR 436-120-0720(7) shall apply to any actions taken after the effective date of these rules.

(5) Applicable to this chapter, the director may, unless otherwise obligated by statute, in the director's discretion waive procedural rules as justice so requires.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.283(2) & ORS 656.340
Hist.: WCB 1-1976, f. 3-29-76, ef. 4-1-76; WCD 3-1977(Admin)(Temp), f. 9-29-77, ef. 10-4-77; WCD 1-1978(Admin), f. & ef. 2-1-78; WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0004, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0004
Notices and Reporting Requirements

(1) The insurer shall inform a worker with a compensable injury of the employment reinstatement rights and responsibilities of the worker under ORS Chapter 659A and this rule. This information shall be given:

(a) At the time of claim acceptance, pursuant to ORS 656.262(6);

(b) At the time of contact of the worker under OAR 436-120-0320 about the need for vocational assistance, pursuant to ORS 656.340(2); and

(c) Within five days of receiving knowledge of the attending physician's release of the worker to return to work, pursuant to ORS 656.340(3), the insurer shall inform the worker about the opportunity to seek reemployment or reinstatement under ORS 659A.043 and 659A.046, and inform the employer about the worker's reemployment rights.

(2) All notices and warnings to the worker issued pursuant to OAR 436-120 shall be in writing, signed and dated, and state the basis for the decision, the effective date of the action, the relevant rule(s), the worker's appeal rights required pursuant to this rule, and the telephone number of the Ombudsman for Injured Workers. However, the insurer's response does not need to be in writing when the insurer approves a worker's request for a particular vocational service. All notices and warnings are subject to the following conditions:

(a) The following headings shall be used for the following notices. Should one notice be used for multiple actions, all appropriate headings shall be listed:

(A) Eligibility: NOTICE OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(B) Ineligibility: NOTICE OF INELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(C) Selection or change of provider: SELECTION OF (OR CHANGE OF) VOCATIONAL ASSISTANCE PROVIDER, EFFECTIVE (date)

(D) Category of assistance: NOTICE OF VOCATIONAL EVALUATION TO BEGIN (date) or NOTICE OF ENTITLEMENT TO TRAIN-

ING, EFFECTIVE (date) or NOTICE OF ENTITLEMENT TO DIRECT EMPLOYMENT SERVICES, EFFECTIVE (date)

(E) End of training: NOTICE OF TRAINING END, EFFECTIVE (date)

(F) End of eligibility: NOTICE OF END OF ELIGIBILITY FOR VOCATIONAL ASSISTANCE, EFFECTIVE (date)

(b) Warning letters do not require specific language in the headings but should include a heading clearly indicating the purpose of the warning.

(c) The insurer shall simultaneously send a copy to the worker's representative. Failure to send a copy of the notice to the worker's representative stays the appeal period until the worker's representative receives actual notice.

(d) All notices and warnings except those notifying a worker of eligibility or entitlement to training shall contain the worker's appeal rights in bold type, as follows:

"If you disagree with this decision, you should contact (person's name and insurer) within five days of receiving this letter to discuss your concerns.
If you are still dissatisfied, you must contact the Workers' Compensation Division within 60 days of receiving this letter or you will lose your right to appeal this decision. A consultant with the division can talk with you about the disagreement and, if necessary, will review your appeal. The address and telephone number of the division are: (address and telephone number of the Workers' Compensation Division)."

(3) If the insurer is unable to determine eligibility or make a decision regarding a particular vocational service because of insufficient data, the insurer shall explain what information is necessary and when it expects to determine eligibility or make a decision.

(4) Notice of Eligibility for vocational assistance shall include the following:

(a) Selection of the category of vocational assistance, if known;

(b) The worker's rights and responsibilities;

(c) Procedures for resolving dissatisfaction with an action of the insurer regarding vocational assistance;

(d) The current list of vocational assistance providers, and an explanation of the worker's participation in the selection of a vocational assistance provider. This notice shall include the following language in bold type:

"If you have questions about the vocational counselor selection process, contact (use appropriate reference to the insurer). If you still have questions contact the Workers' Compensation Division's toll free number (use appropriate telephone number)."

(e) Information about potential reemployment assistance under OAR 436-110.

(5) Notice of Ineligibility for vocational assistance is subject to the following conditions:

(a) The notice shall be sent to the worker by both regular and certified mail.

(b) The notice shall include information about services which may be available at no cost from the Employment Department or the Office of Vocational Rehabilitation Services, and reemployment assistance under OAR 436-110.

(c) If the notice is based on a finding of "no substantial handicap," it shall list some suitable occupations.

(d) If the insurer is not required to determine eligibility pursuant to OAR 436-120-0320(2), no Notice of Ineligibility is required unless the worker or worker's representative requested a determination of eligibility. When the ineligibility is due to no permanent disability award, the notice must inform the worker of entitlement to an eligibility determination upon a final order granting permanent disability.

(6) Notice of Denial of Vocational Service shall be given by the insurer.

(7) Notice of Selection of Category of Vocational Assistance shall be given by the insurer. When direct employment services are selected, the notice shall state the worker is not entitled to training.

(8) The approved, denied or amended return-to-work plan shall be sent to the worker. Notification of Denial of Return-to-Work Plan shall identify any components of the plan that the insurer did not approve.

(9) Notice of End of Training shall state whether the worker is entitled to further training. The effective date of the end of training letter shall be the worker's last date of attendance.

(10) Notice of End of Eligibility for vocational assistance shall be sent by both regular and certified mail to the worker.

(11) Warnings to the worker shall state what the worker must do within a specified time to avoid ineligibility or the ending of eligibility or training.

(12) The insurer shall simultaneously send a copy of the following notices to the department:

(a) Notice of Eligibility;

(b) Notice of Ineligibility;

(c) Approved Return-to-Work Plan and any amendments;

(d) Notice of End of Training; and

(e) Notice of Ending of Eligibility for Vocational Assistance.

(13) The insurer shall file a closing status report with the division for each eligible worker within 30 days after eligibility ends. The insurer shall report the following information:

(a) The date and reason for ending of eligibility, return-to-work and vocational assistance provider information.

(b) For post-1985 injuries, the insurer shall also report cost information for eligibility determination and vocational services provided under these rules as required by the director.

Stat. Auth.: ORS 656.340(9), 656.726(3) & ORS 192.410-192.505
Stats. Implemented: ORS 656.340(5) & ORS 656.340(7)
Hist.: WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0600, 436-120-0610 & 436-120-0620 [WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0008
Administrative Review and Contested Cases

(1) Administrative review of vocational assistance matters: Under ORS 656.283(2) and 656.340(4), a worker wanting review of any vocational assistance matter must apply to the director for administrative review. Also, under ORS 656.340(11) and OAR 436-120-0320(10) when the worker and insurer are unable to agree on a vocational assistance provider, the insurer shall apply to the director for administrative review. Because effective vocational assistance is best realized in a nonadversarial environment, the first objective of the administrative review is to bring the parties to resolution through alternative dispute resolution procedures, including mediation conferences, whenever possible and appropriate. When a dispute is not resolved through mutual agreement or dismissal, the director shall close the record and issue a Director's Review and Order as described in subsections (f) and (g) of this section. A worker need not be represented to request or to participate in the administrative review process, which is as follows:

(a) The worker's request for review must be mailed or otherwise communicated to the department no later than the 60th day after the date the worker received written notice of the insurer's action; or, if the worker was represented at the time of the notice, within 60 days of the date the worker's representative received actual notice. Issues raised by the worker where written notice was not provided may be reviewed at the director's discretion.

(b) The worker, insurer, employer at injury, and vocational assistance provider shall supply needed information, attend conferences and meetings, and participate in the administrative review process as required by the director. Upon the director's request, any party to the dispute shall provide available information within 14 days of the request. The insurer shall promptly schedule, pay for, and submit to the director any medical or vocational tests, consultations, or reports required by the director. The worker, insurer, employer at injury, or vocational assistance provider shall simultaneously send copies to the other parties to the dispute when sending material to the director. If necessary, the director will assist an unrepresented worker in sending copies to the appropriate parties. Failure to comply with this subsection may result in the following:

(A) If the worker fails to comply without reasonable cause, the director may dismiss the administrative review as described in subsection (d); or, the director may decide the issue on the basis of available information.

(B) If the insurer, vocational assistance provider, or employer at injury fails to comply without reasonable cause, the director may decide the issue on the basis of available information.

(c) At the director's discretion, the director may issue an order of deferral to temporarily suspend administrative review. The order of deferral will specify the conditions under which the review will be resumed.

(d) The director may issue an order of dismissal under appropriate conditions.

(e) The director shall issue a letter of agreement when the parties resolve a dispute within the scope of these rules. Any agreement may include an agreement on attorney fees, if any, to be paid to the worker's attorney. The agreement 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 reconsider approval of the agreement upon the director's own motion or upon a motion by a party. The director may revise the agreement or reinstate the review only under one or more of the following conditions:

(A) One or both parties fail 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 of the review.

(f) After the parties have had the opportunity to present evidence, and any meetings or conferences deemed necessary by the director have been held, the director shall issue a final order, including the notice of record contents. The parties will have 60 days from the issuance of the order to request a contested case hearing before the director.

(g) 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 also may request reconsideration of an administrative order upon an allegation of error, omission, misapplication of law, incomplete record, or the discovery of new material evidence 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 for reconsideration must be mailed before the administrative order becomes final, or if appealed, before the contested case order is issued.

(h) During any reconsideration of the administrative review order, the parties may submit new material evidence consistent with this rule and may respond to such evidence submitted by others.

(i) Any party requesting reconsideration or responding to a reconsideration request shall simultaneously notify all other interested parties of their contentions and provide them with copies of all additional information presented.

(j) A request for reconsideration does not stay the 60-day time period within which the parties must request a contested case hearing.

(2) Attorney fees: In any dispute in which a represented worker prevails after a proceeding has commenced before the director, the director shall award an attorney fee to be paid by the insurer or self-insured employer as provided in ORS 656.385 (§2, ch. 756, OL 2003). The attorney fee will be proportionate to the benefit to the injured worker. Primary consideration shall be given to the results achieved and the time devoted to the case. Absent extraordinary circumstances or agreement by the parties, the fee may not exceed $2000, nor fall outside the ranges for fees as provided in the following matrix:

Estimated Benefit Achieved — Professional Hours Devoted
1-2 hours — 2.1-4 hours — 4.1-6 hours — 6.1-8 hours — 8.1-12 hours
$1-$2000 — $100-400 — $200-700 — $300-750 — $600-1000 — $800-1250
$2001-$4000 — $200-500 — $400-800 — $600-900 — $800-1300 — $1050-1500
$4001-$6000 — $300-700 — $600-1000 — $800-1250 — $1000-1450 — $1300-1750
$6001-$10000 — $400-900 — $800-1300 — $1050-1600 — $1350-1800 — $1550-2000

(a) An attorney must submit the following to the director in order to be awarded an attorney fee:

(A) A current, valid retainer agreement, and

(B) A statement of hours spent on the case if greater than two hours. In the absence of such a statement, the director shall assume the time spent on the case was 1-2 hours.

(b) In determining the value of the results achieved, the director may consider, but is not limited to the following:

(A) Where there is a return-to-work plan that includes the disputed service(s), the assumed value is the cost of the disputed service(s) as projected in the plan;

(B) Where the service(s) have not been incorporated in an existing return-to-work plan, the assumed value is the actual or projected cost of the service(s) up to the amount allowed in the fee schedule provided in OAR 436-120-0720;

(C) For the purposes of applying the matrix, the value of an eligibility determination is assumed to be the maximum allowed in the fee schedule provided in OAR 436-120-0720 for completing an eligibility evaluation; the value of vocational assistance or a training plan, unless determined to be otherwise, is assumed to fall within the highest category provided in the above matrix; or

(D) A written agreement between the parties regarding the value of the benefit to the worker submitted to the director prior to the issuance of an order.

(c) If any party believes extraordinary circumstances exist that justify a fee outside of the ranges provided in the above matrix or above $2000, they may submit a written or faxed statement of the extraordinary circumstances to the director.

(d) In order to provide parties an opportunity to inform the director of agreements, or submit statements of extraordinary circumstances or professional hours for consideration in determining the attorney fee, the director will provide the parties notice by phone or fax at least 3 business days in advance that an order or other written resolution of the dispute will be issued. Any information or statements provided to the director must simultaneously be provided to all other parties to the dispute.

(e) An assessed attorney fee shall be paid within 30 days of the date the order authorizing the fee becomes final.

(3) Contested cases regarding the director's administrative review: Under ORS 656.283, orders issued under subsection (1)(f) of this rule and dismissals issued under subsection (1)(d) of this rule may be appealed to the director for a contested case hearing as follows:

(a) The party must send the request for hearing in writing to the administrator of the Workers' Compensation Division and shall simultaneously send a copy of the request to the other party(ies). The request must specify the grounds upon which the order is contested.

(b) The party must mail the request to the division within 60 days of the date of the order.

(c) The hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(4) Contested cases regarding jurisdiction or reimbursement of costs: Under ORS 183.310 through 183.550 and 656.704(2), a worker may appeal an order of dismissal based on lack of jurisdiction under subsection (1)(d) of this rule, or, under ORS 183.310 through 183.550 and 656.704(2), an insurer may appeal department denial of reimbursement for vocational assistance costs under OAR 436-120-0730, as follows:

(a) The party must send the request for hearing to the administrator of the Workers' Compensation Division. The party must also simultaneously send a copy of the request to the other party(ies). The request must specify the grounds upon which the denial is contested.

(b) The party must mail the request to the division no later than the 30th day after the party received the dismissal or written denial.

(c) The hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

(5) Contested case hearings of civil penalties: Under ORS 656.740 an insurer or an employer may appeal a proposed order or proposed assessment of civil penalty pursuant to ORS 656.745 and OAR 436-120-0900 as follows:

(a) The insurer or employer must send the request for hearing in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the proposed order or assessment is contested.

(b) The party must file the request with the division within 60 days after the mailing date of the notice of the proposed order or assessment.

(c) The division shall forward the request and other pertinent information to the Hearings Division of the Workers' Compensation Board.

(d) The Hearings Division shall conduct the hearing in accordance with ORS 656.740 and ORS Chapter 183.

(6) Contested case hearings of sanctions and denials of certification or authorization by the director: Under ORS 183.310 through 183.550, an insurer sanctioned pursuant to ORS 656.447 and OAR 436-120-0900, a vocational assistance provider or certified individual sanctioned pursuant to ORS 656.340(9)(b) and OAR 436-120-0915, a vocational assistance provider denied authorization pursuant to ORS 656.340(9)(a) and OAR 436-120-0800, or an individual denied certification pursuant to ORS 656.340(9)(a) and OAR 436-120-0810 may appeal as follows:

(a) The party must send the request for administrative review in writing to the administrator of the Workers' Compensation Division. The request must specify the grounds upon which the action is contested.

(b) The party must mail the request to the division no later than the 60th day after the party received notification of the action, unless the director determines there was good cause for delay or that substantial injustice may otherwise result.

(c) The hearing will be conducted in accordance with the rules governing contested case hearings in OAR 436-001.

Stat. Auth.: ORS 656.704(2) & 656.726(4)
Stats. Implemented: ORS 183.310-183.555, 656.283(2), 656.340, 656.447, 656.740, 656.745
Hist.: WCD 9-1982(Admin), f. 5-28-82, ef. 6-1-82; WCD 2-1983(Admin), f. & ef. 6-30-83; Renumbered from 436-061-0970, 5-1-85; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0191, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0210 & 436-120-0260; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 14-2003(Temp), f. 12-15-03, cert. ef. 1-1-04 thru 6-28-03; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0320
Determining Eligibility for Vocational Assistance and Selection of Vocational Assistance Provider

(1) Unless one of the provisions in section (2) below applies, the insurer shall contact a worker with an accepted disabling claim or claim for

aggravation to begin the eligibility determination within five days of the following:

(a) The insurer's receipt of a request for vocational assistance from the worker. If the insurer does not know the worker's permanent limitations, the insurer shall contact the attending physician within 14 days of receiving the request for vocational assistance. The insurer shall notify the worker if the eligibility determination is postponed until permanent restrictions are known or can be projected.

(b) The insurer's receipt of a medical or investigative report sufficient to document a need for vocational assistance, including medical verification of projected or actual permanent limitations due to the injury.

(c) The insurer's knowledge that the claim qualifies for closure because the worker is medically stationary. If the claim qualifies for closure under ORS 656.268(1)(b) or (c), the insurer may postpone the determination until the worker is medically stationary or until permanent restrictions are known or can be projected, whichever occurs first.

(d) The worker is granted a permanent disability award.

(2) The insurer is not required to determine eligibility if:

(a) Eligibility has previously been determined under the current opening of the claim and there are no newly accepted conditions;

(b) The worker has returned to regular or other suitable employment with the employer at injury or aggravation; or

(c) The worker's claim was closed with no permanent disability award. The following by themselves do not make a worker ineligible for vocational assistance:

(A) A finding that a worker is not entitled to an additional award of permanent disability

on aggravation, or

(B) A finding that a worker is not entitled to a permanent disability award because of an offset of permanent disability from a prior claim, or

(C) The worker disposes of permanent disability through a claim disposition agreement (CDA).

(3) If the insurer receives a request for vocational assistance from the worker or the worker's representative and the insurer is not required to determine eligibility under section (2), the insurer shall notify the worker in writing, within 14 days of the request and provide:

(a) The reasons the insurer is not required to determine eligibility,

(b) The circumstance which would require the insurer to determine eligibility, and

(c) The appropriate telephone number of the division, with instructions to contact the division with questions about vocational assistance eligibility requirements and procedures.

(4) Nothing in these rules prevents the insurer from finding a worker eligible and providing vocational assistance at any time.

(5) The insurer shall complete the eligibility determination within 30 days of the contact required in section (1) or if the eligibility determination was postponed within 30 days of receipt of verification of projected or actual permanent limitations.

(6) A vocational counselor certified under OAR 436-120 shall determine if a worker meets eligibility criteria.

(7) The insurer shall provide the vocational counselor with all existing relevant medical information regarding the worker's physical capacities and limitations.

(8) After the worker's permanent limitations are known or can be projected, the worker shall, upon written request from the insurer, provide vocationally relevant information needed to determine eligibility within a reasonable time set by the insurer.

(9) A worker entitled to an eligibility evaluation is eligible for vocational services if all the following additional conditions are met:

(a) The worker is authorized to work in the United States.

(b) The worker is available in Oregon for vocational assistance. The insurer shall consider the worker available in Oregon if the worker lives within commuting distance of Oregon or documents, in writing, willingness to relocate to or within commuting distance of Oregon within 30 days of being found eligible. The worker is responsible for costs associated with being available in Oregon. The requirement that the worker be available in Oregon for vocational assistance does not apply if the Oregon subject worker did not work and live in Oregon at the time of the injury.

(c) As a result of the limitations caused by the injury or aggravation, the worker:

(A) Is not able to return to regular employment;

(B) Is not able to return to any other suitable and available work with the employer at injury or aggravation; and

(C) Has a substantial handicap to employment and requires assistance to overcome that handicap.

(d) None of the reasons for ineligibility under OAR 436-120-0350 applies under the current opening of the claim.

(10) Upon determining the worker eligible, the insurer and worker shall jointly select a vocational assistance provider. No later than 20 days from the date the insurer determined the worker eligible, the insurer shall either notify the worker of the selection of vocational assistance provider, or if the parties are unable to agree, refer the dispute to the director. The worker and insurer shall follow the same procedure to select a new vocational assistance provider.

(11) Unless all parties otherwise agree in writing, vocational assistance will be due at any given time with respect only to one claim of the worker. If the worker is eligible for vocational assistance under two or more claims, and there is a dispute about which claim gives rise to the need for vocational assistance pursuant to these rules, the director will select the claim for the injury which results in the most severe vocational impact. If services are provided under more than one claim at a time pursuant to a written agreement of all parties, time and fee limits may extend beyond the limits otherwise imposed in these rules.

Stat. Auth.: ORS 656.726(4) & ORS 656.340(9)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0111, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from OAR 436-120-0060; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0035; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0330 & 436-120-0370; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0340
Determining Substantial Handicap

(1) A certified vocational counselor shall perform a substantial handicap evaluation as part of the eligibility determination unless the insurer finds that the worker has a substantial handicap to employment.

(2) To complete the substantial handicap evaluation the vocational counselor shall submit a report documenting the following information:

(a) Relevant work history for at least the preceding five years;

(b) Level of education, proficiency in spoken and written English or other languages, where relevant, and achievement or aptitude test data if it exists;

(c) Adjusted weekly wage as determined under OAR 436-120-0007 and suitable wage as defined by OAR 436-120-0005(13);

(d) Permanent limitations due to the injury;

(e) An analysis of the worker's transferable skills, if any;

(f) A list of physically suitable jobs for which the worker has the knowledge, skills and abilities, which pay a suitable wage, and for which a reasonable labor market is documented to exist as described in subsection (g) below;

(g) An analysis of the worker's labor market utilizing standard labor market reference materials including but not limited to Employment Department (OED) information such as Oregon Wage Information (OWI), Oregon Comprehensive Analysis File and other publications of the Occupational Program Planning System (OPPS) and material developed by the division. When using the OWI data, the presumed standard shall be the 10th percentile unless there is sufficient evidence that a higher or lower wage is more appropriate. When such data is not sufficient to make a decision about substantial handicap, the vocational counselor shall perform individual labor market surveys as described in OAR 436-120-0410(6); and

(h) Consideration of the vocational impact of any limitations which existed prior to the injury.

Stat. Auth.: ORS 656.726(4)
Stats. Implemented: ORS 656.340(5) & (6)
Hist.: WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0350
Ineligibility and End of Eligibility for Vocational Assistance

A worker is ineligible or the worker's eligibility ends when any of the following conditions apply:

(1) The worker does not or no longer meets the eligibility requirements as defined in OAR 436-120-0320. The insurer must have obtained new information which did not exist or which the insurer could not have discovered with reasonable effort at the time the insurer determined eligibility.

(2) The worker is determined not to have permanent disability after a finding of eligibility.

(3) The worker's lack of suitable employment is not due to the limitations caused by the injury or which existed before the injury.

(4) The worker has been employed at least for 60 days in suitable employment after the injury or aggravation and any necessary worksite modification is in place.

(5) The worker, prior to beginning an authorized return-to-work plan, refused an offer of suitable employment, or left suitable employment after the injury or aggravation for a reason unrelated to the limitations due to the compensable injury. If the employer-at-injury offers employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(6) The worker, prior to beginning an authorized return-to-work plan, refused or failed to make a reasonable effort in available light-duty work intended to result in suitable employment. Prior to finding the worker ineligible or ending eligibility, the insurer shall document the existence of one or more suitable jobs which would have been available for the worker upon successful completion of the light-duty work. If the employer-at-injury offers such employment to a non-medically stationary worker, the offer must be made in accordance with OAR 436-060.

(7) The worker, after completing an authorized training plan, refused an offer of suitable employment.

(8) The worker has declined or has become unavailable for vocational assistance for reasonable cause. If the insurer does not believe the worker had reasonable cause, the insurer shall warn the worker prior to finding the worker ineligible or ending the worker's eligibility under this section.

(9) The worker has failed, after written warning, to participate in the vocational assistance process, or to provide relevant information. No written warning is required if the worker refuses a suitable training site after the vocational counselor and worker have agreed in writing upon a return-to-work goal.

(10) The worker has failed, after written warning, to comply with the return-to-work plan. No written warning is required if the worker fails to attend 2 consecutive training days and fails, without reasonable cause, to notify the vocational counselor or the insurer.

(11) The worker's lack of suitable employment cannot be resolved by providing vocational assistance. This includes circumstances in which the worker cannot benefit from, or participate in, vocational assistance because of medical conditions unrelated to the injury.

(12) The worker has misrepresented a matter material to evaluating eligibility or providing vocational assistance.

(13) The worker has refused, after written warning, to return property provided by the insurer or reimburse the insurer after the insurer has notified the worker of the repossession; or the worker has misused funds provided for the purchase of property or services. No vocational assistance shall be provided under the current or subsequent openings of the claim until the worker has returned the property or reimbursed the funds.

(14) The worker physically abused any party to the vocational process, or after written warning, has continued to sexually harass or threaten to physically abuse any party to the vocational process. This section does not apply if such behavior is the result of a documented medical or mental condition. In such a situation, eligibility should be ended under section (11) of this rule.

(15) The worker has entered into a claim disposition agreement (CDA) which disposes of vocational assistance eligibility. The parties may agree in writing to suspend vocational services pending approval by the Workers' Compensation Board (Board). The insurer shall end eligibility when the Board approves the CDA. No notice regarding the end of eligibility is required.

(16) The worker has received maximum direct employment services and is not entitled to other categories of vocational assistance.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1982(Temp), f. 12-29-82 eff. 1/1/83; WCD 2-1983, 6-30-83, eff. 6-30-83; WCD 5-1983, 12-14-83, eff. 1-1-84; Renumbered from OAR 436-061-0126, 5-1-85; WCD 7-1985, 12-12-85, eff. 1/1/86; Renumbered from OAR 436-120-0090, WCD 11-1987, 12-17-87, eff. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from OAR 436-120-0045; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0360
Redetermining Eligibility for Vocational Assistance

If a worker was previously found ineligible or the worker's eligibility ended for any of the reasons specified in sections (1) through (8), or any of the conditions described in sections (9) through (11) exists, the insurer shall redetermine eligibility upon notification of a change of circumstances. The insurer shall complete the eligibility evaluation within 35 days of the following:

(1) The worker, for reasonable cause, declined or was not available for vocational assistance, or the barrier causing the worker's lack of suitable employment could not be resolved by providing vocational assistance, and those circumstances have changed. The insurer may require the worker to provide documentation the barrier no longer exists, including medical or psychological reports relating to noncompensable conditions.

(2) The worker was not available in Oregon, and the worker becomes available. The worker must request redetermination within six months of the worker's receipt of the insurer's notice.

(3) The worker's claim was denied, and the claim is later accepted and all appeals exhausted.

(4) The worker was not awarded permanent disability and the worker is later awarded permanent disability.

(5) The worker was not authorized to work in the United States, and the worker is now authorized to work in the United States. The time limit set in this section applies to any worker found ineligible or whose eligibility ended because the worker was not authorized to work in the United States regardless of the date the notice of ineligibility or end of eligibility was issued. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker has applied for authorization to work in the United States and is awaiting a decision by the United States Immigration and Naturalization Service (INS). The worker shall promptly provide the insurer with a copy of any decision by the INS. The insurer shall redetermine eligibility upon receipt of documentation of the worker's authorization to work in the United States.

(6) The worker was unavailable for vocational assistance due to short-term incarceration for a matter unrelated to the worker's claim and is now available. Within six months of the date of the worker's receipt of the insurer's notice of ineligibility or end of eligibility, the worker must:

(a) Request redetermination; and

(b) Submit evidence to the insurer that the worker is now available to participate in vocational assistance.

(7) The worker returned to work prior to the worker becoming medically stationary, and the physician later rescinded the release.

(8) The worker returned to work prior to becoming medically stationary, and the worker requests a redetermination within 60 days of the mailing date of the Notice of Closure.

(9) Prior to claim closure a worker's limitations due to the injury became more restrictive.

(10) Prior to claim closure the insurer accepts a new condition which was not considered in the original determination of the worker's eligibility.

(11) The worker's temporary disability compensation is redetermined and increased. The worker must make a written request to the insurer to redetermine vocational eligibility within 60 days of receiving notification of the increase in temporary disability compensation.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; Renumbered from OAR 436-120-0095; 12/17/87 as WCD 11-1987, f. & ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from OAR 436-120-0055; WCD 23-1996; f. 12-13-96, cert. ef. 2-1-97; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 14-2001(Temp), f. 12-17-01, cert. ef. 1-2-02 thru 6-30-02; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0410
Vocational Evaluation

(1) When the insurer selects this category of vocational assistance, a certified vocational counselor shall complete the evaluation and report within 45 days, and provide a copy to all parties.

(a) Vocational testing shall be administered by an individual certified to administer the test.

(b) A work evaluation shall be performed by a Certified Vocational Evaluation Specialist (CVE), certified by the Commission on Certification of Work Adjustment and Vocational Evaluation Specialists.

(2) On-the-job evaluations shall evaluate a worker's work traits, aptitudes, limitations, potentials and habits in an actual job environment.

(a) First, the vocational counselor shall perform a job analysis to determine if the job is within the worker's capacities. The insurer shall submit the job analysis to the attending physician if there is any question about the appropriateness of the job.

(b) The evaluation should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(c) The evaluation does not establish any employer-employee relationship.

(d) A written report shall evaluate the worker's performance in the areas originally identified for assessment.

(3) Situational assessment is a procedure that evaluates a worker's aptitude or work behavior in a particular learning or work setting. It may focus on a worker's overall vocational functioning or answer specific questions about certain types of work behaviors.

(a) The situational assessment requires these steps: planning and scheduling observations; observing, describing and recording work behaviors; organizing, analyzing and interpreting data; and synthesizing data including behavioral data from other pertinent sources.

(b) The assessment should normally be no less than five hours daily for four consecutive days and should normally last no longer than 30 days.

(4) Work adjustment is work-related activities that assist workers in understanding the meaning, value, and demands of work. It may include the assistance of a job coach.

(5) Job analysis is a detailed description of the physical and other demands of a job based on direct observation of the job.

(6) Labor market surveys are obtained from direct contact with employers, other actual labor market information, or from other surveys completed within 90 days of the report date.

(a) A labor market survey is needed when standard labor market reference materials do not have adequate information upon which to base a decision, or there are questions about a worker's specific limitations, training and skills, which must be addressed with employers to determine if a reasonable labor market exists.

(b) The person giving the information must have hiring responsibility or direct knowledge of the job's requirements; and the job must exist at the firm contacted.

(c) The labor market survey report shall include, but is not limited to, the date of contact; firm name, address and telephone number; name and title of person contacted; the qualifications of persons recently hired; physical requirements; wages paid; condition of hire (full-time, part-time, seasonal, temporary); date and number of last hire(s); and available and anticipated openings.

(d) Specific openings found in the course of a labor market survey are not, in themselves, proof a reasonable labor market exists.

(7) The vocational evaluation report shall include an analysis of all vocational information, and a recommendation of the category of vocational assistance needed for the worker to obtain suitable employment. The report must include the worker's signature indicating the worker has read and received a copy of the report. The signature does not imply the worker's agreement with the conclusions of the evaluation. The worker may attach written comments to the evaluation report.

(8) Upon receipt of the vocational evaluation report, the insurer shall notify the worker within 10 days whether the worker will receive direct employment services or training, or that the worker is unable to benefit from vocational assistance.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340(7)
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef 1-1-95; Renumbered from 436-120-0081; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00, Renumbered from 436-120-0420; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0500
Return-to-Work Plans: Development and Implementation

(1) A return-to-work plan should be a collaborative effort between the vocational counselor and the injured worker, and should include all the rights and responsibilities of the worker, the insurer, and the vocational counselor. Prior to submitting the plan to the insurer, the vocational counselor shall review the plan and plan support with the worker. Certain information may be excluded, as allowed by OAR 436-010. The injured worker must be given the opportunity to review the plan with the worker's representative prior to signing it. The vocational assistance provider shall confirm the worker's understanding of and agreement with the plan by obtaining the worker's signature. The counselor shall submit copies signed by the vocational counselor and the worker to all parties no later than 30 days after the selection of direct employment or 60 days after the selection of training. Circumstances beyond the insurer's and worker's control may necessitate an extension of this time frame.

(2) Within 14 days of receipt of the signed return-to-work plan, the insurer shall approve or reject the plan and notify the parties. If the insurer lacks sufficient information to make a decision, the insurer shall advise the parties what information is needed and when it expects to make a decision.

(3) If, during development of a return-to-work plan, an employer offers the worker a job, the insurer shall perform a job analysis, obtain approval from the attending physician, verify the suitability of the wage, and confirm the offer is for a bona fide, suitable job as defined in OAR 436-120-0005(12). If the job is suitable, the insurer shall help the worker return to work with the employer. The insurer shall provide return-to-work follow-up during the first 60 days after the worker returns to work. If return to work with the employer is unfeasible or, during the 60-day follow-up the job proves unsuitable, the insurer shall immediately resume development of the return-to-work plan.

(4) If the vocational goal or category of assistance is later changed, the insurer shall amend the plan. All amendments to the plan shall be initialed by the insurer, vocational assistance provider, and the worker.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340(9)
Hist.: WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0172, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from OAR 436-120-0105 & 436-120-0170; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 23-1996, f. 12-13-96, cert. ef. 2-1-97; Renumbered from 436-120-0600, WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0710
Direct Worker Purchases: Kinds

The insurer shall provide the direct worker purchases described in sections (1) through (12) of this rule without regard to the worker's pre- or post-injury income. The insurer may not require the worker to submit a financial statement in order to qualify for direct worker purchases listed in sections (1) through (12). In determining the necessity of direct worker purchases described in sections (13) through (18), the insurer shall consider, among all factors, the worker's pre-injury net income as compared with the worker's post-injury net income. Permanent partial disability award payments shall not be considered as income. For the insurer to find the purchase necessary, the worker's pre-injury net income, as adjusted by the cost-of-living matrix, must be greater than the worker's post-injury net income, unless the worker can establish financial hardship. The insurer may require the worker to provide information about expenditures or family income when the worker claims a financial hardship.

(1) Tuition, fees, books and supplies for training or studies. Payment is limited to those items identified as mandatory by the instructional facility, trainer or employer. The insurer shall pay the cost in full, and shall not require the worker to apply for grants to pay for tuition, books or other expenses associated with training.

(2) Wage reimbursement for on-the-job training. The amount shall be stipulated in a contract between the training employer and the insurer.

(3) Travel expenses for transportation, meals and lodging required for participation in vocational assistance. For the purposes of this section, "participation in vocational assistance" includes, but is not limited to job search, required meetings with the vocational assistance provider, and meetings with employers or at training sites as required by the plan or plan development. The conditions and rates for payment of travel expenses are as follows:

(a) Transportation. Costs shall be paid at public transportation rates when public transportation is available; otherwise, mileage shall be paid at the rate of reimbursement for State of Oregon classified employees. Costs incidental to mileage, such as parking fees, also shall be paid. For workers receiving temporary total disability or equivalent income, private car mileage shall be paid only for mileage in excess of the miles the worker traveled to and from work at the time of injury. Mileage payment in conjunction with moving expenses shall be allowed only for one vehicle and for a single one-way trip. To receive reimbursement for private car mileage, the worker must provide the insurer with a copy of the driver's valid driver's license and proof of insurance coverage.

(a) Meals and lodging, overnight travel. For overnight travel, meal and lodging expense shall be reimbursed at the rate of reimbursement for State of Oregon classified employees.

(c) Special travel costs. Payment shall be made in excess of the amounts specified in this section when special transportation or lodging is necessary because of the physical needs of the worker, or when the insurer finds prevailing costs in the travel area are substantially higher than average.

(4) Tools and equipment for training or employment. Payment is limited to items identified as mandatory for the training or initial employment, such as starter sets. Purchases shall not include what the trainer or employer ordinarily would provide to all employees or trainees in the training or employment, or what the worker possesses.

(5) Moving expenses. Payment is limited to workers with employment or training outside reasonable commuting distance. In determining the necessity of paying moving expenses, the insurer may consider the availability of employment or training which does not require moving, or which

requires less than the proposed moving distance. Payment is limited to moving household goods weighing not more than 10,000 pounds. If necessary, payment includes reasonable costs of meals and lodging for the worker's family and mileage pursuant to subsection (3)(a) of this rule.

(6) Second residence allowance. The purpose of the second residence is to enable the worker to participate in training outside reasonable commuting distance. The allowance shall equal the rental expense reasonably necessary, plus not more than $200 a month toward all other expenses of the second residence, excluding refundable deposits. In order to qualify for second residence allowance, the worker must maintain a permanent residence.

(7) Primary residence allowance. This allowance is applicable when the worker must change residence for training or employment. Payment includes the first month's rent and the last month's rent only if required prior to moving in.

(8) Medical examinations and psychological examinations for conditions not related to the compensable injury when necessary for determining the worker's ability to participate in vocational assistance.

(9) Physical or work capacities evaluations.

(10) Living expense allowance during vocational evaluation. Payment is limited to workers involved in a vocational evaluation at least five hours daily for four or more consecutive days, and not receiving temporary disability payments. The worker shall not be barred from receiving a living expense allowance if the worker is unable to participate five hours daily because of limitations caused by the injury. Payment shall be based on the worker's temporary total disability rate if the worker's claim were reopened.

(11) Work adjustment, on-the-job evaluation, or situational assessment cost(s).

(12) Membership fees and occupational certifications, licenses, and related testing costs. Payment under this category is limited to $500.

(13) Clothing required for participation in vocational assistance or for employment. Allowable purchases do not include items the trainer or employer would provide or the worker possesses.

(14) Child or disabled adult care services. These services are payable when required to enable the worker to participate in vocational assistance at rates prescribed by the State of Oregon's Department of Human Services. For workers receiving temporary total disability compensation or equivalent income, these costs shall be paid only when in excess of what the worker paid for such services at the time of injury, adjusted using the cost-of-living matrix.

(15) Dental work, eyeglasses, hearing aids and prosthetic devices. These are not related to the compensable injury and enable the worker to obtain suitable employment or participate in training.

(16) Dues and fees of a labor union. Payment shall be limited to initiation fees, or back dues and one month's current dues.

(17) Vehicle rental or lease. There is no reasonable alternative enabling the worker to participate in vocational assistance or accept an available job. The worker shall provide the insurer with proof of a valid driver's license and insurance coverage. Payment under this category is limited to $1,000.

(18) Any other direct worker purchase the insurer considers necessary for the worker's participation as described in the introductory paragraph of this rule. Payment under this category is limited to $1,000.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from OAR 436-120-0087; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0720
Fee Schedule and Conditions for Payment of Vocational Assistance Costs

(1) The director has established the following fee schedule for professional costs and direct worker purchases. The schedule sets maximum spending limits per claim opening for each category; however, the insurer may spend more than the maximum limit if the insurer determines the individual case so warrants. Spending limits are to be adjusted annually, effective July 1. The annual adjustment is based on the conversion factor described in OAR 436-120-0005(2) and published with the cost-of-living matrix. The amounts in section (3) do not include the adjustment effective July 1, 2004.

(2) For workers found to have an exceptional disability or exceptional loss of earning capacity as defined in OAR 436-120-0440 the fee schedule spending limits for the Training category and DE/Training Combined category listed below shall be increased by 30%.

(3) Amounts include professional costs, travel/wait, and other travel expenses: [Table not included. See ED. NOTE.]

(4) Wage reimbursement for on-the-job training contracts, and the living expense allowance during vocational evaluation, are not covered by the fee schedule.

(5) Services and direct worker purchases provided after eligibility ends to complete a plan or employment is subject to the maximum amounts in effect at the time of closure.

(6) The insurer shall pay, within 60 days of receipt, the vocational assistance provider's billing for services provided under the insurer-vocational assistance provider agreement. The insurer shall not deny payment on the grounds the worker was not eligible for the assistance if the vocational assistance provider performed the services in good faith without knowledge of the ineligibility.

(7) An insurer entitled to claims cost reimbursement pursuant to OAR 436-110 for services provided pursuant to OAR 436-120 is subject to the following limitations:

(a) Optional services are not reimbursable.

(b) The director must approve eligibility before any services are provided. The request must be submitted on Form 1084.

(c) The insurer must obtain the director's approval in advance of the following actions:

(A) Notifying the worker of eligibility for vocational services;

(B) Any waiver of the provisions of OAR 436-120; or

(C) Exceeding the fee schedule.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340 & ORS 656.258
Hist.: WCD 6-1980(Admin), f. 5-22-80, ef. 6-1-80; WCD 4-1981(Admin), f. 12-4-81, ef. 1-1-82; WCD 11-1982(Admin)(Temp), f. 12-29-82, ef. 1-1-83; WCD 2-1983(Admin), f. & ef. 6-30-83; WCD 5-1983(Admin), f. 12-14-83, ef. 1-1-84; Renumbered from 436-061-0120, 5-1-85; WCD 7-1985(Admin), f. 12-12-85, ef. 1-1-86; WCD 11-1987, f. 12-17-87, ef. 1-1-88 ; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0070 & 436-120-0215; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 4-2001, f. 4-13-01, cert. ef. 5-15-01; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0830
Classification of Vocational Assistance Staff

Individuals providing vocational assistance shall be classified as follows:

(1) Vocational Rehabilitation Counselor certification allows the individual to determine eligibility and provide vocational assistance services. Vocational Rehabilitation Counselor certification requires:

(a) Certification by the following national certifying organizations: Commission on Rehabilitation Counselor Certification (CRCC), the Commission for Case Managers Certification (CCMC), or the Certification of Disability Management Specialists Commission (CDMSC);

(b) A master's degree in vocational rehabilitation counseling and at least six months of direct experience;

(c) A master's degree in psychology, counseling, or a field related to vocational rehabilitation, and 12 months of direct experience; or

(d) A bachelor's or higher degree and 24 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree.

(2) Vocational Rehabilitation Intern certification allows an individual who does not meet the requirements for certification as a Vocational Rehabilitation Counselor the opportunity to gain direct experience. Vocational Rehabilitation Intern certification requires a master's degree in psychology, counseling, or a field related to vocational rehabilitation; or a bachelor's degree and 12 months of direct experience. Thirty-six months of direct experience may substitute for a bachelor's degree. The Vocational Rehabilitation Intern certification is subject to the following conditions:

(a) The intern must be supervised by a certified Vocational Rehabilitation Counselor who shall co-sign and assume responsibility for all the intern's eligibility determinations, vocational evaluations, return-to-work plans, vocational and billing reports.

(b) When the intern has met the experience requirements, the intern may apply for certification as a Vocational Rehabilitation Counselor.

(3) Return-to-Work Specialist certification allows the person to provide job search skills instruction; job development; return-to-work follow-up and labor market survey; and to determine eligibility for vocational assistance, except where such determination requires a judgment as to whether the worker has a substantial handicap to employment. This certification requires 24 months of direct experience. Full-time (or the equivalent) additional college coursework in psychology, counseling, education, a human services related field, or a field related to vocational rehabilitation may substitute for up to 18 months of direct experience, on a month-for-

month basis. To conduct only labor market research and/or job development does not require certification when conducted under the supervision of a certified vocational rehabilitation counselor.

(4) To meet the direct experience requirements for Vocational Rehabilitation Counselor, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (A) through (J) of this subsection for the required number of months, with at least six months of the experience in one or more of functions listed in paragraphs (A) through (D) of this subsection. The qualifying job functions are:

(A) Return-to-work plan development and implementation;

(B) Employment counseling;

(C) Job development;

(D) Early return-to-work assistance which must include working directly with workers and their employers;

(E) Vocational testing;

(F) Job search skills instruction;

(G) Job analysis;

(H) Transferable skills assessment or employability evaluations;

(I) Return-to-work plan review and approval; or

(J) Employee recruitment and selection for a wide variety of occupations.

(5) To meet the direct experience requirements for Vocational Rehabilitation Intern or Return-to-Work Specialist, the individual must:

(a) Perform return-to-work plan development and implementation for the required number of months; or

(b) Perform three or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule for the required number of months.

(6) To receive credit for direct experience, the individual must:

(a) Perform one or more of the qualifying job functions listed in paragraphs (4)(b)(A) through (J) of this rule at least 50 percent of the work time for each month of direct experience credit. Qualifying job functions performed in a job which is less than full time shall be prorated. For purposes of this rule, full time shall be 40 hours a week. An individual will not receive credit for any function performed less than 160 hours.

(b) Provide any documentation required by the director, including work samples. The director may also require verification by the individual's past or present employers.

(7) All degrees must be from accredited institutions and documented by a copy of the transcript(s) with the application for certification.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95; Renumbered from 436-120-0205; WCD 6-1996, f. 2-6-96, cert. ef. 3-1-96; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

436-120-0840
Professional Standards for Authorized Vocational Assistance Providers and Certified Individuals

(1) Authorized vocational assistance providers and certified individuals shall:

(a) Determine eligibility and provide assistance in an objective manner not subject to any conditions other than those prescribed in these rules;

(b) Fully inform the worker of the categories and kinds of vocational assistance pursuant to OAR 436-120 and reemployment assistance pursuant to OAR 436-110;

(c) Document all case activities in legible file notes or reports;

(d) Provide only vocationally relevant information about workers in written and oral reports;

(e) Recommend workers only for suitable employment;

(f) Fully inform the worker of the purpose and results of all testing and evaluations and

(g) Comply with generally accepted standards of conduct in the vocational rehabilitation profession.

(2) Authorized vocational assistance providers and certified individuals shall not:

(a) Provide evaluations or assistance if there is a conflict of interest or prejudice concerning the worker;

(b) Enter into any relationship with the worker to promote personal gain, or the gain of a person or organization in which the vocational assistance provider or certified individual has an interest;

(c) Engage in, or tolerate, sexual harassment of a worker. "Sexual harassment" means deliberate or repeated comments, gestures or physical contact of a sexual nature;

(d) Violate any applicable state or federal civil rights law;

(e) Commit fraud, misrepresent, or make a serious error or omission, in connection with an application for authorization or certification;

(f) Commit fraud, misrepresent, or make a serious error or omission in connection with a report or return-to-work plan, or the vocational assistance activities or responsibilities of a vocational assistance provider under OAR chapter 436;

(g) Engage in collusion to withhold information, or submit false or misleading information relevant to the determination of eligibility or provision of vocational assistance;

(h) Engage in collusion to violate these rules or other rules of the department, or any policies, guidelines or procedures issued by the director;

(i) Fail to comply with an order by the director to provide specific vocational assistance, except as provided in ORS 656.313; or

(j) Instruct any individual to make decisions or engage in behavior which is contrary to the requirements of these rules.

Stat. Auth.: ORS 656.340(9) & ORS 656.726(4)
Stats. Implemented: ORS 656.340
Hist.: WCD 11-1987, f. 12-17-87, ef. 1-1-88; WCD 10-1994, f. 11-1-94, cert. ef. 1-1-95, Renumbered from 436-120-0207; WCD 6-2000, f. 4-27-00, cert. ef. 6-1-00; WCD 7-2002, f. 5-30-02, cert. ef. 7-1-02; WCD 3-2004, f. 3-5-04 cert. ef. 4-1-04

• • • • • • • • • •

Department of Fish and Wildlife
Chapter 635

Adm. Order No.: DFW 12-2004(Temp)
Filed with Sec. of State: 3-1-2004
Certified to be Effective: 3-1-04 thru 7-31-04
Notice Publication Date:
Rules Amended: 635-042-0022
Subject: Amend rules related to spring chinook gill net commercial fishing in the Columbia River mainstem.
Rules Coordinator: Cristy Mosset—(503) 947-6034

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon, and shad may be taken by gill net 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 and may occur on Tuesdays and Thursdays, beginning February 24, 2004, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) A maximum of three white sturgeon may be possessed or sold by each participating vessel during the open period described in 3(b).

(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 gill net fishery it is *unlawful* to use a gill net having a mesh size less than 9 inches and more than 9-3/4 inches. Use of monofilament nets is allowed.

(a) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open period:

(b) 5 a.m. March 2, 2004 to 9 p. m. March 2, 2004.

(4) During the tangle net fishery 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.

(5) 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.

(6) 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.

(7) 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 part (c) above, must have two red corks at each end of the net.

(8) 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.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) 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.

(11) 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.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) 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.

(14) Nonlegal 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 or in lethargic condition 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; pumping system must be 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 ODFW and WDFW 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 hole opposite the inflow 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.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a valid certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the fishery. A tangle net certificate shall expire on December 31, 2004. No individual may obtain more than one tangle net certificate between January 1, 2004 and December 31, 2004.

(a) The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(b) Nothing in this section sets any precedent for any fishery after the 2004 spring chinook fishery. The fact that an individual may hold a tangle net certificate in spring 2004 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a tangle net fishery in spring 2005 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2004. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(16) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Gnat Creek, are in effect during the open fishing periods described.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Sats. 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

• • • • • • • • • •

Adm. Order No.: DFW 13-2004(Temp)
Filed with Sec. of State: 3-3-2004
Certified to be Effective: 3-3-04 thru 7-31-04
Notice Publication Date:
Rules Amended: 635-042-0022
Subject: Amend rules related to spring chinook gill net commercial fishing in the Columbia River mainstem.
Rules Coordinator: Cristy Mosset—(503) 947-6034

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon, and shad may be taken by gill net 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 and may occur on Tuesdays and Thursdays, beginning February 24, 2004, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) A maximum of three white sturgeon may be possessed or sold by each participating vessel during the open periods described in (3)(b) and (3)(c).

(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 gill net fishery it is *unlawful* to use a gill net having a mesh size less than 9 inches and more than 9-3/4 inches. Use of monofilament nets is allowed.

(a) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open periods:

(b) 5 a.m. March 2, 2004 to 9 p.m. March 2, 2004;

(c) 3 p.m. March 4, 2004 to 7 a.m. March 5, 2004.

(4) During the tangle net fishery 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.

(5) 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.

(6) 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.

(7) 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 associat-

ed 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 part (c) above, must have two red corks at each end of the net.

(8) 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.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) 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.

(11) 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.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) 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.

(14) Nonlegal 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 or in lethargic condition 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; pumping system must be 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 ODFW and WDFW 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 hole opposite the inflow 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.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a valid certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the fishery. A tangle net certificate shall expire on December 31, 2004. No individual may obtain more than one tangle net certificate between January 1, 2004 and December 31, 2004.

(a) The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(b) Nothing in this section sets any precedent for any fishery after the 2004 spring chinook fishery. The fact that an individual may hold a tangle net certificate in spring 2004 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a tangle net fishery in spring 2005 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2004. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(16) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Gnat Creek, are in effect during the open fishing periods described.

Stat. Auth.: ORS 496.138, ORS 496.146, and 506.119
Sats. Implemented: ORS 496.162, ORS 506.129, and ORS 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

• • • • • • • • • •

Adm. Order No.: DFW 14-2004
Filed with Sec. of State: 3-5-2004
Certified to be Effective: 3-5-04
Notice Publication Date: 11-1-03
Rules Amended: 635-120-0001, 635-120-0005, 635-120-0010, 635-120-0015, 635-120-0020
Subject: Rules were amended relating to the Bighorn Sheep Management Plan. The Rocky Mountain Goat was also added in this plan.
Rules Coordinator: Cristy Mosset—(503) 947-6034

635-120-0001
Bighorn Sheep and Rocky Mountain Goat Management Plan Content and Purpose

The document entitled "Oregon's Bighorn Sheep and Rocky Mountain Goat Management Plan" dated December 2003 is incorporated by reference into these rules. Copies of the Plan are available through the Oregon Department of Fish and Wildlife. This document provides program direction, identifies objectives and strategies to fulfill management, research, habitat and status survey needs. It is also intended as an informational document to assist resource management agencies with their wildlife programs.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 497.112
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162& 497.112
Hist.: FWC 74-1986, f. & ef. 11-20-86; FWC 25-1992, f. 4-17-92, cert. ef. 4-21-92; DFW 14-2004, f. & cert. ef. 3-5-04

635-120-0005
Program Objectives
Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 497.112
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162& 497.112
Hist.: FWC 74-1986, f. & ef. 11-20-86; FWC 25-1992, f. 4-17-92, cert. ef. 4-21-92; DFW 14-2004, f. & cert. ef. 3-5-04

635-120-0010
Plan Implementation
Stat. Auth.: ORS 496
Stats. Implemented: ORS 496
Hist.: FWC 74-1986, f. & ef. 11-20-86; DFW 14-2004, f. & cert. ef. 3-5-04

635-120-0015
Authority of the Director
Stat. Auth.: ORS 496
Stats. Implemented: ORS 496
Hist.: FWC 74-1986, f. & ef. 11-20-86; DFW 14-2004, f. & cert. ef. 3-5-04

635-120-0020
Five-Year Review
Stat. Auth.: ORS 496
Stats. Implemented: ORS 496
Hist.: FWC 74-1986, f. & ef. 11-20-86; DFW 14-2004, f. & cert. ef. 3-5-04

• • • • • • • • • •

Adm. Order No.: DFW 15-2004(Temp)
Filed with Sec. of State: 3-8-2004
Certified to be Effective: 3-10-04 thru 4-1-04
Notice Publication Date:

Rules Amended: 635-041-0065
Subject: Amend rules in the winter season for Treaty Indian fishers in the Columbia River above Bonneville Dam. Revisions consistent with action taken March 5, 2004 by the Columbia River Compact.
Rules Coordinator: Katie Thiel—(503) 947-6033

635-041-0065
Winter Salmon Season

(1) Salmon, steelhead, shad, sturgeon between 4 and 5 feet in length, walleye and carp may be taken for commercial purposes from the Columbia River Treaty Indian Fishery, Zone 6, from 12 noon February 2, 2004 to 12 noon March 21, 2004 except as identified in section (5) of this rule.

(2) There are no mesh size restrictions.

(3) Closed areas are set forth in OAR 635-041-0045, with the exception of Spring Creek Hatchery, remain in effect.

(4) Sale of platform and hook-and-line caught fish is allowed during open commercial fishing seasons.

(5) Effective 12 Noon March 10, 2004, the Columbia River Treaty Indian Fishery, Zone 6, between Bonneville Dam and The Dalles Dam, is closed to commercial fishing.

(6) In addition to regulations as defined in OAR-041-0005 through 041-0030, sturgeon 45-60" in overall length may be taken for subsistence purposes from that area as identified in section (5) of this rule.

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

• • • • • • • • • •

Adm. Order No.: DFW 16-2004(Temp)
Filed with Sec. of State: 3-8-2004
Certified to be Effective: 3-8-04 thru 7-31-04
Notice Publication Date:
Rules Amended: 635-042-0022
Subject: Amend rules related to spring chinook gill net commercial fishing in the Columbia River mainstem.
Rules Coordinator: Katie Thiel—(503) 947-6033

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon, and shad may be taken by gill net 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 and may occur on Tuesdays and Thursdays, beginning February 24, 2004, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) A maximum of three white sturgeon may be possessed or sold by each participating vessel during the open periods described in 3(b), 3(c) and 3(d).

(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 gill net fishery it is unlawful to use a gill net having a mesh size less than 9 inches and more than 9-3/4 inches. Use of monofilament nets is allowed.

(a) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open periods:

(b) 5 a.m. March 2, 2004 to 9 p.m. March 2, 2004;

(c) 3 p.m. March 4, 2004 to 7 a.m. March 5, 2004;

(d) 5 a.m. March 9, 2004 to 5 a.m. March 10, 2004.

(4) During the tangle net fishery 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.

(5) 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.

(6) 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.

(7) 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 part (c) above, must have two red corks at each end of the net.

(8) 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.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) 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.

(11) 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.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) 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.

(14) Nonlegal 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 or in lethargic condition 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; pumping system must be 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 ODFW and WDFW 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 hole opposite the inflow 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.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a valid certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the fishery. A tangle net certificate shall expire on December 31, 2004. No individual may obtain more than one tangle net certificate between January 1, 2004 and December 31, 2004.

(a) The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(b) Nothing in this section sets any precedent for any fishery after the 2004 spring chinook fishery. The fact that an individual may hold a tangle net certificate in spring 2004 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a tangle net fishery in spring 2005 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2004. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(16) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Gnat Creek, are in effect during the open fishing periods described.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Sats. 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 7-31-0; DFW 16-2004(Temp), f. & cert. ef. 3-8-04 thru 7-31-04

• • • • • • • • • •

Adm. Order No.: DFW 17-2004(Temp)
Filed with Sec. of State: 3-10-2004
Certified to be Effective: 3-10-04 thru 7-31-04
Notice Publication Date:
Rules Amended: 635-023-0125
Subject: Amend spring sport fishing rules in the mainstem Columbia River upstream of the Rocky Point/Tongue Point line requiring fish, which are to be released, remain totally in the water. Exemptions to the regulation are based on vessel length.
Rules Coordinator: Katie Thiel—(503) 947-6033

635-023-0125
Spring Sport Fishery

(1) The **2004 Oregon Sport Fishing Regulations** provide requirements for the Columbia River Zone and the Snake River Zone. However, additional regulations may be adopted in this rule division from time to time, and, to the extent of any inconsistency, they supersede the **2004 Oregon Sport Fishing Regulations**.

(2) The Columbia River is open from January 1, 2004 through May 15, 2004, from the mouth at Buoy 10 upstream to the I-5 Bridge; from March 16, 2004 through May 15, 2004 from I-5 Bridge upstream to Bonneville Dam and from Tower Island power lines upstream to McNary Dam plus the Oregon between Bonneville Dam and the Tower Island power lines with the following restrictions:

(a) Adipose fin-clipped chinook salmon, adipose fin-clipped steelhead, and shad may be retained.

(b) All non-adipose fin-clipped chinook salmon and non-adipose fin-clipped steelhead must be released immediately unharmed.

(c) Catch limits of two adult salmon or steelhead and five jacks per day are in effect as per permanent regulations.

(3) Effective March 10, 2004 through May 15, 2004, in the mainstem Columbia River upstream of the Rocky Point/Tongue Point line it is unlawful when fishing from vessels which are less than 30' in length, substantiated by Coast Guard documentation or Marine Board Registration, to totally remove from the water any salmon or steelhead required to be released.

(4) All other specifications and restrictions as outlined in the current **2004 Oregon Sport Fishing Regulations** apply.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146, 506.119
Stats. Implemented: ORS 496.162, 506.129
Hist.: DFW 11-2004, f. & cert. ef. 2-13-04; DFW 17-2004(Temp), f. & cert. ef. 3-10-04 thru 7-31-04

• • • • • • • • • •

Adm. Order No.: DFW 18-2004(Temp)
Filed with Sec. of State: 3-10-2004
Certified to be Effective: 3-10-04 thru 7-31-04
Notice Publication Date:
Rules Amended: 635-042-0022
Subject: Amend rules related to spring chinook gill net commercial fishing in the Columbia River mainstem.
Rules Coordinator: Katie Thiel—(503) 947-6034

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon, and shad may be taken by gill net 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 could exceed sixteen hours in length and may occur on Tuesdays and Thursdays, beginning February 24, 2004, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) A maximum of three white sturgeon may be possessed or sold by each participating vessel during the open periods described in (3)(b), (3)(c), (3)(d), and (3)(e).

(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 gill net fishery it is *unlawful* to use a gill net having a mesh size less than 9 inches and more than 9-3/4 inches. Use of monofilament nets is allowed.

(a) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open periods:

(b) 5 a.m. March 2, 2004 to 9 p.m. March 2, 2004;

(c) 3 p.m. March 4, 2004 to 7 a.m. March 5, 2004;

(d) 5 a.m. March 9, 2004 to 5 a.m. March 10, 2004;

(e) 10 a.m. March 11, 2004 to 10 a.m. March 12, 2004.

(4) During the tangle net fishery 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.

(5) 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.

(6) 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.

(7) 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 part (c) above, must have two red corks at each end of the net.

(8) 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.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) 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.

(11) 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.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) 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.

(14) Nonlegal 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 or in lethargic condition 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; pumping system must be 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 ODFW and WDFW 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 hole opposite the inflow 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.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a valid certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the fishery. A tangle net certificate shall expire on December 31, 2004. No individual may obtain more than one tangle net certificate between January 1, 2004 and December 31, 2004.

(a) The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(b) Nothing in this section sets any precedent for any fishery after the 2004 spring chinook fishery. The fact that an individual may hold a tangle net certificate in spring 2004 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a tangle net fishery in spring 2005 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2004. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(16) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Gnat Creek, are in effect during the open fishing periods described.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Sats. 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 7-31-0; 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

• • • • • • • • • •

Adm. Order No.: DFW 19-2004(Temp)
Filed with Sec. of State: 3-12-2004
Certified to be Effective: 3-12-04 thru 3-31-04
Notice Publication Date:
Rules Amended: 635-042-0145, 635-042-0160
Subject: Amend rules related to commercial fishing winter seasons in Youngs Bay and Blind Slough Select Areas.
Rules Coordinator: Katie Thiel—(503) 947-6033

635-042-0145
Youngs Bay Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes in those waters of Youngs Bay from the Highway 101 Bridge upstream to the upper boundary markers at the confluence of the Klaskanine and Youngs rivers; except for those waters which are closed southerly of the alternate Highway 101 Bridge (Lewis and Clark River).

(a) The open fishing periods are established in three segments categorized as the winter fishery, paragraph (A), the spring fishery, paragraph (B), and summer fishery, paragraph (C), as follows:

(A) Winter Season: 6 p.m. February 14 - 12 Noon February 15, 2004; 6 a.m. to 6 p.m. February 18, 2004; 6 p.m. February 21 - 12 Noon February 22, 2004; 6 a.m. to 6 p.m. February 25, 2004; 6 p.m. February 28 - 12 Noon February 29, 2004; 6 a.m. to 6 p.m. March 3, 2004; 6 p.m. March 6 - 12 Noon March 7, 2004; 6 p.m. March 13 - 12 Noon March 14, 2004.

(B) Spring Season: 6 p.m. April 22 - 6 a.m. April 23, 2004; 6 p.m. April 26 - 6 a.m. April 27, 2004; 6 p.m. April 29 - 6 a.m. April 30, 2004; 6 p.m. May 3 - 12 Noon May 4, 2004; 6 p.m. May 6 - 12 Noon May 7, 2004; 12 Noon May 11 - 12 Noon May 14, 2004; 12 Noon May 17 - 12 Noon May 21, 2004; 12 Noon May 24 - 12 Noon May 28, 2004; 12 Noon May 31 - 12 Noon June 4, 2004; 12 Noon June 7 - 12 Noon June 11, 2004; 12 Noon June 15 - 12 Noon June 18, 2004;

(C) Summer Season: 12 Noon June 23 - 12 Noon June 25, 2004; 12 Noon June 30 - 12 Noon July 2, 2004; 12 Noon July 7 - 6 p.m. July 8, 2004; 12 Noon July 14 - 6 p.m. July 15, 2004; 12 Noon July 21 - 6 p.m. July 22, 2004; 12 Noon July 28 - 6 p.m. July 29, 2004;

(b) Gill nets may not exceed 1,500 feet (250 fathoms) in length and weight may not exceed two pounds per any fathom. Monofilament gillnets are allowed. It is unlawful to use a gill net having a mesh size that is less than 7-1/4 inches during February 14, 2004 to March 14, 2004, and it is unlawful to use a gill net having a mesh size that is more than 8 inches April 22, 2004 to June 18, 2004 and June 23, 2004 to July 29, 2004.

(c) A maximum of three white sturgeon may be possessed or sold by each participating vessel during each open period between February 14, 2004 and March 14, 2004.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 32-1979, f. & ef. 8-22-79; FWC 28-1980, f. & ef. 6-23-80; FWC 42-1980(Temp), f. & ef. 8-22-80; FWC 30-1981, f. & ef. 8-14-81; FWC 42-1981(Temp), f. & ef. 11-5-81; FWC 54-1982, f. & ef. 8-17-82; FWC 37-1983, f. & ef. 8-18-83; FWC 61-1983(Temp), f. & ef. 10-19-83; FWC 42-1984, f. & ef. 8-20-84; FWC 39-1985, f. & ef. 8-15-85; FWC 37-1986, f. & ef. 8-11-86; FWC 72-1986(Temp), f. & ef. 10-31-86; FWC 64-1987, f. & ef. 8-7-87; FWC 73-1988, f. & cert. ef. 8-19-88; FWC 55-1989(Temp), f. 8-7-89, cert. ef. 8-20-89; FWC 82-1990(Temp), f. 8-14-90, cert. ef. 8-19-90; FWC 86-1991, f. 8-7-91, cert. ef. 8-18-91; FWC 123-1991(Temp), f. & cert. ef. 10-21-91; FWC 30-1992(Temp), f. & cert. ef. 4-27-92; FWC 35-1992(Temp), f. 5-22-92, cert. ef. 5-25-92; FWC 74-1992 (Temp), f. 8-10-92, cert. ef. 8-16-92; FWC 28-1993(Temp), f. & cert. ef. 4-26-93; FWC 48-1993, f. 8-6-93, cert. ef. 8-9-93; FWC 21-1994(Temp), f. 4-22-94, cert. ef. 4-25-94; FWC 51-1994, f. 8-19-94, cert. ef. 8-22-94; FWC 64-1994(Temp), f. 9-14-94, cert. ef. 9-15-94; FWC 66-1994(Temp), f. & cert. ef. 9-20-94; FWC 27-1995, f. 3-29-95, cert. ef. 4-1-95; FWC 48-1995(Temp), f. & cert. ef. 6-5-95; FWC 66-1995, f. 8-22-95, cert. ef. 8-27-95; FWC 69-1995, f. 8-25-95, cert.

ef. 8-27-95; FWC 8-1995, f. 2-28-96, cert. ef. 3-1-96; FWC 37-1996(Temp), f. 6-11-96, cert. ef. 6-12-96; FWC 41-1996, f. & cert. ef. 8-12-96; FWC 45-1996(Temp), f. 8-16-96, cert. ef. 8-19-96; FWC 54-1996(Temp), f. & cert. ef. 9-23-96; FWC 4-1997, f. & cert. ef. 1-30-97; FWC 47-1997, f. & cert. ef. 8-15-97; DFW 8-1998(Temp), f. & cert. ef. 2-5-98 thru 2-28-98; DFW 14-1998, f. & cert. ef. 3-3-98; DFW 18-1998(Temp), f. 3-9-98, cert. ef. 3-11-98 thru 3-31-98; DFW 60-1998(Temp), f. & cert. ef. 8-7-98 thru 8-21-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 52-1999(Temp), f. & cert. ef. 8-2-99 thru 8-6-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 66-2001(Temp), f. 8-2-01, cert. ef. 8-6-01 thru 8-14-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 15-2002(Temp), f. & cert. ef. 2-20-02 thru 8-18-02; DFW 82-2002(Temp), f. 8-5-02, cert. ef. 8-7-02 thru 9-1-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 17-2003(Temp), f. 2-27-03, cert. ef. 3-1-03 thru 8-1-03; DFW 32-2003(Temp), f. & cert. ef. 4-23-03 thru 8-1-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 37-2003(Temp), f. & cert. ef. 5-7-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04

635-042-0160
Blind Slough and Knappa Slough Select Area Salmon Season

(1) Salmon, sturgeon, and shad may be taken for commercial purposes during open fishing periods described as the winter fishery and the early spring fishery in paragraphs (1)(a)(A) or (1)(a) (B) of this rule in those waters of Blind Slough. Blind Slough is those waters adjoining the Columbia River which extend from markers at the mouth of Blind Slough upstream to markers at the mouth of Gnat Creek which is located approximately 1/2 mile upstream of the county road bridge. In addition, Knappa Slough is open to fishing for salmon, sturgeon and shad during open fishing periods described as the spring fishery in paragraph (1)(a)(B) of this rule. Knappa Slough is all waters bounded by a line from the northerly most marker at the mouth of Blind Slough westerly to a marker on Karlson Island downstream to a north-south line defined by a marker on the eastern end of Minaker Island to markers on Karlson Island and the Oregon shore. The following restrictions apply:

(a) The open fishing periods are established in segments categorized as the winter fishery in Blind Slough only in paragraph (A), and the spring fishery in paragraph (B). The seasons are open nightly, 7:00 p.m. to 7:00 a.m. the following morning (12 hours), as follows:

(A) Blind Slough Only: February 14 - February 15, 2004; February 21 -February 22, 2004; February 28 - February 29, 2004; March 6 - March 7, 2004 and March 13 - March 14, 2004.

(B) Blind and Knappa Sloughs: April 22 - April 23, 2004; April 29 - April 30, 2004; May 3 - May 4, 2004; May 6- May 7, 2004; May 10 - May 11, 2004; May 13 - May 14, 2004; May 17 - May 18, 2004; May 20 - May 21, 2004; May 24 - May 25, 2004; May 27 - May 28, 2004; May 31 - June 1, 2004; June 3 - June 4, 2004; June 7 - June 8, 2004; June 10 - June 11, 2004; June 14 - June 15, 2004; and June 17 - June 18, 2004.

(b) A maximum of three white sturgeon may be possessed or sold by each participating vessel during each open period between February 14, 2004 and March 14, 2004.

(c) Gear restrictions are as follows:

(A) During the winter fishery (see paragraph (1)(a)(A) of this rule) gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. Monofilament gill nets are allowed. It is unlawful to use a gill net having a mesh size that is less than 7-1/4 inches;

(B) During the spring fishery (see paragraphs (1)(a)(B) of this rule) gill nets may not exceed 100 fathoms in length with no weight limit on the lead line. Monofilament gill nets are allowed. It is unlawful to use a gill net having a mesh size that is more than 8 inches.

(2) Oregon licenses are required in the open waters upstream from the railroad bridge.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 496.162, 506.129 & 507.030
Hist.: FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; DFW 15-1998, f. & cert. ef. 3-3-98; DFW 67-1998, f. & cert. ef. 8-24-98; DFW 86-1998(Temp), f. & cert. ef. 10-28-98 thru 10-30-98; DFW 10-1999, f. & cert. ef. 2-26-99; DFW 48-1999(Temp), f. & cert. ef. 6-24-99 thru 7-2-99; DFW 55-1999, f. & cert. ef. 8-12-99; DFW 9-2000, f. & cert. ef. 2-25-00; DFW 42-2000, f. & cert. ef. 8-3-00; DFW 65-2000(Temp) f. 9-22-00, cert. ef. 9-25-00 thru 12-31-00; DFW 3-2001, f. & cert. ef. 2-6-01; DFW 84-2001(Temp), f. & cert. ef. 8-29-01 thru 12-31-01; DFW 86-2001, f. & cert. ef. 9-4-01 thru 12-31-01; DFW 89-2001(Temp), f. & cert. ef. 9-14-01 thur 12-31-01; DFW 106-2001(Temp), f. & cert. ef. 10-26-01 thru 12-31-01; DFW 14-2002(Temp), f. 2-13-02, cert. ef. 2-18-02 thru 8-17-02; DFW 96-2002(Temp), f. & cert. ef. 8-26-02 thru 12-31-02; DFW 12-2003, f. & cert. ef. 2-14-03; DFW 34-2003(Temp), f. & cert. ef. 4-24-03 thru 10-1-03; DFW 36-2003(Temp), f. 4-30-03, cert. ef. 5-1-03 thru 10-1-03; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 89-2003(Temp), f. 9-8-03, cert. ef. 9-9-03 thru 12-31-03; DFW 11-2004, f. & cert. ef. 2-13-04; DFW 19-2004(Temp), f. & cert. ef. 3-12-04 thru 3-31-04

• • • • • • • • • •

Adm. Order No.: DFW 20-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04 thru 7-31-04
Notice Publication Date:
Rules Amended: 635-042-0022
Subject: Amend rules related to spring chinook gill net commercial fishing in the Columbia River mainstem.
Rules Coordinator: Katie Thiel—(503) 947-6033

635-042-0022
Spring Chinook Gill Net and Tangle Net Fisheries

(1) Adipose fin-clipped chinook salmon, sturgeon, and shad may be taken by gill net 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 could exceed sixteen hours in length and may occur on Tuesdays and Thursdays, beginning February 24, 2004, depending upon results from test fisheries or full fleet fisheries conducted prior to each specified weekday.

(b) A maximum of three white sturgeon may be possessed or sold by each participating vessel during the open periods described in 3(b), 3(c), 3(d), 3(e) and 3(f).

(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 gill net fishery it is unlawful to use a gill net having a mesh size less than 9 inches and more than 9-3/4 inches. Use of monofilament nets is allowed.

(a) From the area as described in section (1) of this rule, adipose fin-clipped chinook salmon, sturgeon and shad may be taken for commercial purposes by gill net during the following open periods:

(b) 5 a.m. March 2, 2004 to 9 p.m. March 2, 2004;

(c) 3 p.m. March 4, 2004 to 7 a.m. March 5, 2004;

(d) 5 a.m. March 9, 2004 to 5 a.m. March 10, 2004;

(e) 10 a.m. March 11, 2004 to 10 a.m. March 12, 2004.

(f) 3 p.m. March 15, 2004 to 6 a.m. March 16, 2004.

(4) During the tangle net fishery 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.

(5) 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.

(6) 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.

(7) 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 part (c) above, must have two red corks at each end of the net.

(8) 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.

(9) There are no restrictions on the use of slackers or stringers to slacken the net vertically.

(10) 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.

(11) 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.

(12) It is unlawful to fish more than one net from a licensed commercial fishing boat at any one time.

(13) 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.

(14) Nonlegal 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 or in lethargic condition 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; pumping system must be 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 ODFW and WDFW 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 hole opposite the inflow 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.

(g) All fish placed in recovery boxes must be released to the river prior to landing or docking.

(15) At least one fisher on each boat engaged in the fishery must have in possession a valid certificate issued by a representative of the Oregon Department of Fish and Wildlife (ODFW) or the Washington Department of Fish and Wildlife (WDFW) that indicates the fisher had attended a one-day workshop hosted by ODFW or WDFW to educate fishers on regulations and best methods for conduct of the fishery. A tangle net certificate shall expire on December 31, 2004. No individual may obtain more than one tangle net certificate between January 1, 2004 and December 31, 2004.

(a) The certificate must be displayed to ODFW and WDFW employees, fish and wildlife enforcement officers, or other peace officers upon request.

(b) Nothing in this section sets any precedent for any fishery after the 2004 spring chinook fishery. The fact that an individual may hold a tangle net certificate in spring 2004 does not entitle the certificate holder to participate in any other fishery. If ODFW authorizes a tangle net fishery in spring 2005 or at any other time, ODFW may establish qualifications and requirements that are different from those established for 2004. In particular, ODFW may consider an individual's compliance with these rules in determining that individual's eligibility to participate in any future tangle net fisheries.

(16) Closed waters, as described in OAR 635-042-0005 for Grays River, Elokomin-B sanctuary, Abernathy Creek, Cowlitz River, Kalama-B sanctuary, Lewis-B sanctuary, and Gnat Creek, are in effect during the open fishing periods described.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Sats. 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

Department of Human Services, Child Welfare Programs
Chapter 413

Adm. Order No.: CWP 3-2004(Temp)
Filed with Sec. of State: 3-1-2004
Certified to be Effective: 3-1-04 thru 8-27-04
Notice Publication Date:
Rules Adopted: 413-080-0040, 413-080-0045, 413-080-0050, 413-080-0055, 413-080-0060
Subject: Department of Human Services is issuing temporary rules regarding the type and frequency of caseworker contact with children, parents and caregivers (foster parents, relative care givers, and residential treatment providers) while caseworkers perform child welfare services. Previously, child welfare policy identified the type and frequency of contact for workers only with children placed in substitute care. These new rules incorporate standards of contact for children who are being served by the department and who are not in a substitute care settings, and standards for caseworker contact with parents or caregivers. During the federal Child and Family Service Review (CFSR) in Oregon during 2001, the department was found not to be in compliance with the federal requirements for the type and frequency of caseworker contact. A Program Improvement Plan (PIP) was developed which included the state's agreement to adopt these rules regarding caseworker contact with children, parents and caregivers.
Rules Coordinator: Barbara J. Carranza—(503) 945-6649

413-080-0040
Purpose

The purpose of these rules is to set the minimum requirements for casework staff to have contact with children, who are:

(1) Placed in substitute care; or

(2) Are being served with an open service plan in their own homes. These rules also set the minimum requirements for casework staff contact with parent(s)or legal guardian(s) and caregiver(s) of children described above and for older youth and young adults.

Stat. Auth.: ORS 418.005
Stats. Implemented: PL 105-89, Adoption and Safe Families Act
Hist.: CWP 3-2004(Temp), f. & cert. ef. 3-1-04 thru 8-27-04

413-080-0045
Values

(1) Child safety is the paramount concern guiding the minimum requirements for caseworker contact with children, their parents or legal guardians, caregivers, older youth and young adults. Having contact is one of the most important ways that the department can: assess safety; ensure the well-being of children; provide support; assess, revise and implement service plans; and promote timely implementation of case plans for children and families served by the department.

(2) The needs of children being served by the department are varied and complex. To successfully meet these needs, a teamwork approach among the caseworker, families, and care providers is essential — each bringing a broad range of knowledge and skills to the helping process.

(3) Caseworkers who are assigned child welfare cases are trained to assess and review the children's safety and are considered the primary staff responsible for developing relationships with children.

Stat. Auth.: ORS 418.005
Stats. Implemented: PL 105-89, Adoption and Safe Families Act
Hist.: CWP 3-2004(Temp), f. & cert. ef. 3-1-04 thru 8-27-04

413-080-0050
Definitions

For purposes of OAR 413-080-0040 through 413-080-0055:

(1) "Caregiver" is the person providing foster, adoptive or relative care for a child or the residential treatment program in which a child is placed.

(2) "Child(ren) is:

(a) A person under the age of 18 years for whom the department has an open service plan and who is either placed in substitute care or is being provided services in his/her own home; or

(b) A person 18 years of age and older who remains in the legal custody of the department.

(3) "Contact" is a face-to-face visit, a visit to the home or facility, participation in treatment reviews, court or CRB hearings, family meetings,

telephone or electronic communication, written documents, or other means similarly defined.

(4) "Face-to-Face" is an in person interaction between individuals that will allow for the caseworker to observe the child, parents, or caregivers.

(5) "FACIS" is the Family and Child Information System used by the department.

(6) "ICPC" is the Interstate Compact for the Placement of Children. (Oregon Revised Statute 417.200.)

(7) "Older youth" is a person under age 18 who is not in the care and custody of the department but is accessing voluntary services through the Independent Living Program (See OAR 413-030-0400 through 0455, Policy I-B.2.3.5)

(8) "Young adult" is a person over age 18 who is not in the care and custody of the department but is accessing voluntary services through the Independent Living Program. (See OAR 413-030-0400 through 0455, Policy I-B.2.3.5)

(9) "Substitute care" is the out-of-home placement of a child who is in the legal or physical custody and care of the department.

Stat. Auth.: ORS 418.005
Stats. Implemented: PL 105-89, Adoption and Safe Families Act
Hist.: CWP 3-2004(Temp), f. & cert. ef. 3-1-04 thru 8-27-04

413-080-0055
Caseworker Contact

(1) Contact with Children:

(a) The child's assigned caseworker must have face-to-face visits with the child a minimum of once every 30 days. A caseworker assigned to supervise a child placed in Oregon through the ICPC must have face-to-face visits with that child a minimum of once every 30 days. Based on the child's needs and/or service pIan, more frequent contact may be necessary for some children. The child's assigned caseworker and the caseworker's supervisor must determine whether additional contact between the child and the child's caseworker is necessary to meet the needs of the child. If additional contact is necessary, the type and frequency of the contact must be documented in the case record.

(b) During face-to-face visits between the child's assigned caseworker and the child, the caseworker must assess child safety and must:

(A) Develop and maintain a good working relationship with the child;

(B) Observe the child and gather information from the child and, when present, the child's parents, legal guardians or caregivers

(C) Visit with the child in a setting comfortable and age appropriate for the child in order for the caseworker to perform the functions described above; and;

(D) If appropriate considering the child's age and level of maturity, discuss with the child the status of the current case plan, services involved, and any legal changes in the case and share with the child and gather information about the educational, medical or dental, mental health, or other pertinent information.

(2) Contact with Older Youth The assigned caseworker must have face-to-face contact with an older youth a minimum of once every 30 days.

(3) Contact with Young Adults

(a) The assigned caseworker must have face-to-face contact a minimum of once every 30 days with a young adult who is parenting a child.

(b) The assigned caseworker must have face-to-face contact a minimum of once every 60 days with a young adult who is not parenting a child.(4) Contact with Parents or Legal Guardians

(a) The child's assigned caseworker must have face-to-face contact a minimum of once every 30 days with the child's parents or legal guardians who have an open service plan and with whom the department is working toward a plan for reunification or maintaining a reunification plan that has been achieved.

(b) During the face-to-face contact the caseworker must observe the parents or legal guardians gather information and assess changes in parental functioning. The caseworker must discuss and review the progress of the current case plan, services involved, and any legal changes in the case.

(c) The child's assigned caseworker and the caseworker's supervisor must determine the type and frequency of contact between the child's caseworker and parents in cases where the department is not working toward or maintaining a reunification plan. The type and level of contact determined appropriate for these parents must be documented in the case record.

(5) Contact with Caregivers

(a) The child's assigned caseworker must have contact with the caregiver a minimum of every 30 days.

(b) The child's assigned caseworker must have face-to-face contact with the child's caregiver in the home or facility a minimum of every 60 days.

(c) The child's assigned caseworker and the caseworker's supervisor may determine that additional contact is necessary to meet the needs of the child. If additional contact is necessary, the type and frequency of that contact must be documented in the case record.

(d) Except as provided in (b), contact may be made through visits to the home or facility, during case planning meetings or reviews, by phone or by other means consistent with meeting the needs of the child.

Stat. Auth.: ORS 418.005
Stats. Implemented: PL 105-89, Adoption and Safe Families Act
Hist.: CWP 3-2004(Temp), f. & cert. ef. 3-1-04 thru 8-27-04

413-080-0060
Additional Contact Procedure and Requirements

(1) **Scheduling Contact**

Regularly scheduled visits with children, parents, legal guardians, caregivers, older youth, and young adults must occur in accordance with these rules. There may also be occasions in which advance scheduling is not necessary or is inappropriate. In these instances, the visit will occur in a manner that is consistent with the purpose of the visit and is respectful of the child and the parents or caregivers involved in the visit.

(2) **Caseworker Back-Up** On rare occasion it may be necessary to meet the contact requirements with a staff person other than the child's caseworker. The supervisor, child welfare manager, Consultant, Education, Trainers (CETs) or another caseworker (Social Service Specialist) may provide the required contact, including a face-to-face visitation only after consultation with and approval of the child's caseworker's supervisor. The individual assigned must be familiar with the child and any special needs of the child and is responsible for the required documentation.

(3) **Exceptions** After reviewing the safety and service plan for the child, the caseworker's supervisor or manager may approve an exception, on an individual case basis, to the requirement for a child's caseworker to have face-to-face contact with the child, parents, legal guardians, caregivers, older youth or young adult. The decision to approve an exception to the face-to-face contact requirement must be consistent with meeting the needs of the child. The supervisor or manager is responsible for ensuring that documentation of the reason for the exception to the face-to-face contact, including the criteria for approving an exception and the length of time the exception will be in effect, is in the client's case file. Reasons for granting an exception to the face-to-face contact requirements include, but are not limited to:

(a) Unavailability of the child(ren). Examples include a child on vacation with the caregiver or a child on runaway status.

(b) Permanent foster care. Notwithstanding an exception granted under this subsection, the child's caseworker must have face-to-face contact with the child and the child's caregiver in the caregiver's home a minimum of once every 90 days.

(c) Residential Care Placement. Notwithstanding an exception granted under this subsection, the child's caseworker must meet face-to-face with the child and the child's caregiver a minimum of once every 60 days.

(d) A Child Placed through ICPC. The child's caseworker must request that officials in the receiving state have face-to-face contact with the child a minimum of once every 30 days. If the receiving state declines the caseworker's request for 30 day contact, this will be documented in the case file along with the type and level of contact being provided.

(e) Unavailability of the Parent(s). Examples may include a parent: who is out-of-state; whose location is unknown; who is incarcerated or enrolled in an inpatient program where contact may be limited due to facility location or treatment plan; or who has had their contact with the department restricted in some way

(f) A documented safety risk to the caseworker or DHS staff person. In these rare circumstances, a request will be made to local law enforcement to accompany DHS staff in making contact with the child to assess safety.

(4) **Contact Required Until Cases are Closed** As long as a case plan is open for services and the child's caseworker has not closed the case, the child's caseworker must continue to have contact with the children, parents, legal guardians, caregivers, older youth and young adult as required in these rules.

(5) **Documentation** Face-to-face contact and unannounced visits must be documented in the electronic case file (FACIS) in the "Case Notes" section.

Stat. Auth.: ORS 418.005
Stats. Implemented: PL 105-89, Adoption and Safe Families Act
Hist.: CWP 3-2004(Temp), f. & cert. ef. 3-1-04 thru 8-27-04

Department of Human Services,
Departmental Administration and
Medical Assistance Programs
Chapter 410

Adm. Order No.: OMAP 8-2004
Filed with Sec. of State: 2-26-2004
Certified to be Effective: 3-1-04
Notice Publication Date: 1-1-04
Rules Adopted: 410-007-0200, 410-007-0210, 410-007-0220, 410-007-0230, 410-007-0240, 410-007-0250, 410-007-0260, 410-007-0270, 410-007-0280, 410-007-0290, 410-007-0300, 410-007-0310, 410-007-0320, 410-007-0330, 410-007-0340, 410-007-0350, 410-007-0360, 410-007-0370, 410-007-0380
Rules Repealed: 410-007-0000, 410-007-0010, 410-007-0020, 410-007-0030, 410-007-0040, 410-007-0050, 410-007-0060, 410-007-0070, 410-007-0080
Subject: The adoption of these rules help to integrate and standardize criminal record and background check processes through much of the Department Human Services. The rules define who is subject to the background check and defines the process. The rules establish a common set of potentially disqualifying crimes and the criteria that must be employed to determine fitness or suitability. The rules establish a standardized appeal process.
Rules Coordinator: Pat Bougher—(503) 945-5844

410-007-0200
Statement of Purpose and Statutory Authority

(1) Purpose. The purpose of these rules is to provide for the reasonable screening of subject individuals in order to determine if they have a history of criminal behavior such that they should not be allowed to oversee, live or work closely with, or provide services to vulnerable people.

(2) Authority. These rules are authorized under ORS 181.537, 409.010, 409.050, 410.020(3)(d), 418.016, 418.640, 441.022, 441.055, 443.730, 443.735(3), 688.655 and 688.660.

(3) When Rules Apply. These rules are to be applied when evaluating criminal history of a subject individual and conducting fitness determinations based upon such history. The fact that a subject individual is approved does not guarantee employment or placement.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0210
Definitions

As used in OAR chapter 410, division 007, unless the context of the rule requires otherwise, the following definitions apply:

(1) "Adult Foster Home" has the same definition as is provided in ORS 443.705.

(2) "Approved" means that a subject individual has completed the criminal history check process, including any required fitness determination, and is eligible to provide care or reside in an environment covered by these rules.

(3) "Authorized Designee" means a person who is designated by an approved qualified entity and authorized by the Department to receive and process criminal history check request forms from subject individuals and criminal history information from the Department. The authorized designee conducts fitness determinations.

(4) "Care" means the provision of care, treatment, education, training, instruction, supervision, placement services, transportation, recreation or support to children, the elderly or persons with disabilities.

(5) "Client" means any person who receives care, or funding for care, through the Department.

(6) "Contact Person" means a person who is designated by a qualified entity to receive and process criminal history check request forms from subject individuals, but who is not authorized to receive criminal history information from the Department. The contact person is not allowed to make final fitness determinations. The contact person is allowed to make preliminary fitness determinations only if a weighing test is not required.

(7) "Conviction" means that the subject individual was convicted in a court of law, or was adjudicated in a juvenile court and found responsible for the crime. "Conviction" as used in these rules includes a finding of "guilty except by reason of insanity," "not guilty by reason of insanity," or similarly worded findings. Entering a plea of "guilty" or "no contest" is also considered a conviction for the purpose of these rules unless a subsequent court decision has dismissed the charges.

(8) "Criminal History Check Rules" or "These Rules" means OAR chapter 410, division 007.

(9) "Criminal History Check" or "CHC" means the Oregon Criminal History Check and when required, a National Criminal History Check and/or a State-Specific Criminal History Check, and the processes and procedures required by these rules.

(10) "Criminal History Information" means criminal justice records, fingerprints, court records, sexual offender registration records, warrants, DMV information, information provided on the Department's criminal history check forms, and any other information obtained by or provided to the Department pursuant to these rules for the purpose of conducting a fitness determination. "Criminal history information" does not include violations or infractions (see ORS 161.505-161.585).

(11) "Denied" means that a subject individual who has completed a criminal history check, including a fitness determination, has been found to be not eligible to be certified, licensed, registered or otherwise authorized by the Department to provide care or to reside in an environment covered by these rules.

(12) "Department" means the Oregon Department of Human Services or any subdivision thereof.

(13) "Employer," if the qualified entity is a corporation, means the corporation or parent corporation.

(14) "Facility" means any entity that is licensed or certified by the Department and which provides care.

(15) "Homecare Worker" or "Home Care Worker" means a provider who is enrolled in the Department's client-employed provider program and who provides either hourly or live-in services, as defined in ORS 410.600.

(16) "Independent Provider" means a person who meets the qualifications described in OAR 411-305-0020, 411-330-0020 or 411-340-0020.

(17) "National Criminal History Check" means obtaining and reviewing criminal history outside Oregon's borders. This information may be obtained from the Federal Bureau of Investigation through the use of fingerprint cards and from other criminal information resources.

(18) "Oregon Criminal History Check" means obtaining and reviewing information from the Oregon State Police's Law Enforcement Data System (LEDS). The Oregon Criminal History Check may also include a review of information from the Oregon Judicial Information Network (OJIN), Oregon Department of Corrections records, Motor Vehicles Division, local or regional criminal history information systems, or other official law enforcement agency or court records in Oregon.

(19) "Personal Care Services Provider" means a person who is directly employed by a client of the Department to provide assistance with activities of daily living and other activities as described in OAR chapter 411, division 34.

(20) "Potentially Disqualifying Crime" means a crime listed in OAR-410-007-0280.

(21) "Probationary Status" means a condition in which a subject individual may be allowed by the authorized designee to work, volunteer, be trained or reside in an environment covered by these rules following submission of a completed DHS Criminal History Request form. The term "probationary status" is applicable only during the timeframe prior to a final fitness determination.

(22) "Qualified Entity" means the Department; local government agency; community mental health or developmental disability program; local health department; or an individual or business or organization, whether public, private, for-profit, nonprofit or voluntary, that provides care, including a business or organization that licenses, certifies or registers others to provide care. (See ORS 181.533)

(23) "Qualified Vendor" means a supplier of criminal history information who is approved by the Department of Human Services as having access to substantially the same criminal offender information as the Law Enforcement Data System.

(24) "Related" means spouse, domestic partner, natural parent, child, sibling, adopted child, adopted parent, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, aunt, uncle, niece, nephew or first cousin.

(25) "Service Provider" means a person or entity that is licensed, certified, registered, or otherwise regulated or authorized for payment by the Department and that provides care.

(26) "State-Specific Criminal History Check" means obtaining and reviewing information from law enforcement agencies, courts or other

criminal history information resources located in a state or jurisdiction outside Oregon.

(27) "Subject Individual" means a person who is required to complete a criminal history check pursuant to these rules.

(a) "Subject individual" includes:

(A) An employee of the Department, person who has been offered employment by the Department, volunteer or student over whom the Department has direction and control.

(B) A person who is licensed, certified, registered or otherwise regulated or authorized for payment by the Department and who provides care.

(C) An employee or volunteer who provides care within any entity or agency licensed, certified, registered or otherwise regulated by the Department.

(D) A direct care staffperson secured through the services of a personnel services or staffing agency who works in any long term care facility licensed by the Department pursuant to ORS chapter 441.

(E) Except as provided in paragraphs (27)(b)(C) and (D) of this rule, a person who lives in a facility that is licensed, certified, registered or otherwise regulated by the Department to provide care.

(F) An individual working for a private, licensed child caring agency or system of care contractors providing child welfare services pursuant to ORS chapter 418.

(G) A homecare worker, personal care services provider or an independent provider employed by a Department client and who provides services to the client if the Department helps to pay for the services.

(H) A child care provider reimbursed through the Department's child care program, and employees and other persons in child care facilities that are exempt from certification or registration by the Child Care Division of the Employment Department. This includes all persons who reside in or who are frequent visitors to the residence or facility where the child care services are provided and who may have unsupervised access to the children. (REF: OAR chapter 461, division 165.)

(I) A contact person as defined in OAR 410-007-0210.

(J) A person providing training to staff within a long term care facility.

(K) Any person serving as an owner, operator or manager of a room and board facility pursuant to OAR chapter 411, division 68.

(L) Notwithstanding subsection (27)(b) of this rule, any person who is required to complete a criminal history check pursuant to a contract or written agreement with the Department or by other Oregon Administrative Rules of the Department, if the requirement is within the statutory authority granted to the Department. Specific statutory authority must be specified in the contract.

(b) "Subject Individual" does not include:

(A) Any person under 16 years of age.

(B) A person receiving training in a DHS-licensed facility as a part of the required curriculum through any college, university or other training program and who is not an employee in the facility in which training is provided. Facilities must ensure that all such students have passed a substantially equivalent background check process through the training program or are:

(i) Actively supervised at all times as defined in OAR 410-007-0310, and

(ii) Not allowed to have unsupervised access to vulnerable people.

(C) Residents of facilities licensed, certified or registered by the Department who are receiving care or treatment, unless specific, written permission to conduct a criminal history check is received from the Department. The only circumstance in which the Department will allow a check to be performed on a client pursuant to this paragraph is if the client falls within the definition of "subject individual" as listed in subsection (27)(a) of this rule.

(D) Persons who live in or visit relative adult foster homes. This exemption does not apply to the licensee.

(E) Individuals working in child care facilities certified or registered by the Employment Department.

(F) Individuals receiving spousal pay from the Department for care of a spouse.

(G) Individuals employed by a private business that provides services to clients and the general public and that is not regulated by the Department.

(H) Individuals employed by a business that provides appliance repair or structural repair to clients and the general public, and who are temporarily providing such services in an environment regulated by the Department, but who do not have unsupervised access to vulnerable people. This exclusion does not apply to a business that receives funds from the Department for care provided by an employee of the business.

(I) Individuals employed by a private business in which a client of the Department is working as part of an employment service program sponsored by the Department. This exclusion does not apply to an employee of a business that receives funds from the Department for care provided by the employee.

(J) Employees and volunteers working in hospitals, ambulatory surgical centers, special inpatient care facilities, outpatient renal dialysis facilities, and freestanding birthing centers as defined in ORS 442.015, in-home care agencies as defined on ORS 443.305, and home health agencies as defined in ORS 443.005.

(K) Volunteers who are not under the direction and control of the Department or any entity licensed, certified, registered or otherwise regulated by the Department.

(L) Individuals employed or volunteering in a Medicare-certified health care business which is not subject to licensure by the State of Oregon.

(M) People working in restaurants or at public swimming pools.

(N) Hemodialysis technicians.

(O) Individuals employed by Alcohol and Drug Programs that are certified, licensed, or approved by the Office of Mental Health and Addictions Services to provide Prevention, Evaluation or Treatment Services. This exclusion does not apply to programs specifically required by other Department rules to conduct criminal history checks in accordance with these rules.

(P) Persons working for a transit service provider which conducts background checks pursuant to ORS 267.237.

(Q) Persons being certified by the Department as interpreters pursuant to ORS 409.623. This paragraph is not intended to exempt a Department-certified interpreter from a criminal history check when being considered for a specific position.

(R) Employees and volunteers at the Oregon State Hospital.

NOTE: See OAR chapter 309, division 18.

(S) Provider group categories that were authorized for payment by the Department for care if such provider group categories were not covered by a Department criminal record check process prior to 2004.

(T) Foster and adoptive parents providing care for children pursuant to ORS chapter 418.

(28) "Weighing Test" means a process carried out by one or more authorized designees in which known negative and positive information is considered to determine if a subject individual is approved or denied (see OAR 410-007-0320(5)(c).

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0220
Criminal History Check Required

(1) Who Conducts Check. The Department, or a qualified entity authorized by the Department, conducts criminal history checks on all subject individuals.

(2) When Check Is Required (New Checks and Re-checks). A subject individual is required to have a check in the following circumstances:

(a) A person who becomes a subject individual on or after the effective date of these rules is required to have a criminal history check in accordance with these rules.

(b) The subject individual changes employers, positions, licenses, certifications or registrations.

NOTE: "Licenses," "certifications" and "registrations" refers only to licenses, certifications and registration issued by the Department.

(c) A check is required by other rules adopted by the Department, or by contract or written agreement with the Department.

(d) The Department or the authorized designee has reason, such as any indication of possible criminal behavior, to believe that a check is justified.

(3) When A Check Is Not Required. Regardless of what section (2) of this rule states, changing positions does not require a new check in the following circumstances:

(a) A homecare worker, personal care services provider, respite care provider or an independent provider who is paid with funds received from the Department changes clients or adds another client, and the prior, documented criminal history check conducted through the Department has been approved without a restriction as described in OAR 410-007-0320(5)(c)(C).

(b) The subject individual is a child care provider as described in OAR 461-165-0180 who changes clients or begins providing services to another client.

(c) There is no change of employer, the previous fitness determination identified no potentially disqualifying history, and the authorized designee reviews and determines that the previous fitness determination is sufficient.

(d) Emergency medical technicians and first responders as defined in ORS 682.025 are not required to complete checks when changing employers and positions as identified in subsection (2)(b) of this rule.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0230
Qualified Entity

(1) Approval Required. A qualified entity must be approved in writing by the Department pursuant to these rules in order to appoint an authorized designee.

(2) Revocation. The Department may suspend or revoke the written approval of a qualified entity for failure of the qualified entity, an appointed designee or a contact person to comply with these rules.

(3) Appointment of Authorized Designees and Contact People.

(a) A qualified entity with 10 or more employees may appoint authorized designees or contact people. If a qualified entity has no authorized designee, it must appoint one or more contact people.

(b) A qualified entity with fewer than 10 employees is not eligible to appoint authorized designees, but must rely on the Department or another approved qualified entity to conduct fitness determinations for subject individuals.

(4) Grandfathered Qualified Entities. Qualified entities which appointed authorized provider designees or authorized division representatives pursuant to administrative rule prior to 2004 are approved qualified entities and are required to appoint authorized designees unless the Department revokes the approval, or there is mutual consent to discontinue approval.

(5) Revocation of Approval. Approval may be revoked by the Department if the Department determines that the qualified entity, or a contact person or authorized designee appointed by the qualified entity, has failed to comply with these rules.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0240
Contact Person and Authorized Designee

(1) Contact Person. The contact person must:

(a) Appointment. Be appointed by a qualified entity, and apply to and be registered by the Department. The application must be in writing on a form provided by the Department.

(b) CHC. Complete both an Oregon and a national criminal history check in accordance with these rules and must have:

(A) No conviction for a potentially disqualifying permanent review crime,

(B) No convictions for any other crime in the past fifteen years, and

(C) No outstanding warrants, registration as a sex offender in Oregon or any other state, or any other condition identified in OAR 410-007-0290.

(c) Training. Complete a training program and successfully pass any testing as required by the Department for a contact person not later than 90 days following the date of the application.

(d) Responsibilities.

(A) Ensure that adequate measures are taken to protect the confidentiality of the records required by these rules.

(B) Take reasonable measures to verify identification of a subject individual. When the application is submitted in person, these measures include asking the subject individual for government-issued photo identification (example: driver's license) and confirming information written on the DHS Criminal History Request form with information on the photo identification.

(C) Ensure that when a subject individual must be on probationary status, the need for active supervision pursuant to OAR 410-007-0310 is understood by each person responsible for ensuring that active supervision is provided.

(D) Ensure that the subject individual receives a written, timely notice of the final fitness determination. When the decision results in denial or a restriction, the notice must include information regarding how to appeal the decision.

(E) Ensure that when a response to a Criminal History Request form is not received within a reasonable time, that action is taken to determine the cause of the delay.

NOTE: "Reasonable time" may vary. The contact person must investigate if there is a significant and unexplained increase in response time, or if one or more requests are taking significantly longer than other requests submitted during the same time frame.

(F) Ensure that documentation required by these rules is processed and maintained in accordance with these rules.

(G) May review the DHS Criminal History Request form completed by the subject individual to determine if the subject individual has any potentially disqualifying history.

(i) The contact person may allow a subject individual to work or function on probationary status only after the contact person has reviewed the Request Form and determined there is no indication that the subject individual has potentially disqualifying history.

(ii) The contact person must not allow a subject individual who discloses any potentially disqualifying history to work or function on probationary status.

(2) Authorized Designee. The authorized designee must:

(a) Appointment. Be appointed by an approved qualified entity, and apply to and be registered by the Department. The application must be in writing on a form provided by the Department.

(b) CHC. Complete both an Oregon and a national criminal history check in accordance with these rules and must have:

(A) No conviction for a potentially disqualifying permanent review crime,

(B) No convictions for any other crime in the past fifteen years, and

(C) No outstanding warrants, registration as a sex offender in Oregon or any other state, or any other condition identified in OAR 410-007-0290.

(c) Training. Complete a training program and successfully pass any testing as required by the Department for an authorized designee not later than 90 days following the date of the application.

(d) Responsibilities. The authorized designee has all the responsibilities as a contact person as listed in (1)(d)(A) through (1)(d)(F) of this rule, and in addition has the following responsibilities:

(A) Review the DHS Criminal History Request form completed by the subject individual and conduct a preliminary fitness determination in accordance with OAR 411-007-0320 prior to forwarding the DHS Criminal History Request form to determine eligibility for probationary status.

(B) Conduct a final fitness determination in accordance with OAR 411-007-0320.

(C) Participate in the appeal process if requested by the Department.

(3) Conflict of Interest (Authorized Designee). An authorized designee must not have access to LEDS information, or make a fitness determination, if there is a conflict of interest between the authorized designee and the subject individual.

(a) A conflict of interest exists when one or more of the following circumstances is true:

(A) The authorized designee is related to the subject individual.

(B) The authorized designee has a close personal or financial relationship, other than an employee-employer relationship, with the subject individual.

(b) When there is a conflict of interest, and the qualified entity has no other authorized designees available to conduct the fitness determination, the qualified entity must submit the application to the Department and the Department will complete the determination.

(4) Termination:

(a) When the authorized designee's or contact person's position with the qualified entity is terminated, or when the qualified entity revokes the appointment, the Department's registration of the authorized designee or contact person is terminated. The qualified entity must notify the Department immediately upon the termination of the appointment.

(b) The qualified entity must suspend or revoke the appointment of an authorized designee or contact person for failure to comply with the rules of the Department or failure to continue to meet the qualifications for the position of authorized designee or contact person, as applicable. After suspending or revoking the appointment, the qualified entity must notify the Department's Criminal Records Unit in writing within seven days. Termination is not subject to appeal under these rules.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0250
Oregon Criminal History Check Process

(1) Forms Required. A qualified entity, authorized designee and subject individual must use the Department's form to request the criminal his-

tory check. The Department will make the DHS Criminal History Request form and other forms required under these rules available for use or reproduction to all qualified entities.

(2) Processing:

(a) The Department obtains criminal history information from the Oregon State Police Law Enforcement Data System and from what other sources of criminal, judicial and motor vehicle information as the Department determines necessary to complete the check.

(b) Only an approved qualified entity, working through an authorized designee, may:

(A) Receive and evaluate Oregon criminal history information from the Department.

(B) Conduct fitness determinations.

(c) The Department or the authorized designee may require that a subject individual obtain and provide additional criminal, judicial or other background information.

(d) Criminal history information obtained from the Law Enforcement Data System must be handled in accordance with ORS chapter 181 and the rules adopted pursuant thereto.

NOTE: See OAR chapter 257, division 15.

Stat. Auth.: ORS 181.537, 409.010, 409.050

Stats. Implemented: ORS 181.537

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0260

State-Specific Criminal History Check Process

(1) Notwithstanding the provisions of OAR 410-007-0270, the Department may conduct a state-specific criminal history check in lieu of a national check when the Department has reason to believe that out-of-state history may exist and that a nationwide criminal history check is not warranted.

(2) The Department may conduct a state-specific check in addition to a national check in order to clarify incomplete or conflicting information.

Stat. Auth.: ORS 181.537, 409.010, 409.050

Stats. Implemented: ORS 181.537

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0270

National Criminal History Check Process

(1) National Criminal History Check. In addition to an Oregon check (OAR 410-007-0250), a national criminal history check may be required by the Department under any of the following circumstances:

(a) Out-of-State Residency or Employment.

(A) Child Care Providers (18 months). The subject individual is a child care provider or other person included in OAR 410-007-0210(27)(a)(H) who has lived outside Oregon for 60 or more consecutive days during the previous eighteen months.

(B) Emergency Medical Services (5 years). The subject individual is an Emergency Medical Technician (EMT) or First Responder (FR) as defined in ORS 682.025 who has lived or been employed outside Oregon for 60 or more consecutive days during the previous five years.

(C) Child Welfare System (5 years). The subject individual is working for private, licensed child caring agencies and system of care contractors providing child care pursuant to ORS chapter 418 and has lived outside Oregon for 60 or more consecutive days during the previous five years.

(D) Other Subject Individuals (3 years). The subject individual is not covered by paragraphs (A), (B) or (C) of this subsection and has lived outside Oregon for 60 or more consecutive days during the previous three years.

(b) Multi-state Offender. The LEDS check, or any other information obtained by the Department, indicates there may be criminal history outside of Oregon, or the subject individual self-discloses criminal history outside of Oregon.

(c) Identity or History Questioned. The social security number appears not to be valid or is not provided to the Department on the DHS Criminal History Request form, the subject individual has no Oregon Driver License or Oregon Identification card, or the Department has other reason to question the identity or history of the subject individual.

(2) Fingerprinting a Juvenile. Consent of the parent or guardian is required to obtain fingerprints from a child under the age of 18 years.

(3) Forms and Processing. The subject individual must complete and submit fingerprint cards when requested by the Department.

(a) Fingerprint Cards. The subject individual must use fingerprint cards (Example: FBI Form FD 258) provided by the Department.

(b) Time Frame for Return. The cards must be submitted within 30 days of the request to the Department's Criminal Records Unit to avoid delay or denial.

(c) Extension. The Department may extend the time allowed for good cause.

(d) Information Required from Subject Individual. The Department or the authorized designee may require that a subject individual obtain and provide to the Department additional criminal, judicial or other background information.

(4) Department Makes Fitness Determination. When a subject individual has a potentially disqualifying national criminal history, the Department makes the fitness determination.

Stat. Auth.: ORS 181.537, 409.010, 409.050

Stats. Implemented: ORS 181.537

Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0280

Potentially Disqualifying Crimes

The following crimes are potentially disqualifying. The lists include offenses that are crimes and are not intended to include offenses that are classified as violations (see ORS 161.505 through 161.565).

(1) Permanent Review. The crimes listed in this section are crimes which require that a fitness determination be completed regardless of date of conviction;

(a) ORS 162.155, Escape II;

(b) ORS 162.165, Escape I;

(c) ORS 162.325, Hindering prosecution;

(d) ORS 163.005, Criminal homicide;

(e) ORS 163.095, Aggravated murder;

(f) ORS 163.115, Murder;

(g) ORS 163.118, Manslaughter I;

(h) ORS 163.125, Manslaughter II;

(i) ORS 163.145, Criminally negligent homicide;

(j) ORS 163.160, Assault IV;

(k) ORS 163.165, Assault III;

(l) ORS 163.175, Assault II;

(m) ORS 163.185, Assault I;

(n) ORS 163.200, Criminal mistreatment II;

(o) ORS 163.205, Criminal mistreatment I;

(p) ORS 163.213, Unlawful use of an electrical stun gun, tear gas, or mace I;

(q) ORS 163.225, Kidnapping II;

(r) ORS 163.235, Kidnapping I;

(s) ORS 163.257, Custodial interference I;

(t) ORS 163.355, Rape III;

(u) ORS 163.365, Rape II;

(v) ORS 163.375, Rape I;

(w) ORS 163.385, Sodomy III;

(x) ORS 163.395, Sodomy II;

(y) ORS 163.405, Sodomy I;

(z) ORS 163.408, Unlawful Sexual penetration II;

(aa) ORS 163.411, Unlawful Sexual penetration I;

(bb) ORS 163.415, Sexual abuse III;

(cc) ORS 163.425, Sexual abuse II;

(dd) ORS 163.427, Sexual abuse I;

(ee) ORS 163.525, Incest;

(ff) ORS 163.535, Abandonment of a child;

(gg) ORS 163.537, Buying or selling a person under 18 years of age;

(hh) ORS 163.545, Child neglect II;

(ii) ORS 163.547, Child neglect I;

(jj) ORS 163.555, Criminal nonsupport;

(kk) ORS 163.575, Endangering the welfare of a minor;

(ll) ORS 163.670, Using child in display of sexually explicit conduct;

(mm) ORS 163.673, Dealing sexual condition of children;

(nn) ORS 163.675, Sale sexual condition of children;

(oo) ORS 163.680, Paying for sexual view of children;

(pp) ORS 163.684, Encouraging child sexual abuse I;

(qq) ORS 163.686, Encouraging child sexual abuse II;

(rr) ORS 163.687, Encouraging child sexual abuse III;

(ss) ORS 163.688, Possession of materials depicting sexually explicit conduct of a child I;

(tt) ORS 163.689, Possession of materials depicting sexually explicit conduct of a child II;

(uu) ORS 163.693, Failure to report child pornography;

(vv) ORS 164.057, Aggravated theft I;

(ww) ORS 164.075, Theft by extortion;

(xx) ORS 164.125, Theft of services;

(yy) ORS 164.225, Burglary I;

(zz) ORS 164.325, Arson I;

(aaa) ORS 164.395, Robbery III;
(bbb) ORS 164.405, Robbery II;
(ccc) ORS 164.415, Robbery I;
(ddd) ORS 165.581, Cellular counterfeiting I;
(eee) ORS 166.005, Treason;
(fff) ORS 166.015, Riot;
(ggg) ORS 166.085, Abuse of corpse II;
(hhh) ORS 166.087, Abuse of corpse I;
(iii) ORS 166.155, Intimidation II;
(jjj) ORS 166.165, Intimidation I;
(kkk) ORS 166.220, Unlawful use of weapon;
(lll) ORS 166.272, Unlawful possession of machine guns, certain short-barreled firearms and firearm silencers;
(mmm) ORS 166.275, Possession of weapons by inmates of institutions;
(nnn) ORS 166.429, Firearms used in felony;
(ooo) ORS 166.720, Racketeering activity unlawful;
(ppp) ORS 167.012, Promoting prostitution;
(qqq) ORS 167.017, Compelling prostitution;
(rrr) ORS 167.062, Sadomasochistic abuse or sexual conduct in live show;
(sss) ORS 167.065, Furnishing obscene materials to minors;
(ttt) ORS 167.070, Sending obscene materials to minors;
(uuu) ORS 167.075, Exhibiting an obscene performance to a minor;
(vvv) ORS 167.080, Displaying obscene materials to minors;
(www) ORS 167.087, Disseminating obscene material;
(xxx) ORS 167.262, Adult using minor in commission of controlled substance offense;
(yyy) ORS 167.315, Animal abuse II;
(zzz) ORS 167.320, Animal abuse I;
(aaaa) ORS 167.322, Aggravated animal abuse I;
(bbbb) ORS 167.333, Sexual assault of animal;
(cccc) ORS 181.599, Failure to report as sex offender;
(dddd) ORS 475.992, Prohibited acts generally (regarding drug crimes);
(eeee) ORS 475.995, Distribution to minors;
(ffff) ORS 475.999, Penalty for manufacture or delivery of controlled substance within 1000 feet of school;
(gggg) Any federal crime;
(hhhh) 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, including any crime based on criminal liability for conduct of another pursuant to ORS 161.155;
(iiii) Any crime in any other jurisdiction that is the substantial equivalent of any of the Oregon crimes listed in this section (1) as determined by the authorized designee;
(jjjj) Any crime that is no longer codified in Oregon or other jurisdiction but that is the substantial equivalent of any of the crimes listed in this section (1) as determined by the authorized designee;
(kkkk) A new crime, adopted by the Legislature following the most recent amendment of these rules, that is the substantial equivalent of any of the crimes listed in this section (1) as determined by the authorized designee.
(2) Ten-Year Review. The crimes listed in this section are crimes that require that a fitness determination be completed if the date of conviction is within ten years of the date the DHS Criminal History Request form was signed:
(a) ORS 162.015, Bribe giving;
(b) ORS 162.025, Bribe receiving;
(c) ORS 162.065, Perjury;
(d) ORS 162.075, False swearing;
(e) ORS 162.117, Public investment fraud;
(f) ORS 162.145, Escape III;
(g) ORS 162.175, Unauthorized departure;
(h) ORS 162.185, Supplying contraband;
(i) ORS 162.195, Failure to appear II;
(j) ORS 162.205, Failure to appear I;
(k) ORS 162.247, Interfering with a peace officer;
(l) ORS 162.265, Bribing a witness;
(m) ORS 162.275, Bribe receiving by a witness;
(n) ORS 162.285, Tampering with a witness;
(o) ORS 162.295, Tampering with physical evidence;
(p) ORS 162.305, Tampering with public records;
(q) ORS 162.335, Compounding;
(r) ORS 162.355, Simulating legal process;
(s) ORS 162.365, Criminal impersonation;
(t) ORS 162.367, Criminal impersonation of peace officer;
(u) ORS 162.369, Possession of false law enforcement identification card;
(v) ORS 162.385, Giving false information to police officer for a citation;
(w) ORS 162.405, Official misconduct II;
(x) ORS 162.415, Official misconduct I;
(y) ORS 162.425, Misuse of confidential information;
(z) ORS 163.190, Menacing;
(aa) ORS 163.195, Recklessly endangering another person;
(bb) ORS 163.208, Assaulting a public safety officer;
(cc) ORS 163.212, Unlawful use of an electrical stun gun, tear gas, or mace II;
(dd) ORS 163.245, Custodial interference II;
(ee) ORS 163.275, Coercion;
(ff) ORS 163.435, Contributing to the sexual delinquency of a minor;
(gg) ORS 163.445, Sexual misconduct;
(hh) ORS 163.465, Public indecency;
(ii) ORS 163.467, Private indecency;
(jj) ORS 163.515, Bigamy;
(kk) ORS 163.700, Invasion of personal privacy;
(ll) ORS 163.732, Stalking;
(mm) ORS 163.750, Violating court's stalking protective order;
(nn) ORS 164.043, Theft III;
(oo) ORS 164.045, Theft II;
(pp) ORS 164.055, Theft I;
(qq) ORS 164.085, Theft by deception;
(rr) ORS 164.095, Theft by receiving;
(ss) ORS 164.135, Unauthorized use of a vehicle;
(tt) ORS 164.140, Criminal possession of rented or leased personal property;
(uu) ORS 164.162, Mail theft or receipt of stolen mail;
(vv) ORS 164.215, Burglary II;
(ww) ORS 164.235, Possession of burglar's tools;
(xx) ORS 164.255, Criminal trespass I;
(yy) ORS 164.265, Criminal trespass while in possession of firearm;
(zz) ORS 164.272, Unlawful entry into motor vehicle;
(aaa) ORS 164.315, Arson II;
(bbb) ORS 164.354, Criminal Mischief II;
(ccc) ORS 164.365, Criminal Mischief I;
(ddd) ORS 164.369, Interfering with police animal;
(eee) ORS 164.377, Computer crime;
(fff) ORS 165.007, Forgery II;
(ggg) ORS 165.013, Forgery I;
(hhh) ORS 165.017, Criminal possession of a forged instrument II;
(iii) ORS 165.022, Criminal possession of a forged instrument I;
(jjj) ORS 165.032, Criminal possession of a forgery device;
(kkk) ORS 165.037, Criminal simulation;
(lll) ORS 165.042, Fraudulently obtaining a signature;
(mmm) ORS 165.055, Fraudulent use of a credit card;
(nnn) ORS 165.065, Negotiating a bad check;
(ooo) ORS 165.070, Possessing fraudulent communications device;
(ppp) ORS 165.074, Unlawful factoring of credit card transaction;
(qqq) ORS 165.080, Falsifying business records;
(rrr) ORS 165.085, Sports bribery;
(sss) ORS 165.090, Sports bribe receiving;
(ttt) ORS 165.095, Misapplication of entrusted property;
(uuu) ORS 165.100, Issuing a false financial statement;
(vvv) ORS 165.102, Obtaining execution of documents by deception;
(www) ORS 165.543, Interception of communications;
(xxx) ORS 165.570, Improper use of 9-1-1 emergency reporting system;
(yyy) ORS 165.577, Cellular counterfeiting III;
(zzz) ORS 165.579, Cellular counterfeiting II;
(aaaa) ORS 165.692, Making false claim for health care payment;
(bbbb) ORS 165.800, Identity theft;
(cccc) ORS 166.025, Disorderly conduct;
(dddd) ORS 166.065, Harassment;
(eeee) ORS 166.076, Abuse of a memorial to the dead;
(ffff) ORS 166.115, Interfering with public transportation;
(gggg) ORS 166.180, Negligently wounding another;
(hhhh) ORS 166.190, Pointing firearm at another;
(iiii) ORS 166.240, Carrying of concealed weapon;
(jjjj) ORS 166.250, Unlawful possession of firearms;

(kkkk) ORS 166.270, Possession of weapons by certain felons;

(llll) ORS 166.370, Possession of firearm or dangerous weapon in public building or court facility; exceptions; discharging firearm at school;

(mmmm) ORS 166.382, Possession of destructive device prohibited;

(nnnn) ORS 166.384, Unlawful manufacture of destructive device;

(oooo) ORS 166.470, Limitations and conditions for sales of firearms;

(pppp) ORS 166.480, Sale or gift of explosives to children;

(qqqq) ORS 166.649, Throwing an object off an overpass II;

(rrrr) ORS 166.651, Throwing an object off an overpass I;

(ssss) ORS 166.660, Unlawful paramilitary activity;

(tttt) ORS 167.007, Prostitution;

(uuuu) ORS 167.090, Publicly displaying nudity or sex for advertising purposes;

(vvvv) ORS 167.212, Tampering with drug records;

(wwww) ORS 167.222, Frequenting a place where controlled substances are used;

(xxxx) ORS 167.325, Animal neglect II;

(yyyy) ORS 167.330, Animal neglect I;

(zzzz) ORS 167.355, Involvement in animal fighting;

(aaaaa) ORS 167.365, Dogfighting;

(bbbbb) ORS 167.370, Participation in dogfighting;

(ccccc) ORS 167.820, Concealing the birth of an infant;

(ddddd) ORS 411.630, Unlawfully obtaining public assistance;

(eeeee) ORS 411.675, Submitting wrongful claim or payment (e.g., public assistance);

(fffff) ORS 411.840, Unlawfully obtaining or disposing of food stamp benefits;

(ggggg) ORS 417.990, Penalty for placement of children in violation of compact;

(hhhhh) ORS 418.130, Unauthorized use and custody of records of temporary assistance for needy families program;

(iiiii) ORS 418.140, Sharing assistance prohibited;

(jjjjj) ORS 418.250, Supervision of child-caring agencies;

(kkkkk) ORS 418.327, Licensing of certain schools and organizations offering residential programs;

(lllll) ORS 471.410, Providing liquor to person under 21 or to intoxicated person; allowing consumption by minor on property;

(mmmmm) ORS 475.950, Failure to report precursor substance

(nnnnn) ORS 475.955, Failure to report missing precursor substances;

(ooooo) ORS 475.960, Illegally selling drug equipment;

(ppppp) ORS 475.965, Providing false information on precursor substances report;

(qqqqq) ORS 474.991, Unlawful delivery of imitation controlled substance;

(rrrrr) ORS 475.993, Prohibited acts for registrants;

(sssss) ORS 475.994, Prohibited acts involving records and fraud;

(ttttt) ORS 475.996, Commercial drug offense;

(uuuuu) ORS 657A.280, Failure to certify child care facility;

(vvvvv) ORS 803.230, Forging, altering or unlawfully producing or using title or registration;

(wwwww) ORS 811.140, Reckless driving;

(zzzzz) ORS 811.540, Fleeing or attempting to elude police officer;

(aaaaaa) ORS 811.700, Failure to perform duties of driver when property is damaged;

(bbbbbb) ORS 811.705, Failure to perform duties of driver to injured persons;

(cccccc) Any crime of attempt, solicitation or conspiracy to commit a crime listed in this section pursuant to ORS 161.405 or 161.435, including any conviction based on criminal liability for conduct of another pursuant to ORS 161.155.

(dddddd) Any crime in any other jurisdiction which is the substantial equivalent of any of the Oregon crimes listed in this section (section (2)) as determined by the authorized designee.

(eeeeee) Any crime which is no longer codified in Oregon, but which is the substantial equivalent of any of the crimes listed in this section (section (2)) as determined by the authorized designee.

(ffffff) A new crime, adopted by the Legislature following the most recent amendment of these rules, which is the substantial equivalent of any of the crimes listed in this section (section (2)) as determined by the authorized designee.

(3) Five-Year Review. The crimes listed in this section are crimes which require that a fitness determination be completed if the date of conviction is within five years of the date the DHS Criminal History Request form was signed:

(a) ORS 162.085, Unsworn falsification;

(b) ORS 162.235, Obstructing governmental or judicial administration;

(c) ORS 162.315, Resisting arrest;

(d) ORS 162.455, Interfering with legislative operations;

(e) ORS 162.465, Unlawful legislative lobbying;

(f) ORS 164.245, Criminal trespass II;

(g) ORS 164.345, Criminal mischief III;

(h) ORS 165.047, Unlawfully using slugs;

(i) ORS 165.107, Failing to maintain a metal purchase record;

(j) ORS 165.109, Failing to maintain a cedar purchase record;

(k) ORS 165.555, Unlawful telephone solicitation of contributions for charitable purposes;

(l) ORS 166.075, Abuse of venerated objects;

(m) ORS 166.090, Telephonic harassment;

(n) ORS 166.095, Misconduct with emergency telephone calls;

(o) ORS 167.340, Animal abandonment;

(p) ORS 418.630, Operate uncertified foster home;

(q) ORS 475.525, Sale of drug paraphernalia prohibited;

(r) ORS 475.805, Providing hypodermic device to minor prohibited;

(s) ORS 811.182, Criminal driving while suspended or revoked;

(t) ORS 813.010, Driving under the influence of intoxicants (DUII);

(u) ORS 819.300, Possession of a stolen vehicle;

(v) Any conviction for attempt, solicitation or conspiracy to commit a crime listed in this section pursuant to ORS 161.405 or 161.435, including any conviction based on criminal liability for conduct of another pursuant to ORS 161.155.

(w) Any crime in any other jurisdiction which is the substantial equivalent of any of the Oregon crimes listed in this section (section (3)) as determined by the authorized designee.

(x) A combination of any three crimes not listed in these rules which were committed on three different dates within the previous five years.

(y) Any crime which is no longer codified in Oregon, but which is the substantial equivalent of any of the crimes listed in this section (section (3)) as determined by the authorized designee.

(z) A new crime, adopted by the Legislature following the most recent amendment of these rules, which is the substantial equivalent of any of the crimes listed in this section (section (3)) as determined by the authorized designee.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0290
Other Potentially Disqualifying Conditions

The following are potentially disqualifying conditions:

(1) Failure to Cooperate with Process. Failure of the subject individual to cooperate with the process, including refusal to complete or sign the required forms in a timely manner, failure to provide information listed in OAR 410-007-0300 when requested by the authorized designee, or failure to obtain or provide usable fingerprints in a timely manner.

(2) False Statement. A "false statement" by the subject individual to the qualified entity, authorized designee or Department, including provision of materially false information or failure to disclose requested information.

(3) Sex Offender. The subject individual is a registered sex offender in Oregon or any other jurisdiction.

(4) Warrants. An outstanding warrant against the subject individual for a potentially disqualifying crime.

(5) Deferred Sentence, Diversion Program or Probation. The subject individual has a deferred sentence, conditional discharge, is participating in a diversion program, or has not completed a required diversion program or any condition of probation, for any crime listed in these rules.

(6) Probation Violation. A probation violation during the previous five years for any crime listed in OAR 410-007-0280.

(7) Unresolved Arrests. An unresolved arrest for a potentially disqualifying crime. (Example: An unresolved arrest for a ten-year review crime during the previous ten years).

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0300
Other Information Considered

When other information is disclosed by the subject individual, or is otherwise known by the authorized designee, the authorized designee must consider such information in addition to potentially disqualifying crimes

and conditions when making the fitness determination. Such information includes:

(1) Nature of Crime and Potentially Disqualifying Conditions. Such circumstances may include, but are not limited to:

(a) Age of the subject individual at time of the crime.

(b) Domestic relationships or situations, when applicable.

(c) Details of incidents leading to the charges or disqualifying conditions.

(d) Facts that support the conviction, pending indictment or the making of the false statement.

(2) Other Circumstances. The authorized designee must also consider factors when relevant information is provided by the Department or the subject individual including, but not limited to:

(a) Periods of incarceration of the subject individual.

(b) Passage of time since commission of the crime.

(c) Parolee or probation status.

(d) Completion of a diversion or rehabilitation program.

(e) Other information related to criminal activity including charges, arrests, and convictions.

(f) Likelihood of repetition of criminal behavior, including, but not limited to, the subject individual's acknowledgment and honesty relative to past behavior, and whether the subject individual appears to accept responsibility for past actions, as determined by the authorized designee.

(g) Changes in circumstances subsequent to the criminal activity.

(h) Information from Department protective services investigations and other investigations.

(i) Education.

(j) Work history (employee or volunteer).

(k) Written recommendations from current or past employer(s).

(3) Relevancy of History to Position. The relevancy of the subject individual's criminal history to the paid or volunteer position, or to the environment in which the subject individual will reside or work, must be considered.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0310
Probationary Status

A subject individual may work, volunteer, reside, or be trained in a facility or other environment identified in these rules prior to a final fitness determination only under the following conditions. If allowed to work, volunteer, reside, or be trained under the following conditions, the subject individual is on probationary status:

(1) Request Must Be Submitted. A DHS Criminal History Request form must have been completed and submitted to the Department.

(2) Preliminary Fitness Determination Required. A preliminary fitness determination must have been completed pursuant to OAR 410-007-0320.

(3) Active Supervision. A subject individual who is on probationary status must be actively supervised at all times by someone who completes a history check and is approved pursuant to these rules.

(a) Duties. The person providing active supervision at all times must meet all of the following conditions:

(A) Be in the same building as the subject individual or be within line-of-sight, except as provided in subsection (5)(b) of this rule,

(B) Know where the person on probationary status is and what the person is doing, and

(C) Periodically observe the actions of the person on probationary status.

(b) Supervision by Exempt Person. A client of the Department, an adult client's related adult family member, or a child's parent or guardian, may provide active supervision if authorized in section (5) of this rule without a history check.

(c) Exemption from Active Supervision. A subject individual who was approved without restrictions within the previous 24 months through a documented criminal history check pursuant to these rules or prior DHS criminal history check rules may function on probationary status without active supervision. The qualified entity must maintain the documentation.

NOTE: Time frame (24 months) is based on length of time between date of previous approval and date starting new position.

(4) Status Prior to Final Fitness Determination. Nothing in this rule is intended to require that a subject individual who is eligible for probationary status be allowed to work, volunteer, reside, or be trained in a facility prior to a final fitness determination.

(5) Criteria for Specific Provider Types.

(a) Adult Foster Homes (AFH).

(A) Before a new license or a license renewal is issued, the AFH provider and all subject individuals living or working in the AFH must complete the final fitness determination and be approved by the Department.

(B) Substitute caregivers in AFHs must complete the Oregon criminal history check and, when required, have submitted fingerprint cards, before being allowed to work in an AFH. An expedited review process is available when requested by an AFH because of an immediate staffing need.

(b) Child Care Providers. Responsibility for providing active supervision in the case of child care providers is with the child's parent or guardian, but the supervision is not required to be performed by someone in the building.

(c) Homecare Worker, Personal Care Services Provider and Independent Provider.

(A) A homecare worker, personal care services provider, or independent provider may be actively supervised by the client if the client makes an informed decision to employ the provider.

(B) The Department may allow a homecare worker, personal care services provider, Department volunteer or an independent provider to be actively supervised by someone related to the client.

(d) Child Foster Care. Probationary status is not allowed in child foster care.

(e) Emergency Medical Services. Probationary status is not allowed under these rules for Emergency Medical Technicians and First Responders as defined in ORS 682.025.

(6) Termination of Probationary Status. Probationary status may be terminated by the qualified entity immediately if there is any indication of falsification of application, including but not limited to:

(a) The criminal history check reveals a conviction for any potentially disqualifying crime not disclosed by the subject individual.

(b) The LEDS check identifies the subject individual as a "multi-state offender" and the subject individual did not disclose an out-of-state conviction or arrest.

(c) The subject individual failed to disclose an arrest that did not result in a conviction within the previous five years for a potentially disqualifying crime.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0320
Fitness Determinations

(1) Fitness Determination Before Work or Placement. The qualified entity must not allow a subject individual to be certified or licensed, or to work, volunteer, reside or be trained in a facility or other environment, prior to a fitness determination. NOTE: See exception in OAR 410-007-0240(3).

(2) Termination Following Denial. When a subject individual is denied, the individual must not be allowed to provide care, work, volunteer, reside or be trained in an environment covered by these rules and must be terminated immediately. A denial applies only to the position and application in question.

(3) Preliminary Fitness Determination. A preliminary fitness determination must be completed prior to allowing a subject individual to be on probationary status. The preliminary fitness determination must be made by an authorized designee, or when allowed by subsection (3)(a) of this rule, by a contact person. A person on probationary status must meet all the criteria in either subsection (a) or (b) as listed below:

(a) No Indication of Potentially Disqualifying Crime. If there is no indication of a potentially disqualifying crime or condition on the DHS Criminal History Request form and the authorized designee or contact person has no reason to believe the subject individual has potentially disqualifying history, the subject individual may be on probationary status. Only an authorized designee or a contact person may participate in or make this determination.

(b) Self-Disclosed Criminal History. When a subject individual discloses a conviction or arrest for a potentially disqualifying crime, or any other potentially disqualifying condition, the individual may be on probationary status only after a preliminary fitness determination using a weighing test is completed by an authorized designee.

(4) Final Fitness Determination. Upon receipt of the Oregon criminal history, or when required, the national criminal history, the authorized designee must complete the fitness determination on a timely basis. The fitness determination must be completed within 21 days after receiving the history.

(a) The deadline may be extended by the authorized designee when a criminal history check generates a need to obtain or consider additional information.

(b) The deadline may be extended by the authorized designee when the decision is based on a pending charge for a potentially disqualifying crime.

(5) Potential Outcomes.

(a) Probationary Status. A subject individual may be placed on probationary status following a preliminary fitness determination as described section (3) of this rule.

(b) Automatic Approval. A subject individual is approved in a final fitness determination without a weighing test if after all required criminal history information is received the subject individual meets all of the following conditions:

(A) No potentially disqualifying crimes, warrants, sex offender registration, or probation or parole status,

(B) No unresolved arrests for potentially disqualifying crimes within the previous five years, and

(C) No discrepancies, and no failure to disclose conviction history or out-of-state arrests.

(c) Weighing Test. Only authorized designees may participate in a weighing test. The weighing test must be used to assess fitness unless the subject individual receives automatic approval pursuant to subsection (5)(b) of this rule or the application is closed pursuant to subsection (5)(e) of this rule. In the weighing test, the authorized designee must consider the criminal history disclosed by the subject individual and other information as described in OAR 410-007-0290 and 410-007-0300 in order to assess fitness. When the weighing test is used in a final fitness determination, criminal history discovered during the criminal history check must also be considered. The authorized designee may rely on official written communications and records from law enforcement agencies and judicial systems, and on criminal history provided by the subject individual. Possible outcomes of a weighing test are as follows:

(A) Probationary Status. In a weighing test for a preliminary fitness determination, the outcome is either to allow, or to disallow, probationary status.

(B) Approval. A subject individual may be approved by one or more authorized designees after a weighing test.

(C) Restricted Approval. If the subject individual has potentially disqualifying history, the authorized designee:

(i) May restrict the approval to specific client(s) or environment(s).

(ii) Must complete a new criminal history check before removing a restriction.

(D) Denial. A subject individual who, following such consideration, is determined to pose a significant risk to physical, emotional or financial well-being of children, the elderly or persons with disabilities, must be denied by the authorized designee.

(i) Volunteered History. A subject individual may be denied following a weighing test based upon potentially disqualifying history disclosed by the subject individual without conducting an Oregon, state-specific, or national criminal history check.

(ii) Discovered History. A subject individual may be denied following a weighing test based upon potentially disqualifying history discovered by the authorized designee following an Oregon, state-specific, or national criminal history check.

(d) Fitness Determination by the Department.

(A) A qualified entity must request that the Department conduct the fitness determination when the qualified entity is unable to provide an authorized designee qualified to conduct a fitness determination.

(B) If the Department has reason to believe a fitness determination has not been conducted in compliance with these rules, the Department may repeat the criminal history check and conduct a fitness determination.

(C) If an FBI check identifies potentially disqualifying history, the final fitness determination must be made by the Department. When the Department obtains criminal history information through the Federal Bureau of Investigation that is not in itself potentially disqualifying, but which is related to potentially disqualifying Oregon history, the Department may assess fitness.

NOTE: The Department may not disseminate information obtained through the Federal Bureau of Investigation.

(e) Closed Case. If the subject individual discontinues the application or fails to cooperate with the criminal history check process then the application is considered incomplete. The incomplete application is closed without a fitness determination and there is no right to a contested case hearing. Any of the following circumstances constitutes a discontinuance or failure to cooperate and will result in a closed case:

(A) The subject individual refuses to be fingerprinted when required by these rules.

(B) The subject individual fails to respond to a request from the authorized designee for any information described in OAR 410-007-0300.

(C) The subject individual withdraws the application, leaves the position prior to completion of the check, or cannot be located or contacted by the authorized designee.

(D) The subject individual is disqualified or otherwise determined to not be eligible for reasons other than the criminal history check.

(6) Independent Choices. Clients receiving services through the DHS Independent Choices program (OAR chapter 411, division 36) are not bound by the fitness determination conducted under these rules when selecting care providers.

(7) Notice to Subject Individual. Upon completion of a final fitness determination resulting in a denial or restricted approval, the authorized designee must provide written notice to the subject individual. The notice must be:

(a) In a format approved by the Department, and

(b) Mailed or hand-delivered to the subject individual as soon as possible, but in no case later than fourteen days after the decision. The date of the decision must be recorded on the form.

(8) Documentation. Preliminary and final fitness determinations must be documented in writing.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0330
Contesting a Fitness Determination

(1) Work Pending Appeal Prohibited. If a subject individual is denied, then that person may not hold the position, provide services or be employed, licensed, certified or registered.

(2) History Disputed.

(a) Correcting Disputed History. If a subject individual wishes to challenge the accuracy or completeness of information provided by the Oregon State Police, the Federal Bureau of Investigation or other agencies reporting information to the Department, the subject individual may appeal to the entity providing the information. Such challenges are not subject to the Department's appeal process described in this rule.

(b) Request for Re-Evaluation Following Correction. If the subject individual successfully contests the accuracy or completeness of information provided by the Oregon State Police, the Federal Bureau of Investigation or other agency reporting information to the Department, the Department will conduct a new criminal history check and re-evaluate the criminal history upon submission of a new criminal history request form.

(3) Challenging the Fitness Determination. If a subject individual wishes to dispute an adverse fitness determination, the subject individual may appeal the determination by requesting a contested case hearing. The subject individual must be notified of the opportunity for appeal on a form available from the Department.

(a) Appeal. In order to request a contested case hearing the subject individual or the subject individual's legal representative must complete and sign the hearing request form. The form is available by contacting the DHS Criminal Records Unit.

(b) Deadline for Appeal. The completed and signed form must be received by the Department not later than 45 days after the notice of the fitness determination is mailed to the subject individual. Appeals from employees, applicants, and volunteers of the Department must be received not later than 10 days after the notice.

(c) Extension of Deadline. The Department may extend the time to appeal if the Department determines the delay was caused by factors beyond the reasonable control of the subject individual.

(4) Informal Administrative Review (MANDATORY). When a subject individual is denied and the subject individual requests a contested case hearing, the Department conducts an informal administrative review with the authorized designee who made the fitness decision before referring the appeal to the Office of Administrative Hearings.

(a) Participation by Subject Individual. The subject individual and, if applicable, the subject individual's legal representative, must participate in the informal administrative review. The subject individual's right to a hearing is terminated if, in the opinion of the Department, the subject individual lacks good cause for failure to participate.

(b) Weighing Test Always Applied. The Department will use the weighing test as described in these rules during the administrative review.

(c) Content of Administrative Review. The Department representative, the authorized designee, the subject individual and the subject indi-

vidual's legal representative may discuss any of the matters listed in OAR 137-003-0575(3). The administrative review may also be used to:

(A) Inform the subject individual of the rules that serve as the basis for the denial.

(B) Ensure the subject individual understands the reason for the denial.

(C) Give the subject individual an opportunity to review the information that is the basis for the denial, except as prohibited by state or federal law (see OAR 410-007-0340(2)).

(D) Give the Department and the subject individual the opportunity to correct any misunderstanding of the facts.

(E) Provide an opportunity for the Department and the subject individual to resolve the situation, including developing an agreement whereby the subject individual may be conditionally approved.

(F) Determine if the subject individual wishes to have any witness subpoenas issued should a formal hearing be necessary.

(d) Decision Following Administrative Review. Upon completion of the informal review, the subject individual is advised by the Department in writing of the finding within 14 days.

(e) Hearing Following Administrative Review. If the informal administrative review reverses the denial, no hearing will be held and the appeal will not be forwarded to the Office of Administrative Hearings. If the informal administrative review upholds the denial, the appeal will be referred to the Office of Administrative Hearings and a hearing is held unless the subject individual withdraws the request for a contested case hearing or the Department reverses the denial before the hearing is held.

(5) Contested Case Hearing.

(a) Format. The hearing is conducted in accordance with Attorney General's Uniform and Model Rules of Procedure, "Hearing Panel Rules," OAR 137-003-0501 and the rules that follow.

(b) Department Representation. Employees of the Department may in accordance with ORS 183.452 be authorized by the Department's Director to represent the Department for the contested case hearing. Authorization from the Office of Attorney General is also required. The Department retains the right to be represented by the Attorney General.

(c) Exhibits. The administrative law judge must be provided a complete copy of the criminal history check information as follows:

(A) In the case of federal criminal history and criminal history from jurisdictions outside Oregon, the subject individual must obtain copies of the FBI criminal history report, or a copy of the state criminal history report from each state in which there was criminal or arrest history recorded. The subject individual must provide copies of such documentation to the administrative law judge at least seven days prior to the scheduled hearing. The Department may also provide out-of-state information received from other official sources.

(B) In the case of Oregon criminal history, the Department may provide a copy of the LEDS print-out, OJIN records or other court records to the administrative law judge.

(C) Criminal history information and correspondence regarding the subject individual's criminal history check are prima facie evidence if certified by the Department representative as a true copy.

(d) Role of Administrative Law Judge. The Office of Administrative Hearings and the administrative law judge perform the following duties in the hearing process:

(A) Provide the subject individual with all of the information required under ORS 183.413(2) in writing before the hearing;

(B) Conduct the hearing;

(C) Issue a dismissal by order when neither the subject individual nor the subject individual's representative appears at the hearing; and

(D) Issue a proposed order.

(e) Public Attendance. The informal conference and hearing are not open to the public.

(f) Coordination with Licensure or Certification Hearing. A hearing pursuant to these rules may be conducted in conjunction with a licensure or certification hearing for the subject individual.

(6) Withdrawal. The subject individual may withdraw a hearing request orally or in writing at any time. The withdrawal is effective the date it is received by the Department or the Office of Administrative Hearings. A dismissal order will be issued by the Department or the Office of Administrative Hearings. The subject individual may cancel the withdrawal up to 10 workdays after the date the order is served.

(7) Proposed and Final Order.

(a) Informal Disposition. When an appeal is resolved before being referred to the Office of Administrative Hearings due to an administrative review or withdrawal, the Department will serve a final order confirming the resolution.

(b) Failure to Appear. A hearing request is dismissed by order when neither the subject individual nor the subject individual's legal representative appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing and is served by the Office of Administrative Hearings. The Department will cancel the dismissal order on request of the subject individual or the subject individual's legal representative on a showing that the subject individual and the subject individual's legal representative were unable to attend the hearing and unable to request a postponement for reasons beyond their control.

(c) Proposed Order. After a hearing, the administrative law judge issues a proposed order. If no written exceptions are received by the Department within 10 workdays after the service of the proposed order, the proposed order becomes the final order.

(d) Exceptions. If timely written exceptions to the proposed order are received by the Department, the Department Director or the Director's designee will consider the exceptions and serve a final order.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0340
Record Keeping, Confidentiality

(1) LEDS Reports.

(a) Confidentiality. All LEDS reports and other information (see OAR 410-007-0290 and 410-007-0300) are confidential and must be kept in locked or secure storage.

(A) Authorized Designee Access. LEDS reports are confidential and may only be shared with another authorized designee if there is a need to know consistent with these rules.

(B) Subject Individual Access. The subject individual must be allowed to inspect the LEDS report if the subject individual requests to see it. The LEDS report, and photocopies of the LEDS report, must not be given to the subject individual.

NOTE: Photocopies of the LEDS report should not be made under any circumstances.

(b) Retention. LEDS reports must be maintained by the authorized designee in accordance with applicable Oregon State Police requirements. LEDS reports must be destroyed (shredded or incinerated) within 30 days after receipt by the authorized designee.

(2) National (FBI) Information. National criminal information is confidential and may not be disseminated by the Department.

(3) DHS Forms and Other Documentation.

(a) Confidentiality. All completed DHS Criminal History Request forms must be kept confidential and disseminated only on a need-to-know basis.

(b) Retention Time.

(A) Records documenting the criminal history check and the fitness determination must be retained by the qualified entity for a minimum of two years after the fitness determination, or two years after the subject individual's employment, volunteer status or residency, is terminated, whichever is later.

(B) Documentation must be retained by the qualified entity to demonstrate that the fitness determination was completed pursuant to these rules.

(4) DHS Criminal History Database. The Department maintains a database regarding criminal history checks.

(a) Data. The Department will develop a system that maintains information regarding criminal history checks and minimizes the administrative burden that these rules impose upon subject individuals and providers.

(b) Confidentiality. Records maintained under section (4) of this rule are confidential and are not disseminated by the Department except for the purpose of this section and in accordance with the rules of the Department and the Department of State Police (Oregon State Police).

(c) Retention. Information is maintained in the database for a minimum of three years from the date of the fitness determination.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0350
Immunity from Liability

The qualified entity has immunity from any civil liability that might otherwise be incurred or imposed for determining, in accordance with ORS 181.537(7) that a subject individual is not fit to hold a position, provide services, or be employed, licensed, certified or registered. A qualified entity and an employer or employer's agent who in good faith comply with

ORS 181.537(7) and with the decision of the qualified entity are not liable for the failure to hire a prospective employee or the decision to discharge an employee on the basis of the qualified entity's decision. No employee of the state, a business or an organization is liable for defamation, invasion of privacy, negligence or any other civil claim in connection with the lawful dissemination of information lawfully obtained under ORS 181.537(7).

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0360
Alternate Qualified Vendors

(1) Alternate Vendors Allowed. The criminal history check required by these rules may be conducted by an alternate qualified vendor of criminal history information if the vendor is approved by the Department of Human Services to provide such information pursuant to ORS 181.537.

(2) Access to Information. In order to be approved by the Department, the vendor must demonstrate to the satisfaction of the Department that it has access to substantially the same information that is available to the Department, including, but not limited to the Law Enforcement Data System, the Oregon Judicial Information Network, and the Federal Bureau of Investigation.

(3) Compliance. The qualified vendor must comply with these rules.

(4) Re-Approval. The period of approval is one year. The alternate qualified vendor may request re-approval 90 days prior to the end of the approval period.

(5) Revocation of Approval. The Department may immediately revoke approval of the vendor if the vendor provides incorrect or incomplete information or fails to adhere to these rules.

(a) A vendor whose approval is revoked may request a contested case hearing in accordance with ORS chapter 183.

(b) A vendor that has had approval by the Department revoked is not eligible to reapply for 180 days following revocation.

(6) Qualified Entity Serving as Vendor. A qualified entity may serve as a qualified vendor in order to process the qualified entity's own criminal history checks as provided by this rule.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0370
Variances

The Department may grant variances to the criminal history check rules as described in this rule.

(1) A qualified entity may make a written request to the Department for a variance from these rules. The qualified entity must specify the rule for which a variance is requested, submit a justification for the variance request, and include any supporting documentation. The Department will not grant a variance if to do so would pose a risk to children, the elderly or persons with disabilities.

(2) The Department will approve or disapprove the variance in writing within 90 days of the receipt of the variance request or within 90 days of the receipt of all required criminal offender information records check data. The written notice will set a duration for the approval of the variance.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

410-007-0380
Fees

(1) National Check. The fee for a national criminal history check is as follows:

(a) Long Term Care Facilities. The fingerprint processing fee for nursing facilities, assisted living facilities, and residential care facilities and adult foster homes licensed under OAR chapter 411 is $12 per check.

(b) Emergency Medical Technicians. The fingerprint processing fee for emergency medical technicians is $12 per check.

(2) Fees Established By Contract. The Department may establish fees by contract or written agreement with a qualified entity. Fees may not exceed the cost of providing the service.

Stat. Auth.: ORS 181.537, 409.010, 409.050
Stats. Implemented: ORS 181.537
Hist.: OMAP 8-2004, f. 2-26-04, cert. ef. 3-1-04

• • • • • • • • • •

Adm. Order No.: OMAP 9-2004
Filed with Sec. of State: 2-27-2004
Certified to be Effective: 3-1-04
Notice Publication Date: 2-1-04
Rules Amended: 410-121-0030, 410-121-0040
Rules Repealed: 410-121-0040(T)
Subject: The Pharmaceutical Services program administrative rules govern Office of Medical Assistance Programs' (OMAP) payments for pharmaceutical products and services provided to clients. OMAP temporarily amended rule 410-121-0040 effective December 15, 2003 to change the prior authorization (PA) requirement for non-PMPDP (Practitioner-Managed Prescription Drug Plan) proton pump inhibitors (PPI) from the initial prescription to after eight weeks of acute anti-ulcer therapy. This requires the same therapeutic PA for all PPI products as previously established. Notice was given January 15, 2004 to add FluMist to prior authorization requirements per the recommendations of the Drug Utilization Review Board. This filing is to permanently amend Rule 410-121-0040, effective March 1, 2004. Rule 410-121-0030 is permanently amended to add Calcium Channel Blockers to the PMPDP (PDL) Plan Drug List classes and update the Statin class per annual review. Other revisions are made to take care of necessary housekeeping corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0030
Practitioner-Managed Prescription Drug Plan (PMPDP)

(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) Decisions concerning the clinical effectiveness of the prescription drugs are made by licensed health practitioners, informed by the latest peer-reviewed research;

(b) Decisions 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 a drug(s) as the benchmark drug that has been determined to be the most effective drug(s) available for the best possible price;

(d) The PDL will include other 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 benchmark drug(s). If pharmaceutical manufacturers enter into supplemental discount agreements with DHS that reduce the cost of their drug below that of the benchmark drug for the class, their drug will also be included in 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. Relative price will be determined using the methodology described in subsection (4);

(c) Drug classes and selected drug(s) for the drug classes will be reviewed annually:

(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) New drugs will not be added to the PDL until they have been reviewed by the HRC;

(C) ll changes or revisions to the PDL will be made publicly, using the rulemaking process, and will be published on OMAP's 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. These factors will be weighed with any advice provided by the HRC in reaching a final decision;

(c) DHS will determine the benchmark drug based on (4)(b) and on the Estimated Acquisition Cost (EAC) on the first of the month (OAR 410-121-0180), in which DHS reviews that specific drug class;

(d) Once the cost of the benchmark drug is determined, the cost of the other FDA-approved drugs in the class will be recalculated using EAC for retail pharmacies in effect on the first of the month in which DHS reviews that specific drug class (OAR 410-121-0180), less average available rebate. Drugs with prices under the benchmark drug cost will be included on the PDL.

(5) Regardless of the PDL, prescriptions shall be dispensed in the generic form unless practitioner requests otherwise subject to the regulations outlined in OAR 410-121-0155.

Table 121-0030-1, PMPDP PDL (updated effective 03/01/2004)

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

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

410-121-0040

Prior Authorization Required for Drugs and Products

Products

(1) Prescribing practitioners are responsible for obtaining prior authorization for the following drugs and products:

(a) Isotretinoin (Accutane) and Retinoic Acid (Retin A);

(b) Growth hormone;

(c) Oral Nutritional supplements;

(d) Antihistamines (selected);

(e) Nasal inhalers (selected);

(f) Antifungals (selected);

(g) Weight reduction drugs;

(h) Excessive daily doses;

(i) Excessive drug therapy duration;

(j) Coal tar preparations;

(k) Topical antibiotics;

(l) Topical antivirals (selected);

(m) Topical testosterone;

(n) Dronabinol (marinol);

(o) Drugs with cosmetic indications;

(A) Emollients;

(B) Dermatologicals;

(C) Hair growth products;

(p) Proton Pump Inhibitors (PPI) after eight weeks of acute anti-ulcer therapy;

(q) Gabapentin (Neurontin);

(r) Triptan quantity limits;

(s) FluMist (Influenza Virus Vaccine Live, Intranasal).

(2) Over-the-counter medications not mentioned above are limited to two prescriptions per therapeutic class per month.

(3) Psychotropic prescriptions for children under the age of six cannot be processed when a default 999999 provider number has been entered.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

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

• • • • • • • • • •

Adm. Order No.: OMAP 10-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-120-1160, 410-120-1200, 410-120-1280, 410-120-1340, 410-120-1360, 410-120-1520, 410-120-1540, 410-120-1570
Subject: The General Rules program Administrative rules govern the Office of Medical Assistance Programs (OMAP) payment for services provided to clients. Rules 410-120-1160, 410-120-1200, 410-120-1280, 410-120-1340, 410-120-1520, 410-120-1570, are amended to clarify length of time for provider appeal, add benefit packages to the billing section and to clarify that "medically appropriate" also includes dentally appropriate. Rules 410-120-1360, 410-120-1520 and 410-120-1540 are amended to clarify and broaden audit authority from just OMAP to the Department of Human Services.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-120-1160

Medical Assistance Benefits and Provider Guides

(1) The following services are covered when medically or dentally appropriate and within the limitations established by the Medical Assistance Program and set forth in the Oregon Administrative Rules for each category of medical services:

(a) Acupuncture Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(b) Administrative Examinations, as described in the Administrative Examinations and Billing Services provider rules (OAR 410 Division 150);

(c) Alcohol and Drug Abuse Treatment Services:

(A) Alcohol and Drug Detoxification inpatient services are covered by the Office of Medical Assistance Programs when provided in an acute care hospital and when hospitalization is considered medically appropriate;

(B) Alcohol and Drug Abuse Treatment inpatient hospital services are not covered by the Office of Medical Assistance Programs;

(C) Non-hospital Alcohol and Drug Detoxification and Treatment services are available on a residential or outpatient basis through the Office of Medical Assistance Programs. Contact the client's managed care plan, local alcohol/drug treatment provider or local publicly funded alcohol and drug abuse program for information.

(d) Ambulatory Surgical Center Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(e) Anesthesia Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(f) Audiology Services, as described in the Speech-Language Pathology, Audiology and Hearing Aid Services provider rules (OAR 410 division 129);

(g) Chiropractic Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(h) Dental Services, as described in the Dental/Denturist Services provider rules (OAR 410 division 123);

(i) Early and Periodic Screening, Diagnosis and Treatment services

(EPSDT, Medicheck for children and teens), are covered for individuals under 21 years of age as set forth in the individual program provider rules. OMAP may authorize services in excess of limitations established in the provider guide when it is medically appropriate to treat a condition that is identified as the result of an EPSDT screening;

(j) Family Planning Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130). Family planning services are services and items provided to individuals 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. Services include annual exams, contraceptive education and counseling to address reproductive health issues, laboratory tests, radiological services, medical procedures, including birth control implants, tubal ligation, vasectomy, and pharmaceutical supplies and devices;

(k) Federally Qualified Health Centers and Rural Health Clinic, as described in the Federally Qualified Health Center and Rural Health Clinic provider rules (OAR 410 division 147);

(l) Home and Community Based Waiver Services, as described in the rules of the Mental Health and Developmental Disability Services Division and Seniors and People with Disabilities;

(m) Home Enteral/Parenteral Nutrition and IV Services, as described in the Home Enteral/Parenteral Nutrition and IV Services provider rules (OAR 410 division 148);

(n) Home Health Services, as described in the Home Health Services provider rules (OAR 410 division 127);

(o) Hospice Services, as described in the Hospice Services provider rules (OAR 410 division 142);

(p) Indian Health Services or tribal facility, as described in The Indian Health Care Improvement Act and its Amendments (Public Law 102-573), and the OMAP American Indian/Alaska Native provider rules (OAR 410 division 146);

(q) Inpatient Hospital Services, as described in the Hospital Services provider rules (OAR 410 division 125);

(r) Laboratory Services, as described in the Hospital Services and the Medical-Surgical Services provider rules (OAR 410 division 130);

(s) Licensed Direct Entry Midwife Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(t) Maternity Case Management, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(u) Medical Equipment and Supplies, as described in the Hospital Services, Medical-Surgical Services, Durable Medical Equipment, Home Health Care Services, Home Enteral/Parenteral Nutrition and IV Services and other provider rules;

(v) When client's Medical Care Identification Card indicates a benefit package that includes mental health will be based on the Prioritized List of Health Services. Other Medicaid non-OHP through as described in applicable treatment standard rules;

(w) Naturopathic Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(x) Nutritional Counseling is covered, as described in the Medical/Surgical Services provider rules (OAR 410 division 130);

(y) Occupational Therapy, as described in the Physical and Occupational Therapy Services provider rules (OAR 410 division 131);

(z) Organ Transplant Services, as described in the Transplant Services provider rules (OAR 410 division 124);

(aa) Outpatient Hospital Services, including clinic services, emergency room services, physical and occupational therapy services, and any other outpatient hospital services provided by and in a hospital, as described in the Hospital Services provider rules (OAR 410 division 125);

(bb) Physician, Podiatrist, Nurse Practitioner and Licensed Physician Assistant Services, as described in the Medical-Surgical Services provider rules (OAR 410 division 130);

(cc) Physical Therapy, as described in the Physical and Occupational Therapy and the Hospital Services provider rules (OAR 410 division 131);

(dd) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services, the Home Enteral/Parenteral Nutrition and IV Services and the Hospital Services provider rules (OAR 410 division 121,148 and 125);

(ee) Preventive Services, as described in the Medical-Surgical Services and the Dental/Denturist Services provider rules (OAR 410 division 130 and 123) and prevention guidelines associated with the Health Service Commission's List of Prioritized Health Services (OAR 410-141-0520);

(ff) Private Duty Nursing, as described in the Private Duty Nursing provider rules (OAR 410 division 132);

(gg) Radiology and Imaging Services, as described in the Medical-Surgical Services, the Hospital Services, and Dental and Denturist Services provider rules (OAR 410 division 130,125 and 123);

(hh) Rural Health Clinic Services, as described in the Federally Qualified Health Center and Rural Health Clinic provider rules (OAR 410 division 147);

(ii) School-Based Health Services, as described in the School-Based Health Services provider rules (OAR 410 division 133);

(jj) Speech and Language Therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services and Hospital Services provider rules (OAR 410 division 129 and 125);

(kk) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation provider rules (OAR 410 division 136);

(ll) Vision Services as described in the Visual Services provider rules (OAR 410 division 140).

(2) Other Divisions or Offices, including Vocational Rehabilitation, Mental Health and Developmental Disability Services Division, Office of Alcohol and Drug Abuse Programs, State Office for Services to Children and Families, and Seniors and People with Disabilities Services Division may offer services to Medicaid eligible clients, which are not reimbursed by or available through the Office of Medical Assistance Programs.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

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 73-1980(Temp), f. & ef. 10-1-80; AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 71-1981, f. 9-30-81, ef. 10-1-81; Renumbered from 461-013-0000; 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 94-1982(Temp), f. & ef. 10-18-82; AFS 103-1982, f. & ef. 11-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 62-1983, f. 12-19-83, ef. 1-1-84; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 25-1984, f. 6-8-84, ef. 7-1-84; AFS 14-1985, f. 3-14-85, ef. 4-1-85; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 67-1986(Temp), f. 9-26-86, ef. 10-1-86; AFS 76-1986(Temp), f. & ef. 12-8-86; AFS 16-1987(Temp), f. & ef. 4-1-87; AFS 17-1987, f. 5-4-87, ef. 6-1-87; AFS 32-1987, f. 7-22-87, ef. 8-1-87; AFS 6-1988, f. & cert. ef. 2-1-88; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 69-1988, f. & cert. ef. 12-5-88; AFS 70-1988, f. & cert. ef. 12-7-88; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 8-1989(Temp), f. 2-24-89, cert. ef. 3-1-89; AFS 14-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0102; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HE 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0440; HR 2-1994, f. & cert. ef. 2-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04

410-120-1200

Excluded Services and Limitations

Certain services or items are not covered under any program or for any group of eligible clients. If the client accepts financial responsibility for a non-covered service, payment is a matter between the provider and the client subject to the requirements of OAR 410-120-1280. No payment will be made for any expense incurred for any of the following services or items:

(1) That are not expected to significantly improve the basic health status of the client as determined by the Medical Assistance Program (e.g., OMAP's Medical Director, medical consultants, dental consultants or Peer Review Organization).

(2) That are not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury.

(3) That are determined not medically or dentally appropriate by Medical Assistance Program staff or authorized representatives, including OMPRO or any contracted utilization review organization.

(4) That are not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his/her scope of practice or licensure.

(5) That are for routine checkups or examinations for individuals age 21 or older in connection with participation, enrollment, or attendance in a program or activity not related to the improvement of health and rehabilitation of the client. Examples include exams for employment or insurance purposes.

(6) That are provided by friends or relatives of eligible clients or members of his/her household, except when the friend, relative or household member is a health professional, acting in a professional capacity, or when the friend, relative or household member is directly employed by the client under Seniors & People with Disabilities (SPD) Home and Community Based Waiver.

(7) That are for services or items provided to a client who is in the custody of a law enforcement agency or an inmate of a non-medical public institution, including juveniles in detention facilities, except such services as designated by federal statute or regulation as permissible for coverage under the Medical Assistance Program.

(8) Where the need for purchase, repair or replacement of materials or equipment is caused by adverse actions of clients to personally owned goods or equipment or to items or equipment rented or purchased by the Medical Assistance Program.

(9) That are related to a non-covered service; some exceptions are identified in the individual provider rules. If the provision of a service related to a non-covered service is determined by OMAP to be cost-effective, the related medical service may, at OMAP's discretion and with OMAP's prior authorization, be covered.

(10) Which are considered experimental or investigational or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy.

(11) That are identified in the provider guide appropriate Administrative Rules, including the Hospital guide, Revenue Codes Section, as not covered.

(12) That are requested by or for a client who has been determined by the Medical Assistance Program to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services.

(13) That are for copying or preparing records or documents excepting those Administrative Medical Reports requested by the branch offices or OMAP for casework planning or eligibility determinations.

(14) Whose primary intent is to improve appearance.

(15) Which are similar or identical to services or items which will achieve the same purpose at a lower cost and where it is anticipated that the outcome for the client will be essentially the same.

(16) For the purpose of establishing or reestablishing fertility or pregnancy or for the treatment of sexual dysfunction, including impotence, except as specified by the Prioritized List of Health Services (OAR 410-141-0520).

(17) Items or services which are for the convenience of the client and are not medically or dentally appropriate.

(18) The collection, processing and storage of autologous blood or blood from selected donors unless a physician certifies that the use of autologous blood or blood from a selected donor is medically appropriate and surgery is scheduled.

(19) Educational or training classes which are not medically appropriate (Lamaze classes, for example).

(20) Outpatient social services except Maternity Case Management services and other social services described in the individual provider rules as covered.

(21) Plasma infusions for treatment of Multiple Sclerosis.

(22) Post-mortem exams or burial costs, or other services subsequent to the death of a client.

(23) Radial keratotomies.

(24) Recreational therapy.

(25) Telephone calls, including but not limited to telephone conferences between physicians or between a physician or other practitioner and a client or representative of the client, except for telephone calls for the purpose of tobacco cessation counseling, as described in OAR 410-130-0190, and Maternity Case Management as described in 410-130-0587.

(26) Transsexual surgery or any related services or items.

(27) Weight loss programs, including, but not limited to Optifast, Nutrisystem, and other similar programs. Food supplements will not be authorized for use in weight loss.

(28) Whole blood (whole blood is available at no cost from the Red Cross); the processing, storage and costs of administering whole blood are covered.

(29) Immunizations prescribed for foreign travel.

(30) Services which are requested or ordered but not provided (i.e., an appointment which the client fails to keep or an item of equipment which has not been provided to the client).

(31) DUII-related services already covered by the Intoxicated Driver Program Fund as directed by ORS 813.270(1) and (5).

(32) For transportation to meet a client's personal choice of a provider.

(33) Pain center evaluation and treatment.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

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, Renumbered from 461-013-0030; 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. 11-1-82; AFS 15-1983(Temp), f. & ef. 4-20-83; AFS 31-1983(Temp), f. 6-30-83, ef. 7-1-83; AFS 43-1983, f. 9-2-83, ef. 10-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 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 29-1987(Temp), f. 7-15-87, ef. 7-17-87; AFS 54-1987, f. 10-29-87, ef. 11-1-87; AFS 51-1988(Temp), f. & cert. ef. 8-2-88; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; AFS 58-1988(Temp), f. & cert. ef. 9-27-88; AFS 70-1988, f. & cert. ef. 12-7-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0055; 461-013-0103, 461-013-0109 & 461-013-0112; HR 5-1990(Temp), f. 3-30-90, cert. ef. 4-1-90; HR 19-1990, f. & cert. ef. 7-9-90; HR 23-1990(Temp), f. & cert. ef. 7-20-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 27-1991 (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, Renumbered from 410-120-0420, 410-120-0460 & 410-120-0480; 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 6-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 12-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; 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 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 22-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 8-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 17-2003(Temp), f. 3-13-03, cert. ef. 3-14-03 thru 8-15-03; OMAP 46-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04

410-120-1280
Billing

(1) Medicaid Covered Services: The provider must not bill the Medical Assistance Program more than the provider's Usual Charge (see definitions).

(a) A provider enrolled with the Office of Medical Assistance Programs or a Managed Care Plan under the Oregon Health Plan must not seek payment from a client eligible for Medical Assistance benefit, or from a financially responsible relative or representative of that individual, for any services covered by Medicaid fee-for-service or through contracted managed care plans, including any coinsurance, co-pays, and deductibles.

(b) Except under the circumstances described below:

(A) The client did not inform the provider of Medical Assistance Program 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 the Medical Assistance Program, 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;

(B) The client became eligible for Medical Assistance benefits retroactively but did not meet other established criteria described in these General Rules and the appropriate provider rules (i.e., retroactive authorization);

(C) A third party resource made payments directly to the client for services provided;

(D) The client did not have full Medical Assistance benefits. Clients receiving a limited Medicaid coverage such as the Citizen Alien Waived Emergency Medical Program, MEDS or the Standard benefit package may be billed for services that are not benefits of those programs. The provider must document that the client was informed that the service or item would not be covered by the medical assistance program;

(E) 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;

(F) A client cannot be billed for services/treatment that has been denied due to provider error (i.e. required documentation not submitted, prior authorization not obtained, etc.);

(G) The charge is for a copayment when a client is required to make a copayment as outlined in OMAP General Rules (410-120-1230, 1235) and individual provider rules;

(H) In exceptional circumstances, a client may request to be able to receive 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 OMAP or the client's managed care plan, if the client is a member of a managed care plan;

(ii) The estimated cost of the covered service, including all related charges, the amount that OMAP or the client's managed care plan would pay for the service, and that the client cannot be billed for an amount greater than the maximum OMAP reimbursable rate or managed care plan rate, if the client is a member of a managed care plan;

(iii) That the provider cannot require the client to enter into a voluntary payment agreement for any amount for the covered service;

(iv) And that, if the client knowingly and voluntarily agrees to pay for the covered service, the provider will not be able to submit a claim for payment to OMAP or the client's managed care plan;

(v) 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 shall be given a copy of the signed agreement. A provider may not submit a claim for payment for covered services to OMAP or to the client's managed care plan that are subject to such agreement.

(2) Non-Covered Medicaid Services:

(a) A client may be billed for services that are not covered by the Medical Assistance Program or 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.

(c) A client can not 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 OMAP.

(3) All claims must be billed on the appropriate form as described in the individual provider rules.

(4) Upon submission of a claim to OMAP for payment, the provider agrees that it has complied with all rules of the Medical Assistance Program. Submission of a claim, however, does not relieve the provider from the requirement of a signed provider agreement.

(5) All billings must be for services provided within the provider's licensure or certification.

(6) It is the responsibility of the provider to submit true and accurate information when billing the Medical Assistance Program. Use of a billing provider does not abrogate the performing provider's responsibility for the truth and accuracy of submitted information.

(7) A claim may not be submitted prior to delivery of service. A claim may not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in OMAP's individual provider rules.

(8) 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 guide for specific instructions and requirements. Also, see "Valid Claim" in the Definitions section of these rules.

(9) Diagnosis Code Requirement:

(a) A primary diagnosis code is required on all claims, unless specifically excluded in an individual OMAP medical assistance programs' provider guide;

(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.

(10) For claims requiring a procedure code the provider must bill as instructed in the appropriate Medical Assistance provider guide and must use the appropriate CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, which best describes the specific service or item provided. For claims which require the listing of a diagnosis and/or procedure code as a condition of payment, the code listed on the claim form must be the code which 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 guide Hospitals must follow national coding guidelines:

(a) Where there is no appropriate descriptive procedure code to bill the Medical Assistance Program 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 the Medical Assistance Program using that code rather than itemizing the services under multiple codes. Providers must not "unbundle" services in order to increase payment by the Medical Assistance Program.

(11) No person shall submit or cause to be submitted to the Medical Assistance Program:

(a) Any false claim for payment;

(b) Any claim altered in such a way as to result in a payment for a service which 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) which have not been provided.

(12) 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 the Medical Assistance Program.

(13) A provider who, after having been previously warned in writing by the Medical Assistance Program 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 the Medical Assistance Program for up to triple the amount of the Medical Assistance Program established overpayment received as a result of such violation.

(14) Third Party Resources:

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances the Office of Medical Assistance Program 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 EEVS available to the provider;

(C) Verifying the client's insurance coverage through AIS or the Medical Care Identification card on each date of service and at the time of billing.

(c) Except as noted in (14)(d)(A through E), when third party coverage is known to the provider, as indicated on the Medical Care Identification or through AIS, or any other means available, prior to billing the Medical Assistance Program:

(A) The provider must bill the third party resource; and

(B) Except for pharmacy claims billed through OMAP'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;

(C) Complied with the insurer's billing and authorization requirements;

(D) Appealing 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 third party resource prior to billing the Medical Assistance Program, except under the following circumstances:

(A) Intermediate Care Facility Services for the mentally retarded;

(B) Institutional services for the mentally and emotionally disturbed;

(C) Prenatal and preventive pediatric services;

(D) Services 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 the Medical Assistance Program. The provider may not both place a lien against a settlement and bill the Medical Assistance Program. The provider may withdraw the lien and bill the Medical Assistance Program within 12 months of the date of service. If the provider bills the Medical Assistance Program, the provider must accept payment made by the Medical Assistance Program as payment in full. The provider must not return the payment made by the Medical Assistance Program 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 (14)(d)(A through E) above, the provider may choose to bill the primary insurance prior to billing OMAP. Otherwise, OMAP will process the claim and if applicable will pay the OMAP allowable for these services and seek reimbursement from the liable third party insurance plan.

(ii) In making the decision to bill OMAP the provider should be cognizant of the possibility that the third party payer may reimburse the service at a higher rate than OMAP, and that once payment has been made by OMAP no additional billing to the third party is permitted by the provider.

(e) The provider may bill the Medical Assistance Program 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. See the individual provider rules for further information on services that must be billed to Medicare first:

(A) When a provider receives a payment from any source prior to the submission of a claim to the Medical Assistance Program, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) Except as described in (14), any provider who accepts third party payment for furnishing a service or item to a Medical Assistance client shall:

(i) Submit an Individual Adjustment Request per instructions in the individual provider guide, indicating the amount of the third party payment; or

(ii) When the provider has already accepted payment from OMAP for the specific service or item, the provider shall make direct payment of the amount of the third party payment to the Medical Assistance Program. When the provider chooses to directly repay the amount of the third party payment to the Medical Assistance program, 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 payment by the Medical Assistance Program.

(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;

(g) The Medical Assistance Program reserves the right to make a claim against any third party payer after making payment to the provider of service. The Medical Assistance Program may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, request the provider bill the third party and refund OMAP in accordance with subsection 14;

(h) For services rendered to a Medicare/Medicaid dual eligible client, The Medical Assistance Program 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.

(15) Full Use of Alternate Resources:

(a) The Medical Assistance Program 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 16 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 Program; or

(E) Through other reasonably available resources.

(16) 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 payors of last resort, and are not considered an alternate resource or third party resource;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize veterans facilities whenever possible. Generally Veterans benefits are for service related conditions and as such is not considered an alternate or third party resource. **Table 1280 - TPR Codes**. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

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

410-120-1340
Payment

(1) The Medical Assistance Program will make payment only to the enrolled provider who actually performs the service or the provider's enrolled billing provider for covered services rendered to eligible clients. Federal regulations prohibit OMAP from making payment to collection agencies. The Medical Assistance Program may require that payment for services be made only after review by the Medical Assistance Program.

(2) Fee-for-service payment rates are set by the Office of Medical Assistance Programs and/or the Division administering the program under which the billed services or items are provided.

(3) All fee-for-service payment rates will be the lesser of the amount billed, the Medical Assistance Program allowed amount or the reimbursement specified in the individual program provider rules.

(4) Inpatient hospital service will be reimbursed under the DRG methodology for inpatient hospital services, 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) All out-of-state hospital services are reimbursed at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 division 125) unless the hospital provides highly specialized services and has a contract or service agreement with the Office of Medical Assistance Programs for those services.

(6) Payment rates for in-home services provided through SPD will not be greater than the current Medical Assistance rate for nursing facility payment.

(7) Payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities will be set by Department of Human Services staff 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 Program in that state for that service; or

(c) Is the rate established by SPD for out-of-state nursing facilities.

(8) The Medical Assistance Program will not make payment on claims which have been assigned, sold, or otherwise transferred or on which the billing provider receives a percentage of the amount billed 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) The Medical Assistance Program will not make a separate payment or co-payment 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 and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services 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) The Medical Assistance Program 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 clients with Medicare:

(a) Payment from the Medical Assistance Program is limited to the Medicaid allowed amount less the Medicare payment up to the Medical Assistance Program allowable rate. The amount paid by the Medical Assistance Program cannot exceed the co-insurance and deductible amounts due;

(b) Payment from the Medical Assistance Program for services, which are covered Medical Assistance services but are not covered by Medicare is made at the Medical Assistance Program allowable rate.

(12) Payment for clients with other third-party resources. Payment is the Medical Assistance Program rate less the third party payment but not to exceed the billed amount.

(13) Payment in Full — Medical Assistance Program payments, including contracted managed care plan payments, unless in error, constitute payment in full, except for limited instances involving allowable spendown or copayments. For the Medical Assistance Program this includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding the Medical Assistance Program'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. Publications: Publications referenced are available from the agency.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 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; 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, 461-175 & 461-13-180; 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

410-120-1360
Requirements for Financial, Clinical and Other Records

The Department of Human Services is responsible for analyzing and monitoring the operation of the Medical Assistance Program and for auditing and verifying the accuracy and appropriateness of payment, utilization of services, medical necessity medical appropriateness, the quality of care, and access to care. The provider and/or the provider's designated billing service or other entity responsible for the maintenance of financial, clinical, and other records, shall:

(1) Develop and maintain adequate financial and clinical records and other documentation which supports the specific care, items, or services for which payment has been requested. Payment will be made only for services which are adequately documented. Documentation must be completed before the service is billed to the Medical Assistance Program:

(a) All records must document the specific service provided, the number of services or items comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service. Patient account and financial records must also include documentation of charges, identify other payment resources pursued, indicate the date and amount of all debit or credit billing actions, and support the appropriateness of the amount billed and paid. For cost reimbursed services, the provider is required to maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records must be accurate and in sufficient detail to substantiate the data reported;

(b) Clinical records, including records of all therapeutic services, must document the client's diagnosis and the medical need for the service. The client's record must be annotated each time a service is provided and signed or initialed by the individual who provided the service or must clearly indicate the individual(s) who provided the service. Information contained in the record must be appropriate in quality and quantity to meet the professional standards applicable to the provider or practitioner and any additional standards for documentation found in this rule, the individual provider guide and any pertinent contracts.

(c) Have policies and procedures to ensure the maintenance of the confidentiality of medical record information. These procedures ensure the provider may release such information in accordance with federal and state statutes, ORS 179.505 through 179.507, 411.320, 433.045, 42 CFR part 2, 42 CFR subpart F, 45 CFR 205.50, including ORS 433.045(3) with respect to HIV test information.

(2) Retain clinical records for seven years and financial and other records described in subsections (a) and (b) of this rule for at least five years from the date(s) of service.

(3) Upon written request from the Department of Human Services, the Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services, or their authorized representatives, furnish requested documentation immediately or within the time-frame specified in the written request. Copies of the documents may be furnished unless the originals are requested. At their discretion, official representatives of the Department of Human Services, Medicaid Fraud Unit, or Department of Health and Human Services, may review and copy the original documentation in the provider's place of business. Upon the written request of the provider, the Program or the Unit may, at their sole discretion, modify or extend the time for provision of such records if, in the opinion of the Program or Unit good cause for such extension is shown. Factors used in determining whether good cause exists include:

(a) Whether the written request was made in advance of the deadline for production;

(b) If the written request is made after the deadline for production, the amount of time elapsed since that deadline;

(c) The efforts already made to comply with the request;

(d) The reasons the deadline cannot be met;

(e) The degree of control that the provider had over its ability to produce the records prior to the deadline;

(f) Other extenuating factors.

(4) Access to records, inclusive of medical charts and financial records does not require authorization or release from the client if the purpose of such access is:

(a) To perform billing review activities; or

(b) To perform utilization review activities; or

(c) To review quality, quantity, medical appropriateness of care, items, and services provided; or

(d) To facilitate payment authorization and related services; or

(e) To investigate a client's fair hearing request; or

(f) To facilitate investigation by the Medicaid Fraud Unit or the Department of Health and Human Services; or

(g) Where review of records is necessary to the operation of the program.

(5) Failure to comply with requests for documents and within the specified time-frames means that the records subject to the request may be deemed by the Department of Human Services not to exist for purposes of verifying appropriateness of payment, medical appropriateness, the quality of care, and the access to care in an audit or overpayment determination, and accordingly subjects the provider to possible denial or recovery of payments made by the Medical Assistance Program or to sanctions.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 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 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; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 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; 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 31-1999, f. & cert. ef. 10-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04

410-120-1520
Denial or Recovery of Reimbursement Resulting from Medical Review or Audit

(1) The Department of Human Services' staff or medical review contractor or dental review contractor may review/audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with the Medical Assistance Program's policy and rules and the generally accepted standards of a provider's field of practice or specialty.

(2) Payment may be denied or subject to recovery if medical review or audit determines the service was not provided in accordance with the Medical Assistance Program's policy and rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment. Related practitioner and hospital billings will also be denied or subject to recovery.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 4-1984, f. & ef. 2-1-84; AFS 38-1986, f. 4-29-86, ef. 6-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0189; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0720; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04

410-120-1540
Recovery of Overpayments to Providers resulting from medical review/audit

(1) When the Department of Human Services determines that an overpayment has been made to a provider, the amount of overpayment is subject to recovery:

(a) To determine the overpayment amount, the Department of Human Services may use the random sampling method such as that detailed in the paper entitled "Development of a Sample Design for the Post-Payment Review of Medical Assistance Payments," written by Lyle Calvin, Ph.D., ("Calvin Paper"). The Department of Human Services hereby adopts by reference, but is not limited to, the method of random sampling described in the Calvin Paper;

(b) After the Department of Human Services determines an overpayment amount by the random sampling method set forth in subsection (a) of this rule, the provider may request a 100 percent audit of all billings submitted to the Medical Assistance Program for services provided during the period in question. If a 100 percent audit is requested:

(A) Payment and arrangement for a 100 percent audit is the responsibility of the provider requesting the audit; and

(B) The audit must be conducted by a certified public accountant who is knowledgeable with the Oregon Administrative Rules covering the payments in question, and must be conducted within 120 calendar days of the request to use such audit in lieu of the Medical Assistance Program's random sample.

(2) The amount of medical review/audit overpayment to be recovered:

(a) Will be the entire amount determined or agreed to by the Medical Assistance Program; and

(b) Is not limited to amount(s) determined by criminal or civil proceedings;

(c) Will include interest to be charged at allowable State rates.

(3) The Department of Human Services will deliver to the provider by registered or certified mail or in person a request for repayment of the overpayment and the documentation to support the alleged amount.

(4) If the provider disagrees with the Medical Assistance Program's determination and/or the amount of overpayment the provider may appeal the decision by requesting a contested case hearing or administrative review:

(a) A written request for hearing or administrative review of the decision being appealed must be submitted to the Medical Assistance Program by the provider pursuant to OAR 410-120-1660, Provider Appeal — Hearing Request. The request must specify the area(s) of disagreement;

(b) Failure to request a hearing or administrative review in a timely manner constitutes acceptance by the provider of the amount of the overpayment.

(5) The overpayment is due and payable 30 calendar days from the date of the decision by the Medical Assistance Program:

(a) An additional 30 day grace period may be granted the provider upon request to the Medical Assistance Program;

(b) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due.

(6) The Department of Human Services may extend the reimbursement period or accept an offer of repayment terms. Any change in reimbursement period or terms must be made in writing by the Medical Assistance Program.

(7) If the provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Medical Assistance Program may:

(a) Recoup future provider payments up to the amount of the overpayment; and/or

(b) Pursue civil action to recover the overpayment.

(8) As the result of a hearing or review the amount of the overpayment may be reduced in part or in full.

(9) The Department of Human Services may, at any time, change the amount of the overpayment upon receipt of additional information. Any changes will be verified in writing by the Department of Human Services. Any monies paid to the Medical Assistance Program which exceed an overpayment will be refunded to the provider.

(10) If a provider is terminated or sanctioned for any reason the Department of Human Services may pursue civil action to recover any amounts due and payable to the Medical Assistance Program.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 87-1980, f. 12-8-80, ef. 1-1-81; Renumbered from 461-013-0111; 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 52-1988, f. & cert. ef. 8-4-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0190; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0740; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04

410-120-1570
Provider Appeals (Level 1) — Claims Reconsideration

A provider disputing OMAP's claim(s) decision may request reconsideration. The provider must submit the request in writing to OMAP, Provider Services Unit within one year from OMAP's decision. The request must include the reason for the dispute, and any information pertinent to the outcome of the dispute. OMAP will complete an additional review and respond back to the provider in writing. If the provider is not satisfied with the review, the provider may request an Administrative Review or Contested Case Hearing as outlined in OAR 410-120-1580 through 410-120-1820.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 10-2004, f. 3-11-04, cert. ef. 4-1-04

• • • • • • • • • •

Adm. Order No.: OMAP 11-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-125-0080, 410-125-0410, 410-125-2000
Rules Repealed: 410-125-0225
Subject: The Hospital Services Administrative rules govern Office of Medical Assistance Programs (OMAP) payments for services rendered to clients. OAR 410-125-0225 (renumbered from AFS rule in 1990) is repealed because the rule has no relevance to the Hospital Program; a list of client programs can be obtained from other sources. 410-125-0080, 410-125-0410, and 410-125-2000 are revised to clarify rule intent.
Rules Coordinator: Darlene Nelson—(503) 945-6927

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 (phone number is on the client's Medical Care Identification). The health plan may have different prior authorization requirements than OMAP;

(b) Medicare Clients — OMAP does not require prior authorization for inpatient services provided to clients with Medicare Part A or B coverage;

(c) All other OMAP clients:

(A) Hospital admissions for any of the medical and surgical procedures shown in Table 1 require prior authorization, unless they are urgent or emergent;

(B) Contact Oregon Medical Professional Review Organization (OMPRO) (unless indicated otherwise in Table1) for prior authorization.

(2) Transplant Services:

(a) Complete rules for transplant services are in the Transplant Services provider rulebook;

(b) Clients are eligible for transplants covered by the Health Services Commission's Prioritized List of Health Services. See the Transplant Services provider rulebook for criteria. For clients enrolled in an FCHP, contact the plan for authorization. Clients not enrolled in an FCHP, contact the OMAP 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 OMAP Medical Director's office for authorization for clients not enrolled in a prepaid health plan. For clients enrolled in a prepaid health plan — 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 instate providers (see Elective Admission).

(5) Transfers to Another Hospital:

(a) Transfers for the purpose of providing a service listed in Table 1 of this rule, e.g., inpatient physical rehabilitation care, require prior authorization — contact OMPRO;

(b) Transfers to a 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 plan;

(c) Transfers to the Same or Lesser Level of Inpatient Care — OMAP 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. 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. 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 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) OMAP 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. For prior authorization, contact the OMAP Dental Program Coordinator;

(b) For clients enrolled in an FCHP, contact the client's FCHP;

(c) Emergency dental services do not require prior authorization.

Table 125-0080-1. [ED. NOTE: Table not included. Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

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

410-125-0410
Readmission

(1) A patient whose readmission for surgery or follow-up care is planned at the time of discharge must be placed on leave of absence status, and both admissions must be combined into a single billing. The Office of Medical Assistance Programs (OMAP) will make one payment for the combined service. Examples of planned readmissions include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

(2) A patient whose discharge and readmission to the hospital is within fifteen (15) days for the same or related diagnosis must be combined into a single billing. OMAP will make one payment for the combined service.

(3) Readmissions occurring more than 15 days after the date of discharge or for an unrelated diagnosis are not subject to this rule.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 36-1993, f. & cert. ef. 12-1-93; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04

410-125-2000
Access to Records

(1) Providers must furnish requested medical and financial documentation within 30 calendar days from the date of request. Failure to comply within 30 calendar days will result in recovery of payment(s) made by Office of Medical Assistance Programs (OMAP) for services being reviewed.

(2) OMAP contracts with Oregon Medical Professional Review Organization (OMPRO) to conduct post payment review of admissions. OMPRO may request records from a hospital or may request access to records while at the hospital. OMPRO has the same right to medical information as OMAP.

(3) The hospital has 30 days to provide OMAP or OMPRO with copies of records. In some cases, there may be a more urgent need to review records.

(4) The Medical Payment Recovery Unit (MPRU) conducts recovery activities for OMAP involving third party liability resources. MPRU may request records from the hospital. This unit has the same right to medical and financial information as OMAP.

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 414

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 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 461-015-0040; HR 21-1990, f. & cert. ef. 7-9-90; Renumbered from 461-015-0690; HR 42-1991, f. & cert. ef. 10-1-91; OMAP 11-2004, f. 3-11-04, cert. ef. 4-1-04

• • • • • • • • • •

Adm. Order No.: OMAP 12-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-129-0100, 410-129-0200, 410-129-0260
Subject: The Speech-Language, Pathology, Audiology and Hearing Aids services program administrative rules govern Office of Medical Programs (OMAP) payments for products and services provided to clients. Rule 410-129-0100 is amended to require Speech pathologists to bill Medicare first if client has both Medicare and Medicaid; Rule 410-129-0200 is amended to delete obsolete Speech generating device (SGD) codes and adds new codes for SGD; and, Rule 410-129-0260 is amended to clarify when an audiogram is required.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-129-0100
Medicare/Medicaid Claims

(1) When an individual, not in managed care, has both Medicare and Medicaid coverage, audiologists must bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Payment will be made at OMAP rates. Payment will be based on either Medicare's maximum allowable rate or OMAP's maximum allowable rate, whichever is the lesser. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

(2) Audiologists must bill all hearing aids and related services directly to OMAP on an OMAP 505. Payment authorization is required on most of these services. (See OARs 410-129-0240 and 410-129-0260)

(3) If Medicare transmits incorrect information to OMAP, or if an out-of-state Medicare carrier or intermediary was billed, providers must bill OMAP using an OMAP 505 form. If any payment is made by OMAP, an Adjustment Request must be submitted to correct payment, if necessary.

(4) Send all completed OMAP 505 forms to the Office of Medical Assistance Programs.

(5) Hearing Aid Dealers must bill all services directly to OMAP on a CMS-1500. Payment authorization is required on most services (See OARs 410-129-0240 and 410-129-0260).

(6) When a client, not in managed care, has both Medicare and Medicaid coverage, speech-language pathologists must bill services to Medicare first. Medicare will automatically forward these claims to Medicaid. Payment will be made at OMAP rates. Payment will be based on either Medicare maximum allowable rate or OMAP's maximum allowable rate, whichever is the lesser. For managed care clients with Medicare, contact the client's Managed Care Organization (MCO).

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04

410-129-0200
Speech-Language Pathology Procedure Codes

(1) Speech Therapy Services. Table 200-1. [Table not included. See ED. NOTE.]

(2) Other Speech Services. Table 200-2. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; HR 11-1992, f. & cert. ef. 4-1-92; HR 27-1993, f. & cert. ef. 10-1-93; HR 36-1994, f. 12-30-94, cert. ef. 1-1-95; OMAP 36-1999, f. & cert. ef. 10-1-99; OMAP 6-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04

410-129-0260
Hearing Aids and Hearing Aid Technical Service and Repair

(1) Hearing Aids must be billed to the Office of Medical Assistance Programs at the provider's Acquisition Cost, and will be reimbursed at such rate. For purposes of this rule, Acquisition Cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item.

(2) Submit history of hearing aid use and an audiogram when requesting payment authorization for hearing aids. **Table 129-0260**. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 5-1991, f. 1-18-91, cert. ef. 2-1-91; 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 20-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2001, f. 9-24-01, cert.e f. 10-1-01; OMAP 10-2002, f. & cert. ef. 4-1-02; OMAP 1-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 12-2004, f. 3-11-04, cert. ef. 4-1-04

• • • • • • • • • •

Adm. Order No.: OMAP 13-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-130-0000, 410-130-0180, 410-130-0200, 410-130-0220, 410-130-0240, 410-130-0255, 410-130-0585, 410-130-0587, 410-130-0680, 410-130-0700
Subject: The Medical-Surgical program administrative rules govern the Office of Medical Assistance Programs (OMAP) payment for services provided to clients. The following Rules are amended for technical changes to clarify policy: Rule 410-130-0000; 410-130-0180; 410-130-0200; 410-130-0220; 410-130-0240; 410-130-0255; 410-130-0585; 410-130-0587; 410-130-0680; and 410-130-0700.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-130-0000
Foreword

(1) The Office of Medical Assistance Programs (OMAP) Medical-Surgical Services rules are designed to assist medical-surgical providers to deliver medical services and prepare health claims for clients with Medical Assistance Program coverage. Providers should follow the OMAP rules in effect on the date of service.

(2) OMAP enrolls only the following types of providers as performing providers under the Medical-Surgical program:

(a) Doctors of medicine, osteopathy and naturopathy;
(b) Podiatrists;
(c) Acupuncturists;
(d) Licensed Physician assistants;
(e) Nurse practitioners;
(f) Laboratories;
(g) Family planning clinics;
(h) Social workers (only maternity case management);
(i) Licensed Direct entry midwives;
(j) Portable x-ray providers;
(k) Ambulatory surgical centers;
(l) Chiropractors;
(m) Nutritionists (only maternity case management);
(n) Licensed Dieticians (only maternity case management);
(o) Registered Nurse First Assistants;
(p) Certified Nurse Anesthetists.

(3) For clients enrolled in a managed care plan, contact the client's plan for coverage and billing information.

(4) The Medical-Surgical Services rules contain information on policy, special programs, prior authorization, and criteria for some procedures. All OMAP rules are intended to be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120) and the Oregon Health Plan (OHP) Administrative Rules (OAR 410 division 141).

(5) The Health Services Commission's Prioritized List of Health Services is found at website http://www.ohpr.state.or.us/hsc/index hsc.htm.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 868, f. 12-30-77, ef. 2-1-78; AFS 36-1981, f. 6-29-81, ef. 7-1-81; AFS 27-1982, f. 4-22-82 & 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 50-1986, f. 6-30-86, ef. 8-1-86; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; Renumbered from 461-014-0001 and 461-014-0500; HR 10-1990, f. 3-30-90, cert. ef. 4-1-90; HR 6-1994, f. & cert. ef. 2-1-94; HR 23-1997, f. & cert. ef. 10-1-97; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04

410-130-0180
Drugs

(1) Not covered services 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. This service does not require prior authorization;

(d) Infertility drugs.

(2) Drug Administration. Reimbursement is limited to drugs administered by the prescribing practitioner in the office, clinic or home settings. Drugs for self-administration by the client are not billable, 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-J1816;
(B) J3490;
(C) J7699;
(D) J7799;
(E) J8499;
(F) J9999;
(G) Include the name of the drug, NDC number, and dosage.

(d) Epoetin Alpha (EPO) HCPCS are covered;

(e) Do not bill for local anesthetics. Reimbursement is included in the payment for the tray and/or procedure.

(3) For Not Covered/Bundled services or Prior Authorization Requirements refer to OAR 410-130-0200 Table 130-0200-1 and OAR 410-130-0220 Table 130-0220-1.

(4) 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 Prudent Pharmaceutical Purchasing Program — OAR 410-121-0157.

(5) 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.

Stat. Auth.: ORS 409
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; AFS 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

410-130-0200
Prior Authorization

(1) If the client is covered by a managed care plan, contact the appropriate managed care plan for prior authorization (PA) requirements and instructions for billing the plan.

(2) If the client has both Medicare and Medical Assistance Program coverage, PA is not required from OMAP for services covered by Medicare, except for most transplants.

(3) Kidney and cornea transplants do not require PA unless they are performed out-of-state.

(4) Contact the Office of Medical Assistance Programs (OMAP) Medical Director's Office for PA for transplants other than kidney and cornea, and requests for non-emergent, non-urgent out-of-state services. Refer to the OMAP Transplant Services rule for further information on transplants and refer to the General Rules for further information concerning out-of-state services.

(5) Services for clients of the Medically Fragile Children's Unit must be authorized by that Unit.

(6) For clients enrolled in the fee-for-service (FFS) High Risk Medical Case Managed program, contact the Case Management Contractor shown on the client's Medical Care ID. See the Medical-Surgical Services Supplemental Information guide for details.

(7) All other procedures listed in the Medical-Surgical Services provider rule with a PA indicator must be prior authorized by the Oregon Medical Professional Review Organization (OMPRO) when performed in any setting. A second opinion may be requested by OMAP or OMPRO before authorization of payment is given for a surgery.

(8) Hospital admissions do not require PA unless the procedure requires PA.

(9) PA is not required for emergent or urgent procedures or services.

(10) Treating and performing practitioners are responsible for obtaining PA.

(11) Refer to Table 130-0200-1 for all services/procedures requiring prior authorization.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 868, f. 12-30-77, ef. 2-1-78; AFS 65-1980, f. 9-23-80, ef. 10-1-80; AFS 27-1982, f. 4-22-82 & 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 23-1986, f. 3-19-86, ef. 5-1-86; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; Renumbered from 461-014-0045; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0630; HR 25-1990(Temp), f. 8-31-90, cert. ef. 9-1-90; HR 44-1990, f. & cert. ef. 11-30-90; HR 17-1991(Temp), f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; 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 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; 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

410-130-0220
Not Covered/BundledServices

(1) Refer to the Oregon Health Plan Administrative Rules (OAR 410-141-0520) and General Rules (chapter 410, division 120) for coverage of services. Refer to Table 130-0220-1 for additional information regarding not covered services or for services that are considered by OMAP to be bundled. The following are examples of not covered services:

(a) "After hours" visits during regularly scheduled hours;

(b) Psychotherapy services (covered only through local Mental Health Clinics and Mental Health Organizations);

(c) Room charges (only services and supplies covered);

(d) Routine postoperative visits (included in the payment for the surgery) during 90 days following major surgery (global period) or 10 days following minor surgery;

(e) Services provided at the client's request in a location other than the practitioner's office that are normally provided in the office;

(f) Telephone calls for purposes other than tobacco cessation and maternity case management.

(2) This is not an inclusive list. Specific information is included in the Office of Medical Assistance Programs (OMAP) General Rules, Medical Assistance Benefits: Excluded Services and Limitations (OAR 410-120-1200).

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
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; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0640; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 21-1991, f. 4-16-91, cert. ef. 5-1-91; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; 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 16-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 30-1998, f. & cert. ef. 9-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 37-1999, f. & cert. ef. 10-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04

410-130-0240
Medical Services

(1) All medical and surgical services requiring prior authorization (PA) are listed in OAR 410-130-0200 PA Table 130-0200-1 and services that are Not Covered/Bundled services are listed in OAR 410-130-0220 Table 130-0220-1. Table 130-0220-1 only contains clarification regarding some services that are not covered. Refer to the Health Services List of Prioritized Services for additional information regarding not covered services.

(2) Acupuncture may be performed by a physician, a physician's employee-acupuncturist under the physician's supervision, or a licensed acupuncturist, and bill using CPT 97780 or 97781.

(3) Anesthesia is not covered for procedures that are below the funding line on the Health Services Commission's Prioritized List of Health Services:

(a) Reimbursement is based on the base units listed in the current American Society of Anesthesiology Relative Value Guide plus one unit per each 15 minutes of anesthesia time. Exceptions — anesthesia for neuraxial labor analgesia/anesthesia must be billed at the base units plus one unit for each 15 minutes of face-to-face contact time;

(b) Bill total quantity on one line of the base units plus one unit for each 15 minutes of anesthesia time. For the last fraction of time under 15 minutes, bill one unit for 8-14 minutes. Do not bill a unit for 1-7 minutes of time;

(c) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100-01999;

(d) A valid consent form is required for all hysterectomies and sterilizations;

(e) If prior authorization (PA) was not obtained on a procedure that requires PA, then the anesthesia services may not be paid. Refer to OAR 410-130-0200 PA Table 130-0200-1;

(f) Anesthesia services are not payable to the provider performing the surgical procedure except for conscious sedation.

(4) Chiropractic services must be billed using 99202 and 99212 for the diagnostic visits and 98940-98942 for manipulation. Use CPT lab and radiology codes, which most accurately identifies the services performed.

(5) For Maternity Care and Delivery use Evaluation and Management codes when providing three or fewer antepartum visits:

(a) For births performed in a clinic or home setting, use CPT codes that most accurately describe the services provided. HCPCS supply code S8415 may be billed in addition to the CPT procedure code. Code S8415 includes all supplies, equipment, staff assistance, birthing suite, newborn screening cards, topical and local anesthetics. Bill medications (except topical and local anesthetics) with HCPCS codes that most accurately describe the medications;

(b) For labor management only, bill 59899 and attach a report;

(c) For multiple births, bill the highest level birth with the appropriate CPT code and the other births under the delivery only code. For example, for total OB with cesarean delivery of twins, bill 59510 for the first delivery and 59514 for the second delivery.

(6) Mental Health and Psychiatric Services:

(a) Administrative Exams and reports for Psychiatric or psychological evaluations refer to the Administrative Exam rules;

(b) Psychiatrists can be reimbursed by OMAP for symptomatic diagnosis and services which are somatic (physical) in nature. Contact the local

Mental Health Department for covered psychiatric and psychological services;

(c) Mental Health Services — Must be provided by local Mental Health Clinics or a client's Mental Health Organization (MHO). Not payable to private physicians, psychologists, and social workers.

(7) Neonatal Intensive Care Unit (NICU) procedure codes are reimbursed only to neonatologists and pediatric intensivists for services provided to infants when admitted to a Neonatal or Pediatric Intensive Care Unit (NICU/PICU). All other pediatricians must use other CPT codes when billing for services provided to neonates and infants:

(a) Consultations by specialists other than neonatologists and pediatric intensivists are payable in addition to these codes;

(b) Neonatal intensive care codes are not payable for infants on Extracorporeal Membrane Oxygenation (ECMO). Use specific CPT ECMO codes.

(8) Neurology/Neuromuscular — Payment for polysomnographs and multiple sleep latency test (MSLT) are each limited to two in a 12-month period.

(9) Ophthalmology Services — Routine eye exams for the purpose of glasses or contacts are limited to one examination every 24 months for adults. All materials and supplies must be obtained from OMAP's contractor. Refer to the Vision Program Rules for more information.

(10) Special Services and Reports — OMAP will pay for procedure codes 99052 or 99054 only when the service provided is outside the practitioner's usual or scheduled working hours. These services are not payable to emergency room based physicians.

(11) Speech & Hearing — HCPCS codes V5000-V5299 are limited to speech-language pathologists, audiologists, and hearing aid dealers:

(a) Refer to the Speech and Hearing Program Rules for detailed information;

(b) Payment for hearing aids and speech therapy must be authorized before the service is delivered;

(c) CPT 92593 and 92595 Covered for children under age 21.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: PWC 839(Temp), f. & ef. 4-28-77; PWC 849, f. 7-15-77, ef. 8-1-77; PWC 868, f. 12-30-77, ef. 2-1-78; AFS 14-1978(Temp), f. 4-14-78, ef. 4-15-78; AFS 31-1978, f. & ef. 8-1-78; AFS 26-1980, f. 5-21-80, ef. 6-1-80, AFS 56-1980(Temp), f. 8-29-80, ef. 9-1-80; AFS 2-1981, f. 1-9-81, ef. 2-1-81; AFS 36-1981, f. 6-29-81, ef. 7-1-81; AFS 27-1982, f. 4-22-82 & 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 38-1983, f. & ef. 8-1-83; AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; ; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 48-1989, f. & cert. ef. 8-24-89; Renumbered from 461-014-0021 & 461-14-056; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0650, 461-014-0690 & 461-014-0700; HR 14-1991(Temp), f. & cert. ef. 3-7-91; HR 18-1991(Temp), f. 4-12-91, cert. ef. 4-15-91; ; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 24-1991, f. & cert. ef. 6-18-91; HR 2-1992, f. & cert. ef. 1-2-92; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 18-1992, f. & cert. ef. 7-1-92; HR 36-1992, f. & cert. ef. 12-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 16-1993, f. & cert. ef. 7-2-93; HR 6-1994, f. & cert. ef. 2-1-94; Renumbered from 410-130-0320, 410-130-0340, 410-130-0360 & 410-130-0740; 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 17-1999, f. & cert. ef. 4-1-99; 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 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

410-130-0255
Immunizations and Immune Globulins

(1) Use standard billing procedures for vaccines that are not part of the Vaccines for Children (VFC) Program.

(2) Synagis (palivizumab-rsv-igm) is covered only for high-risk infants and children as defined by the American Academy of Pediatric guidelines. Use 90378 for Synagis.

(3) Providers are encouraged to administer combination vaccines when medically appropriate and cost effective.

(4) Vaccines for Children (VFC) Program:

(a) Under this federal program, certain immunizations are free for clients ages 0 through 18. OMAP does not reimburse the cost of vaccine serums covered by this federal program;

(b) Use the following procedures when billing immunizations included in the VFC Program:

(A) When the sole purpose of the visit is to administer a VFC immunization(s), the provider should bill the appropriate immunization procedure code(s) with modifier -26, or -SL for each injection. Do not bill CPT code 90471-90474 or 99211;

(B) When the immunization is administered as part of an Evaluation and Management service (e.g., well-child visit) the provider should bill the appropriate immunization code with modifier -26, or -SL for each injection in addition to the Evaluation and Management code.

(c) Refer to Table 130-0255-1 for immunization codes included in the VFC Program for clients ages 0 through 18.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.06

Hist.: 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 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; 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 51-2002, f. & cert. ef. 10-1-02; OMAP 23-2003, f. 3-26-03 cert. ef. 4-1-03; Renumbered from 410-130-0800; OMAP 69-2003 f. 9-12-03, cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04

410-130-0585
Family Planning Services

(1) Family planning services are available to individuals of childbearing age (including minors who can be considered to be sexually active) who desire such services. Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size. Counseling services, laboratory tests, medical procedures, and pharmaceutical supplies and devices are covered if provided for family planning purposes. Bill these services using appropriate CPT and HCPCS codes and add modifier FP.

(2) Clients may seek family planning services from any provider enrolled with OMAP, even when the client is enrolled in a Managed Care Organization (MCO):

(a) If the provider is a participating provider with the client's MCO, the MCO must be billed;

(b) If the provider is not a participating provider with the client's MCO, bill OMAP directly and mark the family planning box (24H) on the CMS-1500 claim form.

(3) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, subdermal implants, condoms, and diaphragms.

(4) Bill all family planning with the most appropriate ICD-9-CM diagnosis codes in the V25 series (Contraceptive Management) and add modifier FP to all procedure codes.

(5) For annual family planning visits use CPT Preventative Medicine series (9938X-9939X) and add modifier FP. These codes include comprehensive contraceptive counseling.

(6) When comprehensive contraceptive counseling is the only service provided at the encounter, use the appropriate code from the Preventative Medicine, Individual Counseling series (99401-99404) and add modifier FP.

(7) Bill contraceptive supplies with the most appropriate HCPCS codes.

(8) Where there are no specific CPT or HCPCS codes, use an appropriate unlisted HCPCS code and add modifier — FP. Bill at acquisition cost.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; 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 17-1999, f. & cert. ef. 4-1-99; 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 2-2002, f. 2-15-02, cert. ef. 4-1-02; OMAP 51-2002, 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

410-130-0587
Family Planning Clinic Services

(1) This rule is to be used only by family planning clinics.

(2) Family planning clinics are governmental agencies that receive Title X funding from the state for family planning (FP) services and nongovernmental providers who have contractual agreements approved by the Office of Family Health to provide family planning services.

(3) Family planning clinics will be reimbursed an encounter rate only for all FP services where the primary purpose of the visit is for family planning.

(4) Bill HCPCS code T1015 "Clinic visit/encounter, all-inclusive; family planning" for all encounters where the primary purpose of the visit is contraceptive in nature.

(a) This encounter code includes the visit and any procedure or service performed during that visit including:

(A) Annual family planning exams;

(B) Family planning counseling;

(C) Insertions and removals of implants and IUDs;

(D) Diaphragm fittings;

(E) Dispensing of contraceptive supplies and medications;

(F) Contraceptive injections.

(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or other HCPCS codes;

(c) Bill only one encounter per date of service;

(d) Reimbursement for educational materials is included in T1015. Educational materials are not billable separately.

(5) Reimbursement for T1015 does not include payment for FP supplies and medications.

(a) Bill FP supplies and medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code and bill at acquisition cost:

(A) Bill spermicide code A4269 per tube;

(B) Bill contraceptive pills code S4993 per monthly packet;

(C) Bill emergency contraception with code S4993 and bill per packet.

(b) Add modifier FP after all codes billed for contraceptive services, supplies and medications.

(6) Reimbursement for T1015 does not include laboratory tests.

(a) Clinics and providers who perform lab tests in their clinics and are CLIA certified to perform those tests may bill CPT and HCPCS lab codes in addition to T1015;

(b) Add modifier FP after lab codes to indicate that the lab was performed during a FP encounter;

(c) Labs sent to outside laboratories, such as PAP smears, can be billed only by the performing laboratory.

(7) Encounters where the primary purpose of the visit is not contraceptive in nature, use appropriate CPT codes and do not add modifier FP.

(8) When billing for services provided to clients enrolled in a Managed Care Organization, mark the family planning Box 24 H on the CMS-1500 billing form.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 78-2003, f. & cert. ef. 10-1-03; OMAP 13-2004, f. 3-11-04, cert. ef. 4-1-04

410-130-0680

Laboratory and Radiology

(1) Refer to OAR 410-130-0200 Prior Authorization Table 130-0200-1 and OAR 410-130-0220 Not Covered/Bundled Services Table 130-0220-1.

(2) Payment for newborn screening kits and collection and handling for newborn screening (NBS) tests performed by the Oregon State Public Health Laboratory (OSPHL) is considered bundled into the delivery fee. Replacement of lost NBS kits may be billed with code S3620 with modifier TC if the loss is documented in the client's medical record. Newborn screening confirmation tests performed by reference laboratories at the request of the OSPHL shall be reimbursed only to the OSPHL.

(3) Transplant lab codes are covered only if the transplant is covered and if the transplant service has been authorized.

(4) All lab tests must be specifically ordered by, or under the direction of licensed medical practitioners within the scope of their license.

(5) If a lab sends a specimen to a reference lab for additional testing, the reference lab may not bill for the same tests as provided by the referring lab.

(6) The claim must indicate the date of the specimen collection as the date of service (DOS) regardless of the actual date the test was performed.

(7) A provider who sends a specimen to another provider for testing may bill the Office of Medical Assistance Programs (OMAP) only for drawing a blood sample venipuncture or capillary puncture or collecting a urine sample by catheterization:

(a) Venipuncture or capillary puncture and urinary catheterization are payable only once per day regardless of the frequency performed;

(b) Collection and/or handling of other specimens (such as PAP or other smears, voided urine samples, or stool specimens) are considered bundled into the exam and/or lab procedures and are not payable in addition to the laboratory test.

(8) Pass-along charges from the performing laboratory to another laboratory, medical practitioner, or specialized clinics do not qualify for payment and are not to be billed to OMAP.

(9) Charges for tests performed by independent clinical laboratories may only be billed by and paid to the performing provider or a designated billing agent.

(10) Laboratory Certification — Laboratory services are reimbursable only to facilities with a current, valid Oregon State clinical laboratory license issued by the Oregon Health Division or to laboratories outside of Oregon which are certified by the Centers for Medicare and Medicaid Services (CMS) and meets the requirements of the Clinical Laboratory Improvement Amendments (CLIA) and the provider has notified OMAP of the assigned ten-digit CLIA number. Payment is limited to the level of testing authorized by the state license or CLIA certificate at the time of test performance.

(11) Organ Panels:

(a) OMAP will only reimburse panels as defined by the CPT codes for the year the laboratory service was provided. Tests within a panel may not be billed individually even when ordered separately. The same panel may be billed only once per day per client;

(b) Payment will be made at the panel maximum allowable rate if two or more tests within the panel are billed separately and the total reimbursement rate of the combined codes exceeds the panel rate even if all the tests listed in the panel are not ordered or performed.

(12) CLIA requires all entities that perform even one test, including waived tests on... "materials 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" to meet certain Federal requirements. If an entity performs tests for these purposes, it is considered under CLIA to be a laboratory.

(13) Radiology:

(a) Provision of diagnostic and therapeutic radionuclide(s), HCPCS A9500-A9699, is payable only when used in conjunction with diagnostic nuclear medicine procedures (CPT codes 78000 through 78999) or radiation therapy and radiopharmaceutical procedures (CPT codes 77401-77799 and 79000-7999);

(b) Bill routine screening mammography under CPT code 76092;

(c) HCPCS codes R0070 through R0076 are covered.

(14) Contrast and diagnostic-imaging agents — Reimbursement is bundled in the radiologic procedure except for low osmolar contrast materials (LOCM). Supply of LOCM (A4644-A4646) may be billed in addition to the radiology procedure only when the following criteria are met:

(a) Prior adverse reaction to contrast material, with the exception of a sensation of heat, flushing or a single episode of nausea or vomiting;

(b) History of asthma or significant allergies;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction or pulmonary hypertension;

(d) Decrease in renal function;

(e) Diabetes;

(f) Dysproteinemia;

(g) Severe dehydration;

(h) Altered blood brain barrier (i.e., brain tumor, subarachnoid hemorrhage);

(i) Sickle cell disease, or;

(j) Generalized severe debilitation.

(15) X-ray and EKG interpretations in the emergency room:

(a) OMAP pays for only one interpretation of an x-ray or EKG furnished to an emergency room patient, and that is for the interpretation and report that directly contributed to the diagnosis and treatment of the patient;

(b) A second interpretation of an x-ray or EKG is considered to be for quality control purposes only and is not reimbursable;

(c) Payment will be made for a second interpretation only under unusual circumstances, such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-30-84, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0800; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 43-1991, f. & cert. ef. 10-1-91; HR 8-1992, f. 2-28-92, cert. ef. 3-1-92; HR 27-1992(Temp), f. & cert. ef. 9-1-92; HR 33-1992, f. 10-30-92, cert. ef. 11-1-92; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; 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 15-1998, f. & cert. ef. 5-1-98; OMAP 17-1999, f. & cert. ef. 4-1-99; OMAP 31-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 40-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 51-2002, 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

410-130-0700

HCPCS Supplies and DME

(1) Use appropriate HCPCS codes to bill all supplies and DME.

(2) For items that do not have specific HCPCS codes, use unlisted HCPCS code and bill at acquisition cost, purchase price plus postage.

(3) CPT code 99070 is no longer billable for supplies and materials. Use HCPCS codes.

(4) Use S3620 with modifier TC for lost newborn screening (NBS) kits.

(5) Reimbursement for office surgical suites and office equipment is bundled in the surgical procedures.

(6) Contraceptive Supplies — Refer to OAR 410-130-0585.

(7) A4000-A8999 HCPCS codes listed in Table 130-0240-1 is are covered under this program.

(8) DME/Supply services in the HCPCS series A4000-A9999 which are not listed in Table 130-0240-1 must be referred to a Durable Medical Equipment (DME) provider.

(9) For splints and cast materials, use codes Q4001-Q405. Do not use A4570, A4580, and A4590.

(10) A9150-A9999 (administrative, investigational, and miscellaneous) are not covered, except for A9500-A9699. Refer to OAR 410-130-0680.

(11) B4000-B9999: HCPCS codes B4034-B4036 and B4150-B9999 are not covered for medical-surgical providers. Refer these services to home enteral/parenteral providers.

(12) E0100-E1799: Only the following DME HCPCS codes are covered for medical-surgical providers when provided in an office setting:

(a) E0100-E0116;

(b) E0602;

(c) E0191;

(d) E1399;

(e) Refer all other items with "E" series HCPCS codes to DME providers.

(13) J0000-J9999 HCPCS codes — Refer to OAR 410-130-0180 for coverage of drugs.

(14) K0000-K9999 HCPCS codes — Refer all items with "K" series to DME providers.

(15) L0000-L9999 Refer to the DME program Administrative rules for coverage criteria for orthotics and prosthetics. Refer to Table 130-0220-1 for a list of "L" codes that are not covered:

(a) Reimbursement for orthotics is a global package, which includes:

(A) Measurements;

(B) Moldings;

(C) Orthotic items;

(D) Adjustments;

(E) Fittings;

(F) Casting and impression materials.

(b) Evaluation and Management codes are covered only for the diagnostic visit where the medical appropriateness for the orthotic is determined and for follow-up visits unrelated to the fitting of the orthotic.

(16) Refer to Table 130-0700-1 for supplies and DME covered in the office setting.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 57-1983, f. 11-29-83, ef. 1-1-84; AFS 48-1984(Temp), f. 11-3084, ef. 12-1-84; AFS 29-1985, f. 5-22-85, ef. 5-29-85; AFS 50-1986, f. 6-30-86, ef. 8-1-86; AFS 56-1987, f. 10-29-87, ef. 11-1-87; Renumbered from 461-014-0056; AFS 5-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; AFS 10-1990, f. 3-30-90, cert. ef. 4-1-90; Renumbered from 461-014-0830; HR 19-1991, f. 4-12-91, cert. ef. 5-1-91; HR 40-1992, f. 12-31-92, cert. ef. 2-1-93; HR 6-1994, f. & cert. ef. 2-1-94; HR 42-1994, f. 12-30-94, cert. ef. 1-1-95; 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 17-1999, f. & cert. ef. 4-1-99; OMAP 4-2000, f. 3-31-00, cert. ef. 4-1-00; 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 51-2002, 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

••••••••••

Adm. Order No.: OMAP 14-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-131-0280
Subject: Summary: The Physical and Occupational Therapy Services program administrative rules govern Office of Medical Assistance Programs (OMAP) payments for products and services provided to clients. OAR 410-131-0280 is amended to add CPT code 97755 to list of covered services, and delete part of rule that states code 97110 is not covered on the same date as code 97530.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-131-0280
Occupational and Physical Therapy Codes

(1) Occupational therapists and physical therapists should use any of the following codes which are applicable according to their Licensure and Professional Standards.

(2) Services which do not require payment authorization: Table 280-1.

(3) Services which require payment authorization:

(a) Modalities — need to be billed in conjunction with a therapeutic procedure code;

(b) Supervised — The application of a modality that does not require direct (one-on-one) client contact by the provider. Each individual code in this series may be reported only once for each client encounter: Table 280-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 8-1991, f. 1-25-91, cert. ef. 2-1-91; HR 19-1992, f. & cert. ef. 7-1-92; HR 43-1994, f. 12-30-94, cert. ef. 1-1-95; HR 8-1995, f. 3-31-95, cert. ef. 4-1-95; HR 4-1996, f. & cert. ef. 5-1-96; HR 2-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 8-1998, f. & cert. ef. 3-2-98; OMAP 18-1999, f. & cert. ef. 4-1-99; OMAP 3-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 32-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 16-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 41-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 53-2002, f. & cert. ef. 10-1-02; OMAP 64-2003, f. 9-8-03, cert. ef. 10-1-03; OMAP 14-2004, f. 3-11-04, cert. ef. 4-1-04

••••••••••

Adm. Order No.: OMAP 15-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-148-0000, 410-148-0020, 410-148-0080, 410-148-0120, 410-148-0260, 410-148-0280, 410-148-0300
Subject: The Home Enteral/Parenteral Nutrition and IV Services program administrative rules govern Office of Medical Assistance Programs (OMAP) payments for products and services provided to clients. Rules 410-148-0000, 410-148-0020, 410-148-0080, 410-148-0120, 410-148-0260, 410-148-0280 and 410-148-0300 are being revised to clarify rule language, update code changes with limitations, and take care of general housekeeping corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-148-0000
Foreword

(1) The Home Enteral/Parenteral Nutrition and IV Services rules are a user's manual designed to assist providers in preparing health claims for medical assistance program clients. The Home Enteral/Parenteral Nutrition and IV Services provider rules are to be used in conjunction with the General Rules for Oregon Medical Assistance Programs, the Oregon Health Plan Administrative Rules, the Pharmaceutical Services Administrative Rules, and other relevant provider rules and supplemental information.

(2) The Home Enteral/Parenteral Nutrition and IV Services provider rules include procedure codes with restrictions, and limitations. The Home EPIV code and fee schedule, which is not a part of these rules, is not an exhaustive list of OHP covered service codes. Please consult the Prioritized List of Health Services for the Oregon Health Plan and the OMAP Maximum Allowable Table.

(3) The Office of Medical Assistance Programs (OMAP) endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

(4) Providers should always follow the OMAP Administrative Rules in effect on the date of service.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 3-1995, f. & cer.t ef. 2-1-95; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0600 OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0020
Home Enteral/Parenteral Nutrition and IV Services

(1) The Office of Medical Assistance Programs (OMAP) will make payment for medically appropriate goods, supplies and services for home enteral/parenteral nutrition and IV therapy on written order or prescription. The order or prescription must be dated and signed by a licensed prescribing practitioner, legible and specify the service required, the ICD-9-CM diagnosis codes, number of units and length of time needed. The prescription or order must be retained on file by the provider of service for the peri-

od of time specified in OMAP General Rules. An annual assessment and a new prescription are required once a year for ongoing services. Also covered are services for subcutaneous, epidural and intrathecal injections requiring pump or gravity delivery.

(2) All claims for Enteral/Parenteral Nutrition and IV services require a valid ICD-9-CM diagnosis code. It is the provider's responsibility to obtain the actual diagnosis code(s) from the prescribing practitioner. Reimbursement will be made according to covered services on funded lines of the Health Services Commission's Prioritized List of Health Services, and these rules.

(3) OMAP requires one nursing service visit to assess the home environment and appropriateness of enteral/parenteral nutrition or IV services in the home setting and to establish the client's treatment plan. This nursing service visit for assessment purposes does not require payment authorization and is not required when the only service provided is oral nutritional supplementation. Nursing service visits provided in the home will be reimbursed by OMAP only when performed by a person who is licensed by the Oregon State Board of Nursing to practice as a Registered Nurse. All registered nurse delegated or assigned nursing care tasks must comply with the Oregon State Board of Nursing, Nurse Practitioner Act and Administrative Rules regulating the practice of nursing.

(4) Payment for services identified in the Home Enteral/Parenteral Nutrition and IV Services provider rules will be made only when provided in the client's place of residence, i.e., home or nursing facility.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-016-0290; HR 9-1992, f. & cert. ef. 4-1-92; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0640; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0080
Equipment Rental/Purchase/Repair

(1) The following equipment shall be authorized, if medically appropriate and when cost effective, on a rental basis only:

(a) IV infusion pumps;

(b) Enteral formulae pumps.

(2) Pump rental payment will not be made beyond the purchase price, but no more than 15 consecutive months when the period of use extends beyond 15 consecutive months:

(a) Consecutive months are defined as "any period of continuous use where no more than a 60 day break occurs";

(b) Office of Medical Assistance Programs (OMAP) considers that the maximum rental period toward purchase price is — 15 consecutive months of pump rental. The purchase price has been met at the earlier of the purchase price or 15 consecutive months;

(c) Having met the purchase price as described in (2)(b), the pump becomes property of the client. The provider may bill OMAP for maintenance and servicing of the pump (as long as that maintenance and servicing is not covered under any manufacturer/supplier warranty) when a period of at least six months has elapsed since the final month of pump rental. Payment for the maintenance service will only be made one time during every six-month period.

(3) All other equipment for home enteral/parenteral nutrition and IV services will be authorized as either purchase or based on length of need and medical appropriateness.

(4) All rental or purchase of equipment, full services warranty, pick-up, delivery, set-up, fitting and adjustments are included in the reimbursement. Individual consideration may be given in specific circumstances upon written request to OMAP.

(5) Repair of rental equipment is the responsibility of the provider.

(6) OMAP will not make payment for rental of pumps that are supplied by any manufacturer at no cost to the provider.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 20-1991, f. & cert. ef. 4-16-91; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0700; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0120
Reimbursement Limitations for Clients in a Nursing Facility

(1) The Office of Medical Assistance Programs (OMAP) will not reimburse for the following services/supplies for clients residing in a nursing facility:

(a) Nursing service visits (including assessment visit). Refer to Seniors and People with Disabilities (SPD) administrative rule covering All-Inclusive Rate;

(b) Supplies and items covered in the nursing facility All-Inclusive Rate. Refer to the Supplemental Information section of the Home Enteral/Parenteral Nutrition and IV Services provider website (http://www.dhs.state.or.us/policy/healthplan/guides/homeiv/) for a listing of those supplies and items;

(c) Oral nutritional supplements that are in addition to consumption of food items or meals.

(2) OMAP will reimburse for the following:

(a) Oral nutritional supplements are covered by OMAP for nursing facility clients when medically appropriate, i.e., the client cannot consume food items or meals;

(b) Tube fed enteral nutrition formula, when medically appropriate;

(c) Patient controlled pump for pain control medication (CADD).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 26-1993, f. & cert. ef. 10-1-93; HR 34-1993(Temp), f. & cert. ef. 12-1-93; HR 11-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0730; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0260
Home Enteral Nutrition

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Enteral Nutrition Formula. Use B4150 through B4156 when billing for tube fed nutritional formulae. If the product dispensed is not shown in HCPCS description, select a category equivalent when billing the Office of Medical Assistance Programs (OMAP).

(3) Oral Nutritional Supplements:

(a) Prior authorization is required on all oral supplements;

(b) Oral nutritional supplements can be billed through the on-line Point of Sale pharmacy system, or by paper using the 5.1 Universal Claim Form. Use the product's NDC when billing;

(c) If the product dispensed is not shown in one of the listed categories, select a category which is equivalent when billing OMAP;

(d) Oral nutritional supplements may be approved when the following criteria has been met:

(A) Clients age 6 and above:

(i) Must have a nutritional deficiency identified by one of the following:

(I) Recent low serum protein levels; or

(II) Recent Registered Dietician assessment shows sufficient caloric/protein intake is not obtainable through regular, liquefied or pureed foods.

(III) The clinical exception to the requirements of (I) and (II) must meet the following:

(III-a) Prolonged history (i.e. years) of malnutrition, and diagnosis or symptoms of cachexia, and

(III-b) Client residence in home, nursing facility, or chronic home care facility, and

(III-c) Where (I) and (II) would be futile and invasive

(ii) And have a recent unplanned weight loss of at least 10%, plus one of the following:

(I) Increased metabolic need resulting from severe trauma; or

(II) Malabsorption difficulties (e.g., short-gut syndrome, fistula, cystic fibrosis, renal dialysis; or

(III) Ongoing cancer treatment, advanced AIDS or pulmonary insufficiency.

(iii) Weight loss criteria may be waived if body weight is being maintained by supplements due to patient's medical condition (e.g., renal failure, AIDS)

(B) Clients under age 6:

(i) Diagnosis of 'failure to thrive';

(ii) Must meet same criteria as above, with the exception of % of weight loss.

(4) Enteral Nutrition Equipment:

(a) All repair and maintenance is subject to rule 410-1480-0080;

(b) Procedure Codes:

(A) S5036, Repair of infusion device (each 15 minutes = 1 unit) — PA;

(B) B9998, Enteral Nutrition Infusion Pump Replacement parts will be reimbursed at provider's acquisition cost (including shipping and handling) — PA/BR;

(C) B9000, Enteral Nutrition Infusion Pump, without alarm — rental (1 month = 1 unit) — PA;

(D) B9002, Enteral Nutrition Infusion Pump, with alarm — rental (1 month = 1 unit) — PA;

(E) E0776, IV Pole — Purchase;

(F) E0776, modifier RR, IV Pole — Rental (1 day = 1 unit);

(G) S9342, Enteral Nutrition via pump (1 day = 1 unit) — PA.

(5) Home Infusion Therapy:

(a) S9325, Home infusion, pain management (do not use with code S9326, S9327 or S9328) — PA

(b) S9326, Home infusion, continuous pain management — PA;

(c) S9327, Home infusion, intermittent pain management — PA;

(d) S9328, Home infusion, implanted pump pain management — PA.

(6) Not Otherwise Classified (NOC):

(a) B9998, NOC For Enteral Supplies — PA/BR

(A) Low profile gastronomy replacement kit (including MIC Key button, flexion stomata) must be billed under B9998, requiring PA for billing purposes only, and no PA medical documentation is needed.

(B) MIC Key tubing must be billed under B9998, requiring PA for billing purposes only, and no PA medical documentation is needed.

(b) S9379, Home infusion therapy, NOC — PA/BR.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0840; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0280

Home Parenteral Nutrition

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2)Standard Total Parenteral Nutrition (TPN):

(a) Bill using HCPCS codes S9365 through S9368;

(b) Home infusion for stand TPN includes the following drugs and products in the per diem rate:

(A) Non-specialty amino acids (e.g., aminosyn, freeamine, travasol)

(B) Concentrated dextrose (e.g., D10, D20, D40, D50, D60, D70)

(C) Sterile water;

(D) Electrolytes (e.g., CaC12, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4);

(E) Standard multi-trace elements (e.g., MTE4, MTE5, MTE7);

(F) Standard multi-vitamin solutions (e.g., MVI-13).

(c) The following items are not included in the per diem and should be billed separately:

(A) Specialty amino acids for renal failure, hepatic failure or for high stress conditions (e.g., aminess, aminosyn-RF, nephramine, RenAmin, HepatAmine, Aminosyn-HBC, BranchAmin, FreeAmine HBC, Trophamine);

(B) Specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted patients (e.g., Aminosyn 15%, Novamine 15%, Clinisol 15%);

(C) Lipids

(D) Added trace elements, vitamins not from standard multitrace element or multivitamin solution;

(E) Products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran).

(2) Parenteral Nutrition Solutions:

(a) Bill using HCPCS codes B4164 through B5200. See HCPCS book for description.

(b) Note: Reimbursement for compounding, admixture and administrative fees is included in the unit price.

(3) Parenteral Supply Kits/Supplies — Procedure Codes

(4) Parenteral Nutrition Equipment — Procedure Codes — Table 0280-1.

(5) Not Otherwise Classified (NOC) — B9999, NOC For Parenteral Supplies — PA/BR.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 26-1993, f. & cert. ef. 10-1-93; HR 3-1995, f. & cert. ef. 2-1-95; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0860; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

410-148-0300

Other Home IV and Enteral/ Parenteral Administration Services

(1) Codes that have "PA" indicated require prior authorization. Codes with "BR" indicated are covered by report.

(2) Catheter Care Kits. All catheter care kit allowable amounts are determined on a per diem basis (1 day = 1 unit):

(a) When performed as a stand alone therapy, or during days not covered under per diem by another therapy, bill using catheter care codes S5497 through S5521;

(b) The following supplies for non-routine catheter procedures may be billed separately from per diem reimbursement:

(A) S5517 Catheter declotting supply kit, 1 day=1 unit;

(B) S5518 Catheter repair supply kit, 1 day = 1 unit;

(C) S5520 PICC insertion supply kit, 1 day=1 unit;

(D) S5521 Midline insertion supply kit, 1 day=1 unit;

(E) E0776 IV Pole — Purchase;

(F) E0776 with modifier RR IV Pole — Rental, 1 day = 1 unit.

(3) Home Nursing Visits:

(a) When enteral/parenteral services are performed in the home, only a single provider of skilled home health nursing services may obtain authorization and/or bill for such services for the same dates of service;

(b) Requests made by providers for any intravenous or enteral/parenteral related skilled nursing services, either solely or in combination with any other skilled nursing services in the home are to be reviewed for prior authorization by the OMAP Medical Unit;

(c) Procedure Codes: 99601, Home infusion/specialty drug administration, per visit (up to 2 hours) — 1 visit = 1 unit — PA;

(B) 99602, each additional hour. List separately in addition to code for primary procedure). Use 99602 in conjunction with 99601 — PA;

(C) T1001, Home Nursing Visit for Assessment — 1 visit = 1 Unit.

(4) Not Otherwise Classified (NOC) — S9379, NOC for Home IV Supplies — PA/BR.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 26-1990, f. 8-31-90, cert. ef. 9-1-90; HR 46-1990, f. & cert. ef. 12-28-90; HR 26-1993, f. & cert. ef. 10-1-93; OMAP 7-1998, f. 2-27-98, cert. ef. 3-1-98; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 46-2001, f. 9-24-01, cert. ef. 10-1-01, Renumbered from 410-121-0880; OMAP 22-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 63-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 15-2004, f. 3-11-04, cert. ef. 4-1-04

••••••••••

Adm. Order No.: OMAP 16-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04 thru 8-15-04
Notice Publication Date:
Rules Amended: 410-125-0115, 410-125-0121, 410-125-0181
Subject: The Hospital Services program rules govern Office of Medical Assistance Programs' payment for services provided to clients. OMAP will temporarily amend rules 410-125-0115, 410-125-0121 and 410-125-0181 to revise contiguous and non-contiguous hospital payment methodology to decrease risk of overpayment and to bring into line with in-state hospitals. These rules are effective, retroactively, for services rendered on or after October 1, 2003. These rules, permanently amended on October 1, 2003, are being re-filed as permanently amended to assure compliance with HB 3120, 2003 Or Laws 749 section 5. There is no change in the content of the rule as amended, except to clarify that it is retroactive to October 1, 2003. To the extent that rule 410-125-0181, amended on October 1, 2003, has been later amended as of January 1, 2004, those changes are incorporated.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-125-0115

Non-Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

Non-contiguous area hospitals are out-of-state hospitals located more than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, non-contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for non-contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations from Other Hospitals, DRG Rate Methodology, OAR 410-125-0141 for the methodology used to calculate the unit value at the 50th percentile). No cost outlier, capital or medical

education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 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 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, 461-015-0020 & 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 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, 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. 11-18-91; Renumbered from 410-125-0840; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04

410-125-0121
Contiguous Area Out-of-State Hospitals — Effective for services rendered on or after October 1, 2003

Contiguous area hospitals are out-of-state hospitals located less than 75 miles outside the Oregon border. Unless such hospitals have an agreement or contract with OMAP for specialized services, contiguous area out-of-state hospitals will receive DRG reimbursement or billed charges whichever is less. The unit value for contiguous out-of-state hospitals will be set at the final unit value for the 50th percentile of Oregon hospitals (see Inpatient Rate Calculations for Other Hospitals, DRG Rate Methodology OAR 410-125-0141 for the methodology). Contiguous area out-of-state hospitals are also eligible for cost outlier payments. No capital or medical education payments will be made. The hospital will receive a disproportionate share reimbursement if eligible (see OAR 410-125-0150).

Stat. Auth.: ORS 184.750, ORS 184.770, ORS 411 & ORS 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 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, 461-015-0020 & 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 461-015-0570; HR 31-1990(Temp), f. & cert. ef. 9-11-90; HR 36-1990(Temp), f. 10-29-90, cert. ef. 11-1-90; HR 3-1991, 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 410-125-0840; OMAP 58-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 16-2004(Temp), f. & cert. ef. 3-15-04 thru 8-15-04

410-125-0181
Non-Contiguous and Contiguous Area Out-of-State Hospitals — Outpatient Services

Effective for services rendered on or after March 1, 2003.

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 OMAP 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 an OMAP fee schedule.

(2) Effective for services rendered on or after March 1, 2003: All other outpatient services will be reimbursed at 44 percent of billed charges. There is no cost settlement.

(3) Effective for services rendered on or after January 1, 2004: All other outpatient services will be reimbursed at 50 percent of billed charges. There is no cost settlement.

Stat. Auth.: ORS 409
Stats. Implemented: 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

• • • • • • • • • •

Adm. Order No.: OMAP 17-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 4-1-04 thru 9-15-04
Notice Publication Date:
Rules Amended: 410-141-0520
Subject: The Oregon Health Plan (OHP) Services program rules govern Office of Medical Assistance Programs payment for services provided to clients. Rule 410-141-0520 is temporarily amended to incorporate in rule by reference the Oregon Health Services Commission's Prioritized List of Health Services (Prioritized List). Rule 410-141-0520 is temporarily revised to incorporate the most current updates to the Prioritized List, effective April 1, 2004. This rule will be permanently amended on or after May 1, 2004.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-141-0520
Prioritized List of Health Services (Effective for services rendered on or after April 1, 2004)

(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 Ancillary Services and Preventive Services, 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 (http://www.ohpr.state.or.us/hsc/index_hsc.htm) or, for a hardcopy, contact the Office of Health Policy and Research. This rule incorporates by reference the Prioritized List, effective April 1, 2004, and 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). 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 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) The Prioritized List, effective April 1, 2004, is in effect and condition/treatment pairs through line 549 are funded.

[ED. NOTE: Tables referenced are available from the agency.}
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
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

• • • • • • • • • •

Adm. Order No.: OMAP 18-2004
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 1-1-04
Rules Amended: 410-121-0000, 410-121-0060, 410-121-0061, 410-121-0100, 410-121-0135, 410-121-0140, 410-121-0143, 410-121-0144, 410-121-0145, 410-121-0147, 410-121-0148, 410-121-0150, 410-121-0155, 410-121-0185, 410-121-0190, 410-121-0200, 410-121-0420, 410-121-0580, 410-121-0625
Rules Repealed: 410-121-0154, 410-121-0180

Subject: The Pharmaceutical Services program Administrative Rules govern the Office of Medical Assistance Programs payments for services rendered to clients. 410-121-0140 is amended to move rule language from definitions to rules 410-121-0145, 410-121-0148, and 410-121-0155. Rules 410-121-0154 and 410-121-0180 are repealed and text moved to rule 410-121-0155. The remainder of rules filed are amended to make necessary housekeeping corrections.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0000
Foreword

(1) The Pharmaceutical Services Oregon Administrative Rules are designed to assist providers in preparing claims for services provided to Office of Medical Assistance Programs (OMAP) fee-for-service clients. The Pharmaceutical OARs must be used in conjunction with the General Rules for Oregon Medical Assistance Programs (OAR 410 division 120).

(2) Pharmaceutical services delivered through managed care plans contracted with OMAP, under the Oregon Health Plan, are subject to the policies and procedures established in the Oregon Health Plan Administrative Rules (OAR 410 division 141) and by the specific managed health care plans.

(3) OMAP endeavors to furnish medical providers with up-to-date billing, procedural information, and guidelines to keep pace with program changes and governmental requirements.

(4) Administrative rules and billing guidelines for Home Enteral/Parenteral Nutrition and IV services are included in OAR 410 division 148. Administrative rules and billing guidelines for Durable Medical Equipment are included in OAR 410 division 122.

(5) All OMAP rules are available on the Department of Human Services website.

[ED NOTE: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184
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

410-121-0060
How to Obtain Prior Authorization (PA) 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 the Pharmaceutical Services Supplemental Information on the Department of Human Services website.

(2) Receipt of approval of a PA:

(a) If the PA request is approved, the MAP Help Desk will notify the pharmacy when the dispensing pharmacy information is available:

(A) The PA is given for a specific date of service and an NDC number or product;

(B) The PA does 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. The pharmacy should also check whether the client is enrolled in a managed care plan. An enrollment may have taken place after PA was received;

(c) After a PA request is approved, the patient will be able to fill the prescription at any Medicaid pharmacy provider. 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 is available.

(4) Emergency Need: The Pharmacist may request an emergent or urgent dispensing from the First Health when the client is eligible for covered fee-for-service drug prescriptions:

(a) Emergency dispensing for a 96-hour supply for clients without a PA pending;

(b) Emergency dispensing up to a seven-day supply, pending a submitted PA request for clients.

Stat. Auth.: ORS 409
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

410-121-0061
Durable Medical Equipment and Medical Supplies

Follow the guidelines in the Durable Medical Equipment and Medical Supplies (OAR 410 division 122) and Home Enteral/Parenteral Nutrition and IV Services (OAR 410 division 148) Administrative Rules and Supplemental Information for billing and prior authorization of these medical supplies and services. This information is available on the Department of Human Services website.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 26-1991, f. & cert. ef. 7-1-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0100
Drug Use Review

(1) Drug Use Review (DUR) 4 in Oregon Medical Assistance Programs is a program designed to measure and assess the proper utilization, quality, therapy, medical appropriateness, appropriate selection and cost of prescribed medication through evaluation of claims data. This is done on both a retrospective and prospective basis. This program shall include, but is not limited to, education in relation to overutilization, underutilization, therapeutic duplication, drug-to-disease and drug-to-drug interactions, incorrect drug dosage, duration of treatment and clinical abuse or misuse:

(a) Information collected in a (DUR) program which identifies an individual is confidential and may not be disclosed by the Oregon State Medical Assistance Programs DUR Board or the Retrospective DUR Council to any person other than health care providers appearing on a recipient's medication profile;

(b) Staff of the above-mentioned Board and Council may have access to identifying information to carry out intervention activities approved by Office of Medical Assistance Programs (OMAP), after signing an agreement to keep the information confidential. The identifying information may not be released to anyone other than DUR staff members of the Board or Council, or health care providers appearing on a recipient's medication profile. Identifying information is defined for the purposes of drug use review as names of prescribers, pharmacists and/or clients.

(2) Prospective DUR is the screening for potential drug therapy problems before each prescription is dispensed. It is performed at the point of sale by the dispensing pharmacist:

(a) Each dispensing pharmacist must offer to counsel each OMAP client receiving benefits (or the care giver of such individual), who presents a new prescription, unless the client refuses such counsel. Pharmacists must document these refusals:

(A) Counseling must be done in person, whenever practicable;

(B) If it is not practicable to counsel in person, providers whose primary patient population does not have access to a local measured telephone service must provide access to toll-free services (for example, some mail order pharmacy services) and must provide access to toll-free service for long-distance client calls in relation to prescription counseling.

(b) Prospective DUR is not required for drugs dispensed by FCHPs;

(c) Board of Pharmacy rules defining specific requirements relating to patient counseling, record keeping and screening must be followed.

(3) Retrospective DUR is the screening for potential drug therapy problems based on paid claims data. Through this program the OMAP provides a professional drug therapy review for Medicaid clients:

(a)The criteria used in retrospective DUR are compatible with those used in prospective DUR. The drug therapy review is carried out by a panel of Oregon licensed physicians and pharmacists appointed by the Director of the OMAP. Members of this panel are referred to as council members;

(b)If therapy problems are identified by the review council, an educational letter is mailed to the prescribing provider, the dispensing provider, or both. Other forms of education are carried out under this program with OMAP approval.

(4) The Oregon State Medicaid DUR Board is a group of individuals who comprise an advisory committee to OMAP:

(a) The DUR Board is comprised of health care professionals with recognized knowledge and expertise in one or more of the following areas:

(A) Clinically appropriate prescribing of outpatient drugs covered by Medicaid;

(B) Clinically appropriate dispensing and monitoring of outpatient drugs covered by Medicaid;

(C) Drug use review, evaluation and intervention;

(D) Medical quality assurance.

(b) The Board's membership is made up of at least one-third, but not more than 51 percent, licensed and actively practicing physicians and at

least one-third licensed and actively practicing pharmacists. The Board is composed of five practicing pharmacists;

(A) five practicing physicians;

(B) two persons who represent people on Medical Assistance; and (D) one person actively practicing dentistry.

(c) The retrospective DUR coordinator will attend board meetings in an ex officio capacity;

(d) Appointments to the Board are made by the OMAP Administrator:

(A) Nominations for Board membership may be sought from various professional associations and each member may serve a two-year term;

(B) When a vacancy occurs a new member is appointed to serve the remainder of the unexpired term;

(C) An individual appointed to the Board may be reappointed upon the completion of the his/her term.

(e) Members of the Board receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties;

(f) Members of the Board attend quarterly meetings, two of which must be attended in person.

(5) The Board is designed to develop policy recommendations in the following areas in relation to Drug Use Review:

(a) Appropriateness of criteria and standards for prospective DUR and needs for modification of these areas. DUR criteria are predetermined elements of health care based upon professional expertise, prior experience, and the professional literature with which the quality, medical appropriateness, and appropriateness of health care service may be compared. Criteria and standards will be consistent with the following compendia:

(A) American Hospital Formulary Services Drug Information;

(B) US Pharmacopeia-Drug Information;

(C) American Medical Association Drug Evaluations;

(D) Peer-reviewed medical literature;

(E) Drug DEX.

(b) Recommendations for continued maintenance of patient confidentiality will be sought;

(c) The use of different types of education and interventions to be carried out as part of retrospective DUR and the evaluation of the results of this portion of the program; and

(d) The preparation of an annual report on Oregon Medicaid DUR Program which describes:

(A) The nature and scope of the DUR program and its Board including:

(i) A description of how pharmacies without computers comply with prospective DUR;

(ii) Detailed information on new criteria and standards in use; and

(iii) changes in state policy in relation to DUR requirements for residents in nursing homes.

(B) A summary of the education/intervention strategies developed; and(C) An estimate of the cost savings in the pharmacy budget and indirect savings due to changes in levels of physician visits and hospitalizations.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 38-1992, f. 12-31-92, cert. ef. 1-1-93; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0135

Pharmacy Management Program Requirements

(1) The Pharmacy Management Program requires most fee-for-service clients to be enrolled in one pharmacy to receive their prescription drugs.

(2) The name and phone number of the pharmacy the client is required to use will be on the OMAP Medical Care ID. OMAP will only reimburse the pharmacy listed on the OMAP Medical Care ID.

(3) When no pharmacy is listed on the OMAP Medical Care ID, the client may have their prescriptions filled by any pharmacy that has an OMAP provider number.

(4) See OAR 410-141-0065 for clients who are not required to be enrolled in the Pharmacy Management Program.

(5) A client who is enrolled with a pharmacy may receive drugs from a different pharmacy if:

(a) The client has an urgent need to fill a prescription and the enrolled pharmacy is not available; or

(b) The enrolled pharmacy does not have the prescribed drug in stock.

(6) Call the First Health Technical Help Desk for authorization to fill a prescription in the situations described in (5)(a) or (b) above.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 26-2002, f. 6-14-02 cert. ef. 7-1-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

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) Automated Information System (AIS): A computer system that provides on-line Medicaid eligibility information. AIS is accessed through the provider's touch-tone telephone by dialing 1-800-522-2508.

(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 OMAP Pharmacy Program, "community based care living facilities" include:

(a) Supportive Living Facilities;

(b) 24-Hour Residential Services;

(c) Foster Care;

(d) Semi-independent Living Programs;

(e) Assisted Living and Residential Care Facilities.

(5) Compounded Prescriptions: 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. Compounded prescription is further defined to include the Board of Pharmacy definition of Compounding.

(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 that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches, custom built orthopedic braces. Medical supplies are nonreusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages, and tubing.

(9) Estimated Acquisition Cost (EAC): The estimated cost at which the pharmacy can obtain the product listed in OAR 410-121-0155.

(10) 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) The specific drugs requiring prior authorization (PA) are listed in OAR 410-121-0040;

(b) The practitioner, or practitioner's licensed medical personnel listed in OAR 410-121-0060, may request a PA.

(11) Nursing Facilities: The term "Nursing Facility" refers to an establishment which is licensed and certified by DHS Seniors and People with Disabilities cluster as a Nursing Facility.

(12) Point-of-Sale (POS): A computerized, claims submission process for retail pharmacies which provides on-line, real-time claims adjudication.

(13) 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 a 34-day (See OAR 410-121-0146);

(b) Billing the agency for more than one dispensing fee when the prescription calls for one dispensing for the quantity dispensed;

(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);

(d) Using multiple 30-day cards to dispense a prescription when a lesser number of cards will suffice.

(14) Prescription Volume Survey: A survey used by pharmaceutical providers which determines the providers dispensing rate. This survey documents for each pharmacy the total prescriptions dispensed, the total prescriptions dispensed to OMAP clients, and if used, the types of unit dose system.

(15) 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 State Board of Pharmacy.

(16) Unit Dose Delivery System: OMAP currently recognizes two types of unit dose dispensing systems in a nursing facility or community

based living facility. Both the True and Modified Unit Dose delivery systems are described in OAR 410-121-0148.

Stat. Auth.: ORS 409
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

410-121-0143
Client Confidentiality

Pharmacists are responsible for maintaining the confidentiality of client information in compliance with HIPAA standards. Facilities shall provide adequate privacy for patient consultations.

Stat. Auth.: ORS 409.010 & ORS 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 16-1992, f. & cert. ef. 7-1-92; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0144
Notation on Prescriptions

This rule applies to fee-for-service clients only.

(1) Prescribing practitioners must add a notation on pharmacy prescriptions indicating when there is a non-covered diagnosis.

(2) When the client 's diagnosis is excluded or below the current funding line on the Health Services Commission's Prioritized List of Health Services, use the following notations (or similar language):

(a) "Diagnosis not covered";

(b) "Excluded diagnosis"; or

(c) "Condition below the funding line".

(3) The Office of Medical Assistance Programs (OMAP) will not provide payment for prescriptions when a diagnosis is:

(a) Below the funding line;

(b) An excluded service; or

(c) On the excluded list.

(4) Payment for prescriptions with an excluded or not covered diagnosis is the responsibility of the client. These prescriptions will not be paid under the Oregon Health Plan. Pharmacies are not to bill OMAP for these prescriptions.

Stat.Auth.: ORS 409
Stats.Implemented: ORS 414.065
Hist.: OMAP 39-2002, f. 9-13-02, cert. ef. 9-15-02; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0145
Prescription Requirements

(1) OMAP will make payment for covered drugs supplied on drug order or prescription of a licensed practitioner and dispensed by a pharmacist. Dispensings include new prescriptions, refills of existing prescriptions, and over-the-counter (OTC) medications.

(2) Each drug order or prescription filled for an OMAP client must be retained in the pharmacy's file at the pharmacy's place of business.

(3) All drug orders or prescriptions must comply with the Oregon State Board of Pharmacy rules and regulations as listed in OAR 855 division 041.

Stat. Auth.: ORS 409
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 44-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82; AFS 53-85, f. 9-20-85, 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 53-1985, f. 9-20-85, ef. 10-1-85; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-016-0020; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-016-0200; HR 25-1994, f. & cert. ef. 7-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0147
Exclusions and Limitations

The following items are not covered for payment by the Office of Medical Assistance Programs (OMAP):

(1) Drug Products for diagnosis below the funded line on the Health Services Commission Prioritized List;

(2) Home pregnancy kits;

(3) Fluoride for individuals over 18 years of age;

(4) Expired drug products;

(5) Drug Products from Non-Rebatable Manufacturers;

(6) Drug products that are not assigned a National Drug Code (NDC) number, and are not approved by the Federal Drug Administration (FDA);

(7) Drug products dispensed for Citizen/Alien-Waived Emergency Medical client benefit type;

(8) Desi drugs;

(9) Drug Products and drug product quantities which do not meet OMAP guidelines.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 22-1993(Temp),f. & cert. ef. 9-1-93; HR 34-1993(Temp), f. & cert. ef. 12-1-93; HR 11-1994, f. 2-25-94, cert. ef. 2-27-94; HR 25-1994, f. & cert. ef. 7-1-94; HR 2-1995, f. & cert. ef. 2-1-95; HR 22-1997, f. & cert. ef. 10-1-97; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0148
Dispensing in a Nursing Facility or Community Based Care Living Facility

(1) A pharmacy serving OMAP clients in a nursing facility or a Community Based Care Living Facility must dispense medication in a manner consistent with that facility's system of use, i.e., bulk, unit dose or 30-day card system as set forth in ORS Chapter 441. (16) Unit Dose Delivery System:

(a) OMAP currently recognizes two types of unit dose dispensing systems:

(A) A True Unit Dose delivery system in a nursing facility or community-base care facility requires that:

(i) A pharmacy must deliver each client's medication a minimum of five days weekly, or delivery of medical carts every other day with service available seven days a week;

(ii) Resumption of the same medication after a "stop order" or discontinuance ("DC") order constitutes a new prescription;

(iii) The monthly billing period shall remain the same for all clients;

(iv) Small quantity prescriptions are allowed only when the monthly billing period is interrupted, e.g., hospitalization, new patient admit.

(B) A Modified Unit Dose delivery system in a nursing facility or community-based care facility requires that:

(i) A pharmacy must deliver each client's medication in a sealed single-or multi-dose package;

(ii) A pharmacy must dispense the greater of the quantity prescribed or a 30-day supply, except when short-term therapy is specified by the prescriber;

(iii) A pharmacy must bill OMAP for the date of dispensing within the timely filing limit;

(iv) Manufacturer's Unit Dose packaging of drugs is not reimbursable.

(b) Unit Dose dispensing is a 30-day blister pack, bingo or punch card containing multiple sealed single doses of medication:

(A) The pharmacy must have a system for dispensing and recovery of unused doses that has been approved by the State Board of Pharmacy;

(B) A 30-day card system that does not meet the requirements of the State Board of Pharmacy for recovery of unused doses, or for other reasons does not qualify for payment is not considered a True or Modified Unit Dose Delivery System.

(c) True and Modified Unit Dose providers must:

(A) Supply OMAP with a list of the nursing and community based care living facilities it will serve under this system;

(B) Sign an agreement to abide by the requirements of the program;

(C) Keep a separate, detailed Medication Administration Record (MAR) of all medications dispensed for each facility client served.

(2) Pharmacies that do not dispense through a unit dose or 30-day card system may bill OMAP for a dispensing fee for each dispensing of legend drugs to eligible clients on an OMAP fee-for-service basis.

(3) The pharmacy must submit a written notification to OMAP of the agreement between the pharmacy and the nursing or community based care living facility. The notice must be received in OMAP by the 15th of the month prior to the month the pharmacy initiates service to a facility. This notice must consist of the following:

(a) A completed Facility Dispensing Statement (OMAP 3063) signed by the pharmacist in charge, stating the dispensing method to be used for each qualified facility;

(b) The name, address, and telephone number of each facility served by the pharmacy.

(4) Pharmacies dispensing through a unit dose or 30-day card system must bill OMAP only for the medications actually dispensed. Only one dispensing fee will be reimbursed per medication dispensed in a 30-day period, for a medication ordered continuously for 30 days or more.

(5) The pharmacy must submit written notification to OMAP through a completed Facility Dispensing Statement (OMAP 3063) signed by the pharmacist in charge if at least one of the following situations arise:

(a) The percentage level of true or modified unit dose dispensings falls below the percentage level defined in OAR 410-121-0160;

(b) The dispensing system changes from unit dose either true or modified, to bulk dispensing or vice versa;

(c) The pharmacy discontinues providing services to a specific facility already on record as being served by the pharmacy.

(6) Pharmacies shall not bill OMAP for repackaging/handling fees. There may only be one billing for each dispensing.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409

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 44-1982, 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 83-1982 (Temp), f. & ef. 9-2-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 58-1983, f. 11-30-83, ef. 1-1-84; AFS 16-1985, f. 3-26-85, ef. 5-1-85; AFS 52-1986, f. & ef. 7-2-86; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-016-0070; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-016-0230; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0150
Billing Requirements

(1) When billing the Office of Medical Assistance Programs (OMAP) for pharmaceuticals, the provider must not bill in excess of the usual and customary charge to the general public.

(2) The National Drug Code (NDC), as it appears on the package from which the prescribed medications are dispensed, must be indicated.

(3) Actual metric decimal quantity dispensed, must be billed.

(4) The provider must accurately furnish all information required on the 5.1 Universal Claims Form if submitting paper claim.

(5) The prescribing physician's Medicaid Provider Identification (ID) Number is required on all claims. Use of the appropriate provider ID number is mandatory. Claims will deny for a missing or invalid Prescriber ID number. Exceptions to this include but are not limited to:

(a) Out-of-state providers;

(b) Mental Health providers working at county clinics which have no individual provider number;

(c) Inactive Medicaid providers contracted by managed care plans prescribing class seven (7) or eleven (11) drugs.

(6) When clients have private insurance, providers are required to bill the private insurance as primary and OMAP as secondary.

(7) When clients have Medicare prescription drug coverage, providers are required to bill Medicare as primary and OMAP as secondary.

(8) Billing for Death With Dignity services:

(a) All Death With Dignity services must be billed directly to OMAP, even if the client is in a managed care plan;

(b) Prescriptions must be billed on an 5.1 Universal Claims Form paper claim form using an NDC number ;

(c) Claims for Death With Dignity services cannot be billed through Point-of-Sale;

(d) Claims for Death With Dignity services must be submitted on paper billing forms to OMAP at PO Box 992, Salem, Oregon 97308-0992.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409

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

410-121-0155
Reimbursement

Payment for fee-for-service pharmaceutical prescriptions will be the lesser of the usual and customary amount billed or the Estimated Acquisition Cost (EAC) of the generic form, minus any applicable copayments, plus a professional dispensing fee. Refer to OAR 410-120-1230 for client copayment details.

(1) EAC is the lesser of :

(a) Centers for Medicaid and Medicare Services (CMS) federal upper limits (FUL) for payment; or

(b) Oregon Maximum Allowable Cost (OMAC); or

(c) Retail pharmacies: eighty-five percent of Average Wholesale Price (AWP) of the drug; or

(d) Unit dose or modified unit dose pharmacies: eighty-nine percent of AWP for long-term care clients in a nursing facility or community based living facility; or

(e) Contracted mail order pharmacy: seventy-nine percent of AWP for brand (trade) name drugs, forty percent of AWP for generic drugs and eighty-two percent of AWP for injectable drugs.

(2) The Office of Medical Assistance Programs (OMAP) shall revise its estimated acquisition cost file twice monthly.

(3) Pharmacies must make available to OMAP any information necessary to determine the pharmacy's actual acquisition cost of pharmaceutical goods dispensed to OMAP clients.

(4) Payment for trade name forms of multisource products will be the lesser of the amount billed or the EAC of the trade name form of the product, minus applicable copayments, plus a professional dispensing fee only if the prescribing practitioner has received a prior authorization for a trade name drug.

(5) Payment for individual special admixtures, fluids or supplies shall be limited to the lesser of:

(a) Eighty percent of the usual and customary charges to the general public;

(b) The amount Medicare allows for the same product or service;

(c) The amount the agency negotiates with an individual provider, less any amount paid or payable by another third party; or

(d) The amount established or determined by OMAP.

(6) No professional dispensing fee is allowed for dispensing :

(a) condoms, contraceptive foams, suppositories, inserts, jellies, and creams;

(b) pill splitters/cutters;

(c) medical supplies and equipment; or

(d) oral nutritional supplements.

(7) Over-the-counter contraceptive drugs and devices will be reimbursed at the lesser of billed amount or EAC, plus fifty percent of EAC;

(8) Oral nutritional supplements will be reimbursed at the lesser of billed amount or EAC, plus one third of EAC.

(9) Pill splitters/cutters with a National Drug Code (NDC) number will be reimbursed at the lesser of billed amount, or EAC. A practitioner prescription is not required. The limit is one per client in a twelve-month period.

Stat. Auth.: ORS 184.750, 184.770, 409, 411 & ORS 414

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 846(Temp), f. & ef. 7-1-77; PWC 858, f. 10-14-77, ef. 11-1-77; PWC 869, f. 12-30-77, ef. 1-1-78; AFS 15-1979(Temp), f. 6-29-79, ef. 7-1-79; AFS 41-1979, f. & ef. 11-1-79; AFS 15-1981, f. 3-5-81, ef. 4-1-81; AFS 35-1981(Temp), f. 6-26-81, ef. 7-1-81; AFS 53-1981(Temp), f. & ef. 8-14-81; AFS 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, 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 74-1982 (Temp), f. 7-22-81, ef. 8-1-82; AFS 99-1982, f. 10-25-82, ef. 11-1-82; AFS 113-1982(Temp), f. 12-28-82, ef. 1-1-83; AFS 13-1983, f. & ef. 3-21-83; AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 18-1984, f. 4-23-84, ef. 5-1-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 42-1986(Temp), f. 6-10-86, ef. 7-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-016-0100; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-016-0250; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; 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 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 32-2002, f. & cert. ef. 8-1-02; OMAP 40-2003, f. 5-27-03, cert. ef. 6-1-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0185
Pharmacy Based Immunization Delivery

(1) A pharmacist may administer vaccines to persons who are over the age of eighteen as provided by ORS 689.205 and The Board of Pharmacy Administrative rule 855-041-0500.

(2) Two billing methods are allowed:

(a) Use CMS-1500 when billing for vaccines administration. Use the appropriate CPT-code (90471 or 90472) for the administration plus the appropriate vaccine code(s) 90476-90749:

(A) An ICD-9 diagnosis must be shown in field 21 of the CMS-1500;

(B) The diagnosis code must be shown to the highest degree of specificity; or,

(b) Use the Point-of-Sale system when billing for vaccine administration. 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
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

410-121-0190
Clozapine Therapy

(1) Clozapine is covered only for the treatment of clients who have failed therapy with at least two anti-psychotic medications. Clozapine Supervision is the management and record keeping of clozapine dispensings as required by the manufacturer of clozapine.

(2) Clozapine supervision:

(a) Pharmacists are to bill for Clozapine Supervision by using code 90862, adding TC modifier.

(b) Providers billing for clozapine supervision must document all of the following:

(A) Exact date and results of White Blood Counts (WBCs), upon initiation of therapy and at recommended intervals per the drug labeling;

(B) Notations of current dosage and change in dosage;

(C) Evidence of an evaluation at intervals recommended per the drug labeling requirements approved by the FDA;

(D) Dates provider sent required information to manufacturer.

(E) Only one provider, either pharmacist or physician, may bill per week per client;

(F) Limited to five units per 30 days per client;

(G) An ICD-9 diagnosis must be shown in Field 21 of the CMS-1500. The diagnosis code must be shown to the 5th digit on the CMS-1500 and OMAP 505.

(3) Drug Products — The information required on the 5.1 Universal Claim Form must be included in the billing. The actual drug product may be billed electronically or submitted on the 5.1 Universal Claim Form;

(4) Venipuncture — If the pharmacy performs venipuncture, bill for that procedure on a CMS-1500 (and OMAP 505 if the client has Medicare coverage). Use Type of Service "S" and Procedure Code G0001.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; HR 6-1995, f. 3-31-95, cert. ef. 4-1-95; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 17-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 31-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 45-2002, f. & cert. ef. 10-1-02; 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 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

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 OMAP Medical Care Identification has been presented. In the absence of a valid Medical Care Identification, the provider should call the Automated Information System or contact the local branch office where the client is being served;

(c) All completed 5.1 Universal Claim Forms should be mailed to the Office of Medical Assistance Programs; A paper claim must be used when the billed amount exceeds $99,999;

(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 OMAP Durable Medical Equipment and Medical Supplies Administrative Rules and Supplemental Information, and the OMAP 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
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

410-121-0420
DESI Less-Than-Effective Drug List

(1) An October 23, 1981 ruling by District of Columbia Federal Court directed the Department of Health and Human Services to stop reimbursement, effective October 30, 1981, under Medicaid and Medicare Part B for all DESI less-than-effective drugs which have reached the Federal Drug Administration Notice-of-Opportunity-for-Hearing stage.

(2) Since this ruling means the Federal funding for these drugs will be terminated, payment for drugs will not be made by OMAP. The "Active Ingredient" and "Route" of administration columns are the major controlling factors regarding the FDA's less-than-effective drug determinations and CMS's reimbursement decisions regarding these drugs. The products' trade names, dosage forms and names of the producing firms are supplied for informational purposes. Thus, even though a drug's trade name, dosage form, is not shown on this list, if by its generic make up and route of administration it is identical, similar, or related to a drug on this list, no Federal Financial Participation (FFP) is available for such a drug. Therefore, OMAP will not reimburse for DESI drugs or dispensings of products that are identical, related, or similar.

(3) In accordance with current policy, Federal financial participation will not be provided for any drug on the FUL listing for which the FDA has issued a notice of an opportunity for a hearing as a result of the Drug Efficacy Study and Implementation (DESI) program and the drug has been found to be a less than effective or is identical, related or similar (IRS) to the DESI drug. The DESI drug listing is identified by the Food and Drug Administration or reported by the drug manufacturer for purposes of the Medicaid drug rebate program.

(4) The manufacturer has the responsibility of determining the DESI status of a drug product.

(5) DESI Less Than Effective Drug List is available for download on the Department of Human Services website. If you would like to request a hard copy of this list, please call OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; AFS 64-1989(Temp), f. 10-24-89, cert. ef. 11-15-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 17-1990(Temp), f. 6-29-90, cert. ef. 7-1-90; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-016-0390; HR 20-1991, f. & cert. ef. 4-16-91; HR 20-1994, f. 4-29-94, cert. ef. 5-1-94; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 29-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

410-121-0580
Oregon Medicaid and Pharmaceutical Manufacturers' Dispute Resolution Procedures

(1) Within 60 days after the end of each calendar quarter, the Office of Medical Assistance Programs (OMAP) shall report the number of units dispensed for each drug National Drug Code (NDC) for which payment was made to the manufacturer of said product. Utilization reports to manufacturers shall follow this schedule:

(a) The period from January 1 through March 31 will be Quarter 1. Quarter 1 invoices shall be due by May 30 of that same year;

(b) The period from April 1 through June 30 will be Quarter 2. Quarter 2 invoices shall be due by August 29 of that same year;

(c) The period from July 1 through September 30 will be Quarter 3. Quarter 3 invoices shall be due by November 29 of that same year;

(d) The period from October 1 through December 31 will be Quarter 4. Quarter 4 invoices shall be due by February 29 of the following year.

(2) A manufacturer must make payment within 30 days of receipt of utilization reports, i.e., rebate invoice. Using eight days as reasonable time for reports to reach the manufacturer, payment of the invoiced amount is due per the following schedule:

(a) Rebate payment for Quarter 1 shall be due by July 7 of that same year;

(b) Rebate payment for Quarter 2 shall be due by October 7 of that same year;

(c) Rebate payment for Quarter 3 shall be due by January 6 of the following year;

(d) Rebate payment for Quarter 4 shall be due by April 6 of the following year.

(3) OMAP considers any failure to make timely payment in full of the amount due to be a dispute. Timely is defined by OMAP as 38 days after the postmarked date of the invoice.

(4) If a manufacturer does not indicate in writing, by specific NDC number(s), the reason(s) for non-payment in full, a letter asking for clarification will be sent and interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution, beginning 38 days after the postmarked date of each invoice.

(5) Utilization/unit disputes shall be handled by a careful examination of paid claims data to determine the reasonableness of the reported units of products provided to Oregon recipients. If it is determined that the manufacturer is in error a letter notifying the manufacturer of the completed review and findings will be mailed to the manufacturer and interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution.

(6) If a manufacturer determines that incorrect information was sent to the Centers for Medicare and Medicaid Services (CMS), the manufacturer must still make payment in full to Oregon Medicaid for the invoiced rebate amount. Oregon Medicaid will credit the manufacturer's account through CMS's prior period adjustment process.

(7) Interest will accrue as set forth in the Rebate Agreement, Section V, Dispute Resolution, on the 31st day after a manufacturer receives information from OMAP on the number of units paid by NDC number (i.e., rebate invoice).

(8) Manufacturer requests for audit information by product and zip codes will be acknowledged by OMAP in letter form. Each letter will include an OMAP Audit Request Form and instructions to the manufacturer on how to complete the form. The letter will also include a standard explanation of the audit process.

(9) Days referred to in this process shall be considered calendar days.

(10) Efforts should be made through an informal rebate resolution process as outlined in this rule before a hearing will be scheduled. Hearings will follow OAR 410-120-0760 through 410-120-1060 and be held in Marion County, OR.

(11) Oregon Medicaid will notify CMS of all disputing manufacturers in writing.

Stat. Auth.: ORS 409.010 & ORS 409.110
Stats. Implemented: ORS 414.065
Hist.: HR 21-1992, f. 7-31-92, cert. ef. 8-1-92; OMAP 18-2004, f. 3-15-04 cert. ef. 4-1-04

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. Please bill the nursing facility for these items.

(2) The all-inclusive list is available for downloading in the Office of Medcical Assistance Programs Web page on the Department of Human Services website.

Stat. Auth.: ORS 409
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

• • • • • • • • • •

Adm. Order No.: OMAP 19-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04 thru 4-14-04
Notice Publication Date:
Rules Amended: 410-121-0146, 410-121-0160
Subject: The Pharmaceutical Services program Administrative Rules govern the Office of Medical Assistance Programs' payments for services rendered to clients. Rules 410-121-0146 and 410-121-0160 are temporarily amended to delay the change in compound dispensing fee from one dispensing fee per prescription ingredient to $7.50 per compound prescription. Originally intended to be effective March 15, 2004, this will be in effect April 15, 2004.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0146
Dispensing Limitations

(1) The quantity indicated by the prescriber on the prescription may not be reduced except when in conflict with the limitations below. The Office of Medical Assistance Program (OMAP) will consider any form of prescription splitting, except as required below in this rule, as a billing offense and will take appropriate action as described in the General Rules (OAR 410 division 120).

(2) The following dispensing limitations apply to OMAP reimbursement:

(a) Dispensing, except as otherwise noted in this rule, is limited to the amount prescribed but not to exceed a 34-day supply of the drug;

(b) Exceptions to the 34-day supply limitation includes mail order pharmacy dispensed through OMAP contracted Mail Order Pharmacy and prescription in the drug classes listed below. These drug classes are limited to the amount prescribed by the physician, but not to exceed a 100-day supply of the drug. Exceptions (codes are from First Data Bank's Standard Therapeutic Classification Codes):

(A) Anticonvulsants, Code 48;
(B) Thyroid Preparation, Code 55;
(C) Rauwolfias, Code 70;
(D) Vasodilators, Coronary, Code 72;
(E) Vasodilators, Peripheral, Code 73;
(F) Digitalis preparations, Code 74;
(G) Xanthine derivatives, Code 75;
(H) Contraceptives, Topical, Code 36;
(I) Contraceptives, Oral, Code 63.

(c) After stabilization of a diabetic, a minimum of a one-month supply of Insulin should be provided per dispensing;

(d) For vaccines available in multiple dose packaging, a dispensing fee will be allowed for each multiple dose. When vaccines are administered at the pharmacy, refer to OAR 410-121-0185;

(e) For compounded prescriptions, components of the prescription shall be billed separately. A dispensing fee will be allowed for each component eligible for reimbursement. Any reimbursement received from a third party for compounded prescriptions must be split and applied equally to each component.

Stat. Auth.: ORS 409
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 70-1981, f. 9-30-81, ef. 10-1-81; AFS 44-1982, 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 99-1982, f. 10-25-82, ef. 11-1-82; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 26-1984, f. & ef. 6-19-84; AFS 53-1985, f. 9-20-85, ef. 10-1-85; AFS 52-1986, f. & ef. 7-2-86; AFS 15-1987, f. 3-31-87, ef. 4-1-87; AFS 4-1989, f. 1-31-89, cert. ef. 2-1-89; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-016-0090; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; Renumbered from 461-016-0210; HR 16-1992, f. & cert. ef. 7-1-92; HR 25-1994, f. & cert. ef. 7-1-94; HR 6-1996(Temp), f. & cert. ef. 8-1-96; HR 27-1996, f. 12-11-96, cert. ef. 12-15-96; HR 20-1997, f. & cert. ef. 9-12-97; OMAP 1-1999, f. & cert. ef. 2-1-99; 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 74-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04

410-121-0160
Dispensing Fees

(1) Pharmacy providers must apply for an Office of Medical Assistance Program (OMAP) review of their pharmacy dispensing fee level by completing a Pharmacy Prescription Survey (OMAP 3062) when one of the following situations occurs:

(a) The pharmacy initiates dispensing medications to clients in facilities and the most recent two months' worth of dispensing data is available. OMAP will only accept the most recent two months' worth of data; or

(b) The pharmacy discontinues dispensing medications to clients in facilities. The pharmacy provider is required to notify OMAP within 60 days and complete a new Pharmacy Prescription Survey with the most recent two-months worth of dispensing data available. OMAP will only accept the most recent two months worth of data; or

(c) A completed Pharmacy Prescription Survey signed by the pharmacist in charge must be submitted to OMAP to initiate a review of dispensing fees.

(2) Unless otherwise provided, the professional dispensing fee allowable for services is as follows:

(a) $3.50 — Retail Pharmacies;

(b) $3.91 — Institutional Pharmacies operating with a True or Modified Unit Dose Delivery System as defined by OMAP;

(A) This dispensing fee applies to clients identified on DHS case files as residing in a Long Term Care Facility;

(B) All other dispensing fees for institutional pharmacies will be at the retail rate.

(3) The True or Modified Unit Dose Delivery System applies to those providers who give this service to over fifty percent of their patient population base associated with a particular Medicaid provider number.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 41-1984(Temp), f. 9-24-84, ef. 10-1-84; AFS 1-1985, f. & ef. 1-3-85; AFS 54-1985(Temp), f. 9-23-85, ef. 10-1-85; AFS 66-1985, f. 11-5-85, ef. 12-1-85; AFS 13-1986(Temp), f. 2-5-86, ef. 3-1-86; AFS 36-1986, f. 4-15-86, ef. 6-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 28-1987(Temp), f. & ef. 7-14-87; AFS 50-1987, f. 10-20-87, ef. 11-1-87; AFS 41-1988(Temp), f. 6-13-88, cert. ef. 7-1-88; AFS 64-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-016-0101; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 20-1990, f. & cert. ef. 7-9-90; Renumbered from 461-016-0260; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 21-1993(Temp), f. & cert. ef. 9-1-93; HR 12-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 5-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 22-1998, f. & cert. ef. 7-15-98; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 50-2001(Temp) f.

9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 60-2001, f. & cert. ef. 12-11-01; OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04

• • • • • • • • • •

Adm. Order No.: OMAP 20-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04 thru 4-30-04
Notice Publication Date:
Rules Amended: 410-122-0040
Subject: The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) program Administrative Rules govern the Office of Medical Assistance Programs payments for services rendered to clients. 410-122-0040 is temporarily amended to delay implementation of centralizing prior/payment authorizations of durable medical equipment, prosthetics, orthotics and supplies. Originally intended to be effective March 15, 2004, centralization will be in effect May 1, 2004.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-122-0040
Prior Authorization of Payment

Temporary Rule effective March 15, 2004-April 30, 2004

(1) Procedure codes in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) rules that indicate prior authorization (PA) is required are intended for fee-for-service clients only. Failure to obtain PA for a service as indicated in rule, is not reimbursable by the Office of Medical Assistance Programs. To determine PA requirements for clients enrolled in Managed Care Plans, contact the Plan for their policy governing PA.

(2) PA of payment is required for non-Medicare clients for DMEPOS. This is indicated by the notation, "PA required…", immediately following the description of the procedure code, even if private insurance is billed first. PA is not required for Medicare clients except for services not covered by Medicare. When a client is in a skilled nursing facility (SNF) under a covered, Medicare part A stay, all services must be billed to Medicare by the SNF, except for customized prosthetic devices, therefore no prior authorization from OMAP is required for DMEPOS. Obtaining PA is the responsibility of the durable medical equipment provider.

(3) Prior authorization authorities for PA requests (or for changes to existing PA's) are as follows:

(a) Services for clients identified on the Office of Medical Assistance Programs (OMAP) Medical Care ID as Medically Fragile Children's Unit clients are prior authorized by the Department of Human Service's (DHS) Medically Fragile Children's Unit;

(b) Services for clients identified on the OMAP Medical Care ID as being enrolled in the fee-for-service (FFS) Medical Case Management (MCM) program are prior authorized by the MCM contractor;

(c) Services for clients identified on the OMAP Medical Care ID as Children, Adults and Families (CAF) (formerly Adult and Family Services) (AFS) or State Office of Services for Children and Families (SOSCF) (formerly Children's Services Division) (CSD) are prior authorized by OMAP. All required documentation must be submitted to OMAP.

(d) Most services for clients identified on the OMAP Medical Care ID as Seniors and People with Disabilities (SPD) (formerly Senior and Disabled Services Division) (SSD) are prior authorized by the local branch office designated on the OMAP Medical Care ID. All required documentation must be submitted to the local branch office designated on the OMAP Medical Care ID. Services for SPD clients authorized by OMAP only are noted throughout the DMEPOS rulebook immediately following the code description.

(4) DMEPOS providers must submit the PA request to the authorizing authority in writing via mail or fax. Postmark or fax dates will be used as the date of contact. Providers may use the OMAP 3122, or a reasonable facsimile which contains the same information, for the request.

(5) An authorization request for a service provided after the authorizing authority's normal working hours, must be received by the authorizing authority in writing within five working days from the initiation of service.

(6) PA does not guarantee eligibility or payment — always check for the client's eligibility on the date of service.

(7) For clients determined eligible after services are provided, authorization may still be obtained if the PA would have been granted had eligibility been determined prior to service.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
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

• • • • • • • • • •

Adm. Order No.: OMAP 21-2004
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 4-15-04
Notice Publication Date: 9-1-03, 1-1-04
Rules Amended: 410-121-0160
Subject: The Pharmaceutical Services program administrative rules govern Office of Medical Assistance Programs' (OMAP) payments for pharmaceutical products and services provided to clients. OAR 410-121-0160 is permanently amended to take care of necessary housekeeping corrections. This correction is in effect 4/15/2004.
Rules Coordinator: Darlene Nelson—(503) 945-6927

410-121-0160
Dispensing Fees

(1) Pharmacy providers must apply for an Office of Medical Assistance Program (OMAP) review of their pharmacy dispensing fee level by completing a Pharmacy Prescription Survey (OMAP 3062) when one of the following situations occurs:

(a) The pharmacy initiates dispensing medications to clients in facilities and the most recent two months' worth of dispensing data is available. OMAP will only accept the most recent two months' worth of data; or

(b) The pharmacy discontinues dispensing medications to clients in facilities. The pharmacy provider is required to notify OMAP within 60 days and complete a new Pharmacy Prescription Survey with the most recent two-months worth of dispensing data available. OMAP will only accept the most recent two months worth of data; or

(c) A completed Pharmacy Prescription Survey signed by the pharmacist in charge must be submitted to OMAP to initiate a review of dispensing fees.

(2) Unless otherwise provided, the professional dispensing fee allowable for services is as follows:

(a) $3.50 — Retail Pharmacies;

(b) $3.91 — Institutional Pharmacies operating with a True or Modified Unit Dose Delivery System as defined by OMAP;

(A)This dispensing fee applies to clients identified on DHS case files as residing in a Long Term Care Facility;

(B) All other dispensing fees for institutional pharmacies will be at the retail rate.

(c) $7.50 — Compound prescriptions with two or more ingredients.

(3) The True or Modified Unit Dose Delivery System applies to those providers who give this service to over fifty percent of their patient population base associated with a particular Medicaid provider number.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 51-1983(Temp), f. 9-30-83, ef. 10-1-83; AFS 56-1983, f. 11-17-83, ef. 12-1-83; AFS 41-1984(Temp), f. 9-24-84, ef. 10-1-84; AFS 1-1985, f. & ef. 1-3-85; AFS 54-1985(Temp), f. 9-23-85, ef. 10-1-85; AFS 66-1985, f. 11-5-85, ef. 12-1-85; AFS 13-1986(Temp), f. 2-5-86, ef. 3-1-86; AFS 36-1986, f. 4-15-86, ef. 6-1-86; AFS 52-1986, f. & ef. 7-2-86; AFS 12-1987, f. 3-3-87, ef. 4-1-87; AFS 28-1987(Temp), f. & ef. 7-14-87; AFS 50-1987, f. 10-20-87, ef. 11-1-87; AFS 41-1988(Temp), f. 6-13-88, cert. ef. 7-1-88; AFS 64-1988, f. 10-3-88, cert. ef. 12-1-88; AFS 56-1989, f. 9-28-89, cert. ef. 10-1-89; Renumbered from 461-016-0101; AFS 63-1989(Temp), f. & cert. ef. 10-17-89; AFS 79-1989, f. & cert. ef. 12-21-89; HR 20-1990, f. & cert. ef. 7-9-90; Renumbered from 461-016-0260; HR 29-1990, f. 8-31-90, cert. ef. 9-1-90; HR 21-1993(Temp), f. & cert. ef. 9-1-93; HR 12-1994, f. 2-25-94, cert. ef. 2-27-94; OMAP 5-1998(Temp), f. & cert. ef. 2-11-98 thru 7-15-98; OMAP 22-1998, f. & cert. ef. 7-15-98; OMAP 1-1999, f. & cert. ef. 2-1-99; OMAP 50-2001(Temp) f. 9-28-01, cert. ef. 10-1-01 thru 3-1-02; OMAP 60-2001, f. & cert. ef. 12-11-01; OMAP 32-2003(Temp), f. & cert. ef. 4-15-03 thru 9-15-03; OMAP 57-2003, f. 9-5-03, cert. ef. 10-1-03; OMAP 7-2004, f. 2-13-04 cert. ef. 3-15-04; OMAP 19-2004(Temp), f. & cert. ef. 3-15-04 thru 4-14-04; OMAP 21-2004, f. 3-15-04, cert. ef. 4-15-04

• • • • • • • • • •

Department of Human Services, Mental Health and Developmental Disability Services
Chapter 309

Adm. Order No.: MHD 1-2004
Filed with Sec. of State: 2-26-2004

Certified to be Effective: 3-1-04
Notice Publication Date: 1-1-04
Rules Repealed: 309-018-0100, 309-018-0110, 309-018-0120, 309-018-0130, 309-018-0140, 309-018-0150, 309-018-0160, 309-018-0170, 309-018-0180, 309-018-0190
Subject: These rules are repealed and new rules adopted to help integrate and standardize criminal record and background check processes through much of the Department of Human Services.
Rules Coordinator: Pat Bougher—(503) 945-5844

• • • • • • • • • •

Department of Human Services,
Public Health
Chapter 333

Adm. Order No.: PH 6-2004
Filed with Sec. of State: 3-11-2004
Certified to be Effective: 3-11-04
Notice Publication Date: 1-1-04
Rules Amended: 333-675-0000, 333-675-0020, 333-675-0030, 333-675-0040
Rules Ren. & Amended: 333-675-0010 to 333-675-0050
Subject: Amends existing rules to reflect an updated guideline of the construction plans submittal and review process for health care or residential care occupancies. Amendments include more specific requirements for functional program outlines, fire and life safety plan submittals, project design conferences, and construction document submittals. Because of constant changes to health industry programs and technology, the above additional information is not currently being identified on the plan submissions or current rule requirements.
Rules Coordinator: Christina Hartman—(503) 731-4405

333-675-0000
Submission of Project Plans and Specifications for Review

(1) Any person proposing to make certain alterations or additions to an existing health care or residential care facility, or to construct new facilities must, before commencing such alteration, addition or new construction, submit plans and specifications to Department of Human Services, Health Services, Facilities Planning and Safety, 3420 Cherry Ave. NE, Suite #110, Keizer, OR 97303 for plans approval or recom-menda-tions with respect to com-pliance with rules authorized by ORS 441.055, 443.420 and for compliance to National Fire Protection Association standards when the facility is also to be Medicare or Medicaid certified.

(2) Project plans and specifications must be submitted for review and approval to Facilities Planning and Safety when the project conforms to one or more of the following criteria:

(a) When a new structure or addition to an existing structure is proposed, regardless of cost;

(b) When alterations to a building wing or service area, or a mechanical or electrical system serving it, exceeds either 25 percent of equiva-lent replacement cost, $50,000 for a hospital project, or $25,000 for a nursing home or residen-tial care project;

(c) When a clinically related health or ancillary service, or dietary or laundry service is to be initiated or relo-cated within the facility; or when significant changes in the use of rooms or corridors within such areas will occur, regardless of cost;

(d) When a project involves the correction of licensure or fire and life safety code deficien-cies issued by Health Services, Seniors and People with Disabilities or Office of the State Fire Marshal. Plans shall be submitted to Facilities Planning and Safety prior to making proposed corrections; or

(e) When an existing building is to be converted for first time use as a licensed facility or changed in its usage from one licensure category to another having differing physical requirements.

(3) Waivers of review: Facilities Planning and Safety may waive review of construction plans, and all or part of the review fee, despite criteria of section (2), when rules do not exist for the project type planned; the facilities will be temporary or mobile; or plans have previously been approved for an identical or similar facility. For projects similar or identical to prior approved projects, the review fee may be reduced up to 50 percent of the normal fee.

(4) Schematic Plans Submission and Project Design Conference:

(a) Schematic plans must be submitted to Facilities Planning and Safety for review and approval prior to the production of construction documents when one or more of the following conditions apply:

(A) A new licensed facility is proposed;

(B) A new health program, not previously offered, is proposed;

(C) Renovations to an existing licensed facility exceeds $500,000 for hospitals or $150,000 for nursing homes or residential care facilities;

(D) An existing unlicensed facility is to be converted for a licensable use or an existing licensed facility is to be converted from one classification of licensed facility to another. Facilities Planning and Safety may conduct an onsite investigation of existing buildings as a part of this review.

(b) Schematic plans submissions must include one copy of the following items, as applicable to the project. Review of the submission will not begin until the required items are received by Facilities Planning and Safety;

(A) Plans Review Input Form PR-1 and a review fee of 1/3 the amount required by OAR 333-675-0050, **Table 1**;

(B) Functional Program as required by OAR 333-675-0000(6);

(C) Scale drawings, including:

(i) Drawing title showing the name and address of the Oregon licensed architect or engineer, when the project will require an architect or engineer's stamp according to ORS 671.030;

(ii) Site plan, if applicable, showing the location of the building on the site, main roadway and sidewalk approaches, accessibility parking and any major features or restrictions affecting construction;

(iii) Floor plan(s) showing the intended title or use of each room area, plumbing fixtures, doors, windows and exits. For patient or resident bedrooms or apartments, include proposed furnishings and equipment locations with intended licensed capacity for each room and apartment type for patient treatment areas;

(iv) Fire and Life Safety plan of entire floor(s) with project area(s) identified, including building code, occupancy classifications, construction type(s), locations and ratings of smoke barriers, fire walls and other significant structural features affecting compliance to the required codes;

(v) Phasing plan, if applicable; or

(vi) Other drawings, as required, to explain the project.

(D) Infection Control Risk Assessment as required by OAR 333-535-0035.

(c) Project Design Conference: A project design conference must be scheduled when schematic plans are submitted according to subsection (4)(a) of this rule. The conference will be attended by Facilities Planning and Safety staff and the project architect or engineer. Other attendees may include, but not be limited to, the owner's representative, staff from the licensing agency having authority, representatives from the Building Code agency having jurisdiction, Office of the State Fire Marshal representative, and other interested parties, as arranged by project sponsor;

(d) Waiver of Schematic Plans Submission or Design Conference: Facilities Planning and Safety may waive in writing schematic design review or the design conference when determined appropriate.

(5) Construction Document Submission:

(a) Finalized construction drawings and specifications must be submitted for review and approval prior to the initiation of related construction. Such submis-sion must be accompanied by payment of the review fee outlined in OAR 333-675-0050, **Table 1** and a completed **PR-1** submission form.

(b) Construction documents submissions must include the following, a applicable to the project:

(A) Scale drawings, including the following:

(i) Detailed site plan and civil drawings if applicable;

(ii) Complete architectural plans including floor plans, equipment plans, ceiling plans, elevations, details, door and room finish schedules;

(iii) Complete mechanical, plumbing and electrical drawings, low voltage drawings, information system drawings, nurse call system, security and alarm drawings;

(iv) Fire and Life Safety drawings and information per subsection (4)(b)(C)(iv) of this rule, and rated wall and ceiling assembly details, door rating schedules, fire stopping details, and other details necessary to describe the Fire and Life Safety plan ; and

(v) Other drawings necessary to complete the project.

(B) Project specifications;

(C) Infection Control Risk assessment as required by OAR 333-535-0035, if not previously submitted;

(D) Functional Program as defined in OAR 333-675-0000(6), if not previously submitted;

(E) In addition to drawings, electronic files of project drawings, for purposes of read only, must be submitted when available;

(c) Number of Submissions; Project sponsors must contact Facilities Planning and Safety regarding the number of plans required to be submitted, which may vary.

(d) When the project involves fast track design and construction methods, design build contracts, or other alternatives which do not allow for submission of full contract documents at the same time, Facilities Planning and Safety may allow for such irregularities; but it is the responsibility of the project sponsor to seek approval of such submission methods prior to plans approval or the start of construction.

(6) Functional Program Requirements, as applicable to the project: The project sponsor must supply for each project a brief written narrative functional program for the facility that describes the following items:

(a) The purpose of the project;

(b) Department relationships and flow of patients, staff, visitors and supplies;

(c) Size and function of each space;

(d) Description of those services necessary for the complete operation of the facility;

(e) Special design feature(s);

(f) Occupant load, numbers of staff, patients or residents, visitors and venders;

(g) Issue of privacy/confidentiality for patient or resident;

(h) For hospitals, in treatment areas, describe;

(A) Types of procedures;

(B) Design considerations for equipment; and

(C) Requirements where the circulation patterns are a function of asepsis control

(i) For Ambulatory Surgery facilities, describe;

(A) Level of medical gas system per NFPA 99; and

(B) Type of central electrical system.

(7) Plans of corrections: Project sponsors must submit written response to deficiencies identified in con-struction document reviews, indicating method(s) being used for their correction. When Facilities Planning and Safety determines that a satisfactory response has been received, including revised drawings as appropriate, a Notice of Construction Plans Approval will be issued by Facilities Planning and Safety.

(8) Major Project Changes: Revised plans and specifications for major project changes must be submitted for review and approval prior to initiation of related work when changes significantly affect the:

(a) Arrangement or use of rooms in clinically related areas;

(b) Provision of mechanical and electrical systems shown on plans; or

(c) Major additions or reductions to the project area or bed capacity.

(9) Time period for reviews: Facilities Planning and Safety will issue plan review comments to project sponsors within 15 working days of receipt of plans and the appropriate review fee. When circumstances do not allow for review to be completed within this time period, Facilities Planning and Safety will inform the project sponsor of the approxi-mate date such review will be completed.

[ED. NOTE: Forms & Tables referenced are available from the agency.]
Stat. Auth.: ORS 441, 442
Stats. Implemented: ORS 441, 442
Hist.: HD 13-1994, f. & cert. ef. 4-22-94; PH 6-2004, f. & cert. ef. 3-11-04

333-675-0020
Required Notification and Surveys Prior to Taking Occupancy

(1) Notification by the project architect or sponsor prior to taking occupancy of areas which have received major alter-ations or which involve new construction must be made to Facilities Planning and Safety by filing a "Project Substantial Completion Notice" at least three weeks in advance. A "Project Substantial Completion Notice" form is sent to the project architect with the "Notice of Construction Plans Approval." Facilities Planning and Safety staff will conduct an onsite inspection of projects in conjunction with licensure staff or unilaterally. When deficiencies or incomplete items are found, the architect, engineer and project sponsor will be notified of such issues within 3 working days following the inspection. When deficiencies are corrected, a Notice of Project Approval must be issued by Facilities Planning and Safety prior to occupancy or use by patients or residents.

(2) Project sponsors or their consultants shall make the following available prior to or as part of a final project inspection, as applicable to the project:

(a) Certificate of Occupancy from the Building Code agency having jurisdiction;

(b) For hospitals and nursing homes, medical gas systems documentation of independent testing and approval and documentation that all brazing is completed by certified personnel when these systems are included;

(c) For hospitals and nursing homes, one copy of the heating, ventilation and air conditioning balancing report, showing both design and final supply, exhaust quantities, resulting pressure gradient and design engineers verification that all systems comply with licensing ventilation requirements;

(d) Other documentation, as may be requested by Facilities Planning and Safety, to confirm compliance with rules and/or applicable codes.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 441, 442
Stats. Implemented: ORS 441, 442
Hist.: HD 13-1994, f. & cert. ef. 4-22-94; PH 6-2004, f. & cert. ef. 3-11-04

333-675-0030
When Plans Are Not Submitted as Required

When a project is implemented which required prior submis-sion of plans with OAR 333-675-0000, but such plans were not sub-mitted, Facilities Planning and Safety will, upon learning of the project, require sub-mission of plans and the applicable review fee, and initiate on-site inspection of any completed construction in cooperation with the applicable licensure program staff, or Office of the State Fire Marshal. When a project area has been occupied without a plans approval or a final inspection, the applicable licensure and certification program will be notified.

Stat. Auth.: ORS 441, 442
Stats. Implemented: ORS 441, 442
Hist.: HD 13-1994, f. & cert. ef. 4-22-94; PH 6-2004, f. & cert. ef. 3-11-04

333-675-0040
Optional Reviews

(1) When a project sponsor is not required by rule to file plans and specifications, but wishes to do so to reduce risk of noncompliance with licensure or fire and life safety standards, the project sponsor may obtain such review by submitting **Form PR-1** and a review fee according to **Table 1** of OAR 333-675-0050.

(2) When a party proposing construction of a residential care facility wishes to also obtain review of the project for conformance to nursing home standards, both reviews may be obtained by paying the review fee for health care facilities according to OAR 333-675-0050, **Table 1**.

[ED. NOTE: Tables and Forms referenced are available from the agency.]
Stat. Auth.: ORS 441, 442
Stats. Implemented: ORS 441, 442
Hist.: HD 13-1994, f. & cert. ef. 4-22-94; PH 6-2004, f. & cert. ef. 3-11-04

333-675-0050
Construction Project Review Fees

(1) Submission of plans and specifications for project review must be accompanied by payment of a fee according to the schedule contained in **Table 1**.When schematic plans have previously been reviewed and part of the review fee has been paid, the fee submission shall be only for the amount yet unpaid. Estimated construction costs provided by project sponsors must coincide with amounts reported to the certificate of need program, equal actual building contract amounts, or if neither is applicable, be within the average building cost guidelines of the Dodge Research Report, "Hospital/Health Care Building Costs," for the project type planned.

(2) When an existing structure, not presently a licensed health or residential care facility, is to be renovated for such use, the review fee shall be based on approximate value of the renovated structure. Approximate value, for purposes of this rule, is calculated as tax assessed value of the structure plus estimated renovation costs.

(3) If major project changes occur during the plan review process, per subsection (8) of OAR 333-675-0000, or construction that alter the design or increase the construction cost of the project, the plan review fee will be reassessed according to OAR 333-675-0050, **Table 1**.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 441, 442
Stats. Implemented: ORS 441, 442
Hist.: HD 13-1994, f. & cert. ef. 4-22-94; PH 6-2004, f. & cert. ef. 3-11-04, Renumbered from 333-675-0010

• • • • • • • • • •

Department of Human Services,
Self-Sufficiency Programs
Chapter 461

Adm. Order No.: SSP 3-2004(Temp)
Filed with Sec. of State: 2-19-2004
Certified to be Effective: 2-19-04 thru 6-30-04
Notice Publication Date:

Rules Amended: 461-135-1120, 461-135-1130
Subject: Rule 461-135-1120 is amended to state that an Oregon Health Plan (OHP) premium payment is required to be received on or before the 20th of the month for which the premium was billed to be considered on time. This change also clarifies the consequences for clients who do not pay premiums on time. Clients are informed through the billing process that OHP premium payments are due on the 20th of the month for which the premium was billed. Clients who fail to make a premium payment on time may be disqualified under rule 461-135-1130.

Rule 461-135-1130 is amended to clarify that an Oregon Health Plan (OHP) disqualification is rescinded if the past due premium payment is received by the 20th of the month following the month for which the premium was billed.
Rules Coordinator: Annette Tesch—(503) 945-6067

461-135-1120
Premium Requirement; OHP-OPU

In the OHP-OPU program, a monthly premium must be paid when the benefit group includes at least one non-exempt (HPN) client (see OAR 461-135-1100) as follows:

(1) The following HPNs are exempt from the premium requirement:

(a) Members of a federally recognized Indian tribe, band, or group.

(b) Eskimos, Aleuts, and other Alaska natives enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act.

(c) Persons eligible for benefits through an Indian Health Program.

(d) Clients who are eligible for the CAWEM program (see OAR 461-135-1070).

(2) The amount of the premium is determined in accordance with OAR 461-155-0235.

(3) All non-exempt clients in the benefit group are responsible for payment of premiums.

(4) Once the amount of the premium is established, the amount will not change during the certification period unless:

(a) An HPN client becomes pregnant.

(b) A pregnant client becomes an HPN client following the end of her assumed eligibility period provided for in OAR 461-135-1100.

(c) An HPN client becomes eligible for another program (for example, GA, OSIP or TANF).

(d) An HPN client leaves the filing group.

(e) OHP cases are combined during their certification periods.

(f) An HPN client's exemption status changes.

(g) An HPN client is no longer a member of the benefit group.

(5) For premiums billed on or after July 1, 2003 and prior to February 1, 2004, a premium is considered paid on time when payment is received by the Oregon Health Plan billing office on or before the 20th day of the month after the benefit month for which the premium was billed. For premiums billed prior to July 1, 2003, a premium is considered paid on time when payment is received by the Oregon Health Plan billing office on or before the 25th day of the month after the benefit month for which the premium was billed. The day the payment arrives in the office's post office box is the date it is received.

(6) For premiums billed on or after February 1, 2004, a premium is considered paid on time when the payment is received by the Oregon Health Plan billing office on or before the 20th of the month for which the premium was billed. The day the payment arrives in the office's post office box is the date it is received. A premium not paid on time is past due. A client who does not pay a required premium on time is disqualified under OAR 461-135-1130.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 19-1997, f. & cert. ef. 10-1-97; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; Administrative correction 2-23-99; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 19-2001, f. 8-31-01, cert. ef. 9-1-01; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 16-2003, f. & cert. ef. 7-1-03; SSP 19-2003(Temp), f. & cert. ef. 7-1-03 thru 9-30-03; SSP 23-2003, f. & cert. ef. 10-1-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 3-2004(Temp), f. & cert. ef. 2-19-04 thru 6-30-04

461-135-1130
Disqualification for Nonpayment of OHP Premium

(1) Disqualification for failure to pay a premium on time. Clients are disqualified from receiving OHP benefits for failure to pay an OHP premium required by OAR 461-135-1120. Clients who are disqualified are ineligible under the OHP-OPU program. The disqualification affects only non-exempt HPN clients applying for or receiving benefits under the OHP-OPU program as follows:

(a) A non-exempt HPN applicant is disqualified if the applicant has an OHP premium arrearage.

(b) All non-exempt HPN recipients in a benefit group are disqualified if a required OHP premium for the group is not paid on time. The disqualification is rescinded if the past due premium payment is received by the 20th of the month following the month for which the premium was billed.

(c) A non-exempt HPN applicant is disqualified when joining an OHP filing group that includes a person with an OHP premium arrearage.

(2) Duration of the disqualification:

(a) A disqualification resulting from a premium arrearage incurred prior to February 1, 2003, remains in effect until the arrearage is paid or is waived in accordance with this rule.

(b) A disqualification resulting from a premium billed after February 1, 2003, remains in effect until the premium is paid and for a minimum of six months. The six-month disqualification period starts the first day of the month after the notice period ends.

(c) A disqualification resulting from a non-exempt HPN applicant joining an OHP filing group that includes a person with a premium arrearage remains in effect until the arrearage is paid unless the entire arrearage was incurred prior to February 1, 2003, and is waived in accordance with this rule.

(3) Only for premiums billed before February 1, 2003, an arrearage is canceled and there is no disqualification based on the arrearage if the applicant is otherwise eligible for OHP and any of the following is true:

(a) The financial group has no income in the budget month and had no income in the prior two months.

(b) One of the following occurred either during the certification period in which the arrearage occurred or during the current budget month:

(A) A member of the filing group was the victim of a crime resulting in the loss of income or resources.

(B) A member of the filing group was the victim of domestic violence.

(C) The filing group was the victim of a natural disaster.

(D) A member of the filing group died.

(E) The filing group was homeless or lost their housing.

(c) The arrearage was incurred while the client was exempt from the requirement to pay a premium (see OAR 461-135-1120).

(d) The arrearage is a debt that has been stayed in a bankruptcy proceeding.

(e) The arrearage is over three years old.

(4) Any premium arrearage over three years old is canceled and no disqualification is based on the arrearage.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 414.025
Hist.: AFS 19-1997, f. & cert. ef. 10-1-97; AFS 17-1998, f. & cert. ef. 10-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; Administrative correction 2-23-99; AFS 15-1999, f. 11-30-99, cert. ef. 12-1-99; AFS 17-2000, f. 6-28-00, cert. ef. 7-1-00; AFS 13-2002, f. & cert. ef. 10-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 22-2003(Temp), f. & cert. ef. 9-15-03 thru 12-31-03; SSP 31-2003(Temp) f. & cert. ef. 12-1-03 thru 12-31-03; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 35-2003(Temp), f. 12-31-03 cert. ef. 1-1-04 thru 3-31-04; SSP 3-2004(Temp), f. & cert. ef. 2-19-04 thru 6-30-04

• • • • • • • • • •

Adm. Order No.: SSP 4-2004
Filed with Sec. of State: 2-26-2004
Certified to be Effective: 3-1-04
Notice Publication Date: 1-1-04
Rules Repealed: 461-165-0400
Subject: These rules are repealed and new rules adopted to help integrate and standardize criminal record and background check processes through much of Department of Human Services.
Rules Coordinator: Pat Bougher—(503) 945-5844

• • • • • • • • • •

Adm. Order No.: SSP 5-2004(Temp)
Filed with Sec. of State: 3-1-2004
Certified to be Effective: 3-1-04 thru 3-31-04
Notice Publication Date:
Rules Amended: 461-155-0235
Subject: Rule 461-155-0235 is being amended as a temporary rule to reflect the annual increase in the federal poverty levels that were published in the Federal Register. This rule includes standards/allowances based on the federal poverty levels.
Rules Coordinator: Annette Tesch—(503) 945-6067

461-155-0235
OHP Premium Standards

In the OHP program, the following steps are followed to determine the amount of the monthly premium for the filing group:

(1) The number of persons in the OHP need group is determined in accordance with OAR 461-110-0630.

(2) The financial group's countable income is determined in accordance with OAR 461-150-0055 and 461-160-0700.

(3) Based on the number in the need group and the countable income, the monthly premium for each non-exempt OHP-OPU client in the benefit group is determined from the following table: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060, 411.070
Hist.: AFS 35-1995, f. 11-28-95, cert. ef. 12-1-95; AFS 22-1996, f. 5-30-96, cert. ef. 6-1-96; AFS 5-1997, f. 4-30-97, cert. ef. 5-1-97; AFS 6-1998(Temp), f. 3-30-98, cert. ef. 4-1-98 thru 5-31-98; AFS 8-1998, f. 4-28-98, cert. ef. 5-1-98; AFS 3-1999, f. 3-31-99, cert. ef. 4-1-99; AFS 10-2000, f. 3-31-00, cert. ef. 4-1-00; AFS 6-2001, f. 3-30-01, cert. ef. 4-1-01; AFS 5-2002, f. & cert. ef. 4-1-02; SSP 1-2003, f. 1-31-03, cert. ef. 2-1-03; SSP 6-2003(Temp), f. 2-26-03, cert. ef. 3-1-03 thru 6-30-03; SSP 7-2003, f. & cert. ef. 4-1-03; SSP 5-2004(Temp), f. & cert. ef. 3-1-04 thru 3-31-04

• • • • • • • • • •

Department of Human Services, Seniors and People with Disabilities
Chapter 411

Adm. Order No.: SPD 3-2004
Filed with Sec. of State: 2-26-2004
Certified to be Effective: 3-1-04
Notice Publication Date: 1-1-04
Rules Repealed: 411-009-0000, 411-009-0005, 411-009-0015, 411-009-0021, 411-009-0040, 411-009-0050, 411-009-0060, 411-009-0070, 411-009-0080, 411-009-0090, 411-009-0100, 411-009-0110
Subject: These rules are repealed and new rules adopted to help integrate and standardize criminal record and background check processes through much of the Department of Human Services.
Rules Coordinator: Pat Bougher—(503) 945-5844

• • • • • • • • • •

Department of Human Services, Vocational Rehabilitation Services
Chapter 582

Adm. Order No.: VRS 2-2004
Filed with Sec. of State: 3-9-2004
Certified to be Effective: 3-9-04
Notice Publication Date: 1-1-04
Rules Amended: 582-070-0010, 582-070-0030
Subject: Amends regulations on client financial participation and institutes an annual financial needs test. Identifies purposes of the client financial contribution policy. Identifies clients exempt from the mandatory contributions. Identifies services exempt from mandatory client financial contributions. Establishes the amount of mandatory annual client financial contributions in relation to family size and income, including the income levels under which no contribution is required. Defines family income and other terms used in the policy. Establishes contribution levels for clients whose family members choose not to share financial information. Establishes criteria for an extenuating circumstances exception to the policy. Describes when client payments are not covered by the policy. Allows voluntary, unenforceable client payments. Clarifies rules applicable to student financial aid and comparable services and benefits consistent with current federal regulations.
Rules Coordinator: Robert Trachtenberg—(503) 945-6734

582-070-0010
General Policy

NOTE: For community rehabilitation programs and medical or related services refer also to OAR 582-010, 582-075 and 582-085.

It is the policy of the OVRS to reimburse vendors who provide previously-authorized services and/or supplies to persons who qualify for such services; in accordance with:

(1) The lesser of:

(a) The vendor's usual charge for such service, i.e., that fee for service which the vendor under ordinary circumstances charges to the general public for such services; or

(b) A pre-determined charge which has been negotiated between the vendor and an agency person authorized to consummate agreements between this agency and the vendor.

(2) In addition to any such general contracts or agreements, actual services to individuals must be specifically prior authorized and are not considered approved or billable until the vendor receives a completed Agency Authorization for Purchase (AFP) form or its equivalent, listing specific prior authorized services and estimated billable amounts, signed by the appropriate agency representative(s):

(a) Only in extreme emergencies may services be prior authorized verbally and any such verbal authorization must be documented promptly and followed with a written AFP within 72 hours;

(b) Apparent fraud, misrepresentation or substantial discrepancies between services rendered and billed amounts shall be investigated and, as appropriate, legal steps taken to prevent or recover overpayments.

(3) Except as specified in OAR 582-070-0010(4), Rehabilitation Services funds will not be expended before OVRS determines that "comparable benefits and services" are not available to meet, in whole or in part, the cost of such services, unless such a determination would interrupt or delay:

(a) The progress of the individual toward achieving the employment outcome identified in the Individualized Plan for Employment;

(b) An immediate job placement; or

(c) The provision of vocational rehabilitation services to any individual who is determined to be at extreme medical risk, based on medical evidence provided by appropriate qualified medical personnel. Further, except for student loans, for training provided in institutions of higher education (any training institutions where such grant assistance may likely be available) OVRS assures that maximum effort has been made by the client to obtain and use any "comparable benefits or services" before expending Rehabilitation Services funds.

(4) The following vocational rehabilitation services are exempt from a determination of the availability of comparable services and benefits:

(a) Assessment for determining eligibility and vocational rehabilitation needs;

(b) Counseling and guidance, including information and support services to assist an individual in exercising informed choice;

(c) Referral and other services to secure needed services from other agencies, including other components of the statewide workforce investment system, if those services are not available from OVRS;

(d) Job-related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;

(e) Rehabilitation Technology, including telecommunications, sensory, and other technological aids and devices.

(f) Post-employment services consisting of any of the services in OAR 580-070-0010(4)(a - e); and

(5) Purchases shall be of the most reasonable and satisfactory quality at the lowest available cost, subject to supervisory and/or administrative review and/or approval prior to authorization; accordingly, OVRS reserves the right to establish upper limits on the utilization of existing services, subject to an exception process.

(6) Preliminary diagnostic assessment is limited to a review of existing data and such additional data as is necessary to determine eligibility or, for Rehabilitation Services, to assign priority for order of selection for service (when appropriate). Comprehensive assessment and/or extended evaluation services may be provided only until eligibility/ineligibility or extent and scope of needed Rehabilitation Services can be determined. Additionally, other services are available (including the use of Rehabilitation Technology services, as appropriate) to determine the nature, scope and types of services needed to attain a specific vocational rehabilitation objective of the eligible client. Continued eligibility is contingent upon reasonable progress by the client toward attainment of measurable intermediate objectives within time-lines arrived at and agreed to through joint counselor/client development of the plan and any amendments thereto.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 344
Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730
Hist.: VRD 1-1978, f. 3-14-78, ef. 3-15-78; VRD 2-1992, f. & cert. ef. 4-20-92; VRD 4-1993, f. & cert. ef. 11-1-93; VRS 2-2004, f. & cert. ef. 3-9-04

582-070-0030
Limitations of Payments

NOTE: For medical and related services refer also to OAR 582-075 and 582-085; and, for community rehabilitation program (CRP) services refer also to OAR 582-

010.

(1) Payment in Full: Vendors providing any services authorized by OVRS shall not make any charge to or accept any payment from the client/applicant or his/her family for such services unless the amount of the service charge or payment to be borne by the client is previously agreed to by the individual or his/her family, known to and, where applicable, approved by OVRS.

(2) Client Financial Participation and the Financial Needs Test: Except as expressly exempted, services funded by OVRS are subject to Client Financial Participation. Clients will be allowed or required to contribute financially as set forth in OAR 582-070-0030. The contribution requirements apply starting July 1, 2004 for clients submitting applications for services and for annual IPE reviews.

(a) The purpose of client participation in service costs is to encourage the commitment of the client to their vocational rehabilitation goal, create a cooperative relationship with the client, and conserve limited OVRS resources.

(b) Except as provided in OAR 582-070-0030(2)(j) and (k), the following individuals are exempted from the Financial Needs Test and Client Financial Participation:

(A) Any individual who has been determined eligible for and is currently the recipient/beneficiary of Social Security Benefits under Title II (Social Security Disability Insurance, SSDI) or Title XVI (Supplemental Security Income, SSI) of the Social Security Act;

(B) Recipients of qualifying needs-based public assistance

programs including Self Sufficiency Cash Benefits, Oregon Health Plan, Temporary Assistance for Needy Families, and Food Stamps;

(C) Homeless or transient individuals.

(c) Except as provided in OAR 582-070-0030(2)(j) and (k), the following services are exempt from Client Financial Participation:

(A) Assessment for determining eligibility, vocational rehabilitation needs, or priority for services, including assessment by personnel skilled in rehabilitation technology;

(B) Vocational rehabilitation counseling and guidance, including information and support services to assist an individual in exercising informed choice;

(C) Referral and other services necessary to assist applicants and eligible individuals to secure needed services from other agencies, including other components of the statewide workforce investment system and to advise those individuals about client assistance programs;

(D) Job related services, including job search and placement assistance, job retention services, follow-up services, and follow-along services;

(E) Personal assistance services provided by one or more persons designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability;

(F) Auxiliary aids or services required to participate in the vocational rehabilitation program, such as interpreter services including sign language and oral interpreter services for individuals who are deaf or hard of hearing; or tactile interpreting services for individuals who are deaf-blind.

(d) Under the Financial Needs Test, clients with annual family income of less than either 250 percent of the federal poverty guidelines or $60,000 are not subject to Client Financial Participation and are exempt from the guidelines set out in OAR 582-070-0030(2)(e).

(e) Client Financial Participation will be determined on an annual basis, not to exceed the annual cost of non-exempt services to OVRS, applying the following contribution schedule:

(A) Clients with family income between $60,000 and $69,999 are subject to a mandatory financial contribution of $700.

(B) Clients with family income between $70,000 and $79,999 are subject to a mandatory financial contribution of $900.

(C) Clients with family income between $80,000 and $89,999 are subject to a mandatory financial contribution of $1300.

(D) Clients with family income between $90,000 and $99,999 are subject to a mandatory financial contribution of $1700.

(E) Clients with family income between $100,000 and $109,999 are subject to a mandatory financial contribution of $2100.

(F) Clients with family income between $110,000 and $119,999 are subject to a mandatory financial contribution of $2900.

(G) Clients with family income between $120,000 and $129,999 are subject to a mandatory financial contribution of $3700.

(H) Clients with family income at $130,000 or higher are subject to a mandatory financial contribution of $3700 plus ten percent of their family income in excess of $130,000.

(f) OVRS will use the following definitions to calculate Client Financial Participation:

(A) "Income" is determined by the adjusted gross income from the most recent federal tax return, unless unusual circumstances merit other documentation.

(B) "Family income" consists of income from the client, the spouse of the client if residing with the client, and includes parents if the client is under 18 and living with parents, or the parents claim the client as a dependent on federal taxes, or the client maintains dependent status for financial aid reasons.

(C) "Federal poverty guidelines" are the current poverty guidelines of the United States Department of Health and Human Services.

(D) "Size of the family unit" for purposes of selecting the appropriate federal poverty guideline includes those family members residing with the client or claimed on federal taxes as dependents; but if the client is under 18 and living with parents, or the parents claim the client as a dependent on federal taxes, or the client maintains dependent status for financial aid reasons, the family unit may include those family members residing with the parents or claimed on the federal taxes of the parents as dependents

(g) If the client or their family choose not to share information about their income as part of the calculation of the financial needs test, an annual, mandatory client contribution of $3700 shall be established, not to exceed the annual cost of non-exempt services to OVRS, unless OVRS concludes that the annual family income of a client may exceed $130,000 in which case the client contribution shall be established at 100 percent for items and services subject to Client Financial Participation.

(h) Subsequent Financial Needs Tests will be conducted with the annual review of the Individualized Plan for Employment, and may also be conducted if there is a change in the financial situation of either the client or the family unit.

(i) "Extenuating Circumstances" will be considered when the counselor identifies other information related to the individual's financial situation that negatively affects the individual's ability to participate in the cost of the rehabilitation program or if requiring the expected financial contribution will result in undue delay in the rehabilitation program. In determining whether to make an adjustment for extenuating circumstances, OVRS may consider the client's current income and the reasons for the request. If there are extenuating circumstances that justify an exception, OVRS may delay or waive all or part of the client's financial contribution. In such cases the counselor will:

(A) Obtain written approval of their supervisor;

(B) Provide documentation of the reasons for the exception;

(C) Maintain both the signed exception and the documentation of circumstances in the client file record.

(j) If a client prefers an upgrade, enhancement, optional feature, or more expensive vendor of essentially the same equipment or item available from a less expensive vendor, and this preference is not required to satisfy the vocational rehabilitation goals that justify the expenditure, OVRS and the client may agree that the client will pay the difference in cost between the service or item purchased and the service or item available that would have satisfied the vocational rehabilitation goals that justify the expenditure. In this situation, client payment is required regardless of whether the financial needs test authorizes client payments; and any client payments in this situation do not count toward the client's mandated financial contribution.

(k) An Individualized Plan for Employment (IPE) may include voluntary client contributions. A client agreement in an IPE to make a voluntary contribution is not enforceable.

(3) Student Financial Aid: OVRS assures that "maximum" effort is made by Rehabilitation Services clients to secure student financial aid for any approved training in institutions of higher education. "Maximum" effort includes making timely application for such grant assistance on a consistent basis and utilizing such benefits as are available in lieu of Vocational Rehabilitation funding:

(a) Coverage: All clients, including graduate students, must apply for all financial aid benefits each academic year, but student loans are not required nor treated as "comparable benefits." After identifying all costs associated with enrollment and attendance in the training, and after identifying all available resources, including but not limited to Financial Aid, SSDI/SSI, family, loans, work-study, the counselor and client will mutually agree as to which costs will be paid for with the available funds.

(b) Other Comparable Benefits or Services: If a third party (e.g., employer, insurance company, WCD) is required to or agrees to pay or reimburse to OVRS all of the case service rehabilitation costs of the client, the financial aid grant offer need not be applied against the plan costs nor treated as a "comparable benefit;"

(c) Late Applications: Pending determination of student aid by the financial aid officer, Division funds can be expended for education-related expenses between the date of application and determination of the client's eligibility for assistance provided that such expenditures are reduced by any amounts of comparable benefits subsequently received, excepting student loans;

(d) Duplicate Payments: When student financial aid is approved arrangements must be made promptly to reduce projected OVRS payments and/or recover duplicate payments;

(e) Parent Non-Participation: With the Field Services Manager's approval, the counselor may fund the parental contribution portion of the student's budget (as prepared by the college or university FAO) if the parents refuse or are unable to contribute.

(4) For Industrially-Injured Workers: OVRS will provide only for the cost of those rehabilitation services which are not the responsibility of the employer, insurer or the Oregon Worker's Compensation Division.

(5) Increased Cost Maintenance: OVRS will not provide client maintenance except for additional costs incurred while participating in authorized services, such as when the client must maintain a second residence away from the regular household in order to achieve a rehabilitation goal. Such maintenance will be provided according to the provisions under OAR 582-070-0020(3).

(6) Physical and Mental Restoration Services: Are provided only to ameliorate a diagnosed physical or mental condition which presents a substantial impediment to employment or independent living for the eligible individual. The services must be essential for the individual's achievement of a vocational or independent living goal:

(a) Drugs: When a physician (MD or OD) or dentist recommends prescription medication, if practical, the lowest price (e.g., generic) will be obtained prior to authorizing drugs;

(b) Dental Services: Dental care may be provided by OVRS when the condition of teeth or gums imposes a major impediment to employment (e.g., endangers health, emergency needs, or serious cosmetic needs). Dentures may be purchased from licensed dentists or certified denturists;

(c) Eye Glasses: Eye glasses may be purchased when determined essential for evaluation of eligibility or the achievement of the vocational or independent living goal, limited to basic frames and lenses unless other features are medically required (e.g., sun glasses, tints, contact lenses);

(d) Wheelchairs: A wheelchair may be purchased when it is essential to a vocational or independent living plan. Wheelchairs must be prescribed by a physiatrist or, if one is not available, physical therapist or other qualified medical specialist;

(e) Hearing Aids: Hearing aids may be provided only when essential to evaluation, vocational services (including independent living) or the individual's ability to obtain or retain employment. In order to purchase hearing aids for a client, the following are required:

(A) An evaluation by a physician skilled in diseases of the ear or an otologist; and

(B) An evaluation by a speech and hearing center or by a private audiologist.

(f) Other Prosthetic Devices: Prosthetic devices may be purchased only upon the authorization of the counselor and with a written prescription by a specialist;

(g) Psychotherapy: Group or individual psychotherapy may be provided in those instances when required for a person to reach a vocational or independent living goal and when an immediate and positive goal related impact is anticipated. Such services must be recommended by the OVRS office psychological or psychiatric consultant, but when so recommended may not be provided by that consultant. A specific number of sessions or a specified time limit is required;

(h) Exclusions: Physical or mental restoration services will not be provided by OVRS for the treatment of an acute medical or psychological condition unless this condition interferes with provision of OVRS Services. Physical and mental restoration services will not be provided for clients with rapidly progressive (worsening) conditions unless intervention can materially limit, correct or prevent onset of substantially handicapping disability, or in other than plan status unless an acute condition results from an OVRS authorized diagnostic procedure (excepting eye glasses or hearing aids essential to the diagnostic/evaluation process). OVRS will not provide transsexual surgery;

(i) Unusual Treatment: Unusual treatment procedures are not normally provided by OVRS. Unusual treatment procedures include but are not limited to the following:

(A) Abortion;

(B) Surgical Sterilization;

(C) Breast Enlargement or Reduction;

(D) Hysterectomy;

(E) Electric Shock Therapy;

(F) Acupuncture/Acupressure;

(G) Surgical Treatment for Obesity;

(H) Open Heart Surgery;

(I) Removal of Lung;

(J) Brain Surgery;

(K) Corneal Transplant;

(L) Total Joint Replacement;

(M) Radiation Therapy;

(N) Experimental or Research Procedures;

(O) Organ Transplant;

(P) AIDS or AIDS Related Complex; or

(Q) Megavitamin Treatment.

(7) Services not Provided: The following services cannot be provided or authorized at any time by OVRS:

(a) Any client-incurred debt;

(b) Any services obtained by the client prior to the date of application;

(c) Purchase of land or stationary buildings;

(d) Fines or penalties, such as traffic violations, parking tickets, library fines, etc.;

(e) Breakage fees and other refundable deposits;

(f) Contributions and donations;

(g) Entertainment costs;

(h) Payments to credit card companies;

(i) Authorization to supermarkets or grocery stores for food items;

(j) Basic Client Maintenance;

(k) Except for eye glasses or hearing aids essential to completing diagnostic/evaluation services (to determine Rehabilitation Services eligibility) in applicant status, or occupational tools or licenses essential to Extended Evaluation Services, the following may never be authorized for an individual who has applied but has not yet been found eligible for rehabilitation services:

(A) Prosthetic devices;

(B) Occupational tools and licenses;

(C) Placement services.

Stat. Auth.: ORS 344

Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730

Hist.: VRD 1-1978, f. 3-14-78, ef. 3-15-78; VRD 2-1981, f. & ef. 12-1-81; VRD 2-1992, f. & cert. ef. 4-20-92; VRD 4-1993, f. & cert. ef. 11-1-93; VRS 2-2004, f. & cert. ef. 3-9-04

••••••••••

Adm. Order No.: VRS 3-2004
Filed with Sec. of State: 3-12-2004
Certified to be Effective: 3-12-04
Notice Publication Date: 2-1-04
Rules Adopted: 582-030-0025
Rules Amended: 582-030-0000, 582-030-0005, 582-030-0008, 582-030-0010, 582-030-0020, 582-030-0030, 582-030-0040
Subject: Amends rules on confidentiality of client information and release of information. Identifies purposes of the rules. Amends definitions used in this division. Clarifies and amends rules on billing policy, program use, disclosure, subpoenas, and written consent exceptions to assure consistency with DHS administrative rules and policies, state and federal statutes, and federal regulations.
Rules Coordinator: Robert Trachtenberg—(503) 945-6734

582-030-0000
General Provisions

The purposes of this division are to:

(1) Implement policies and procedures for the protection, use and release of personal information about OVRS clients, consistent with federal statutes and regulations for vocational rehabilitation;

(2) Implement the confidentiality statutes for vocational rehabilitation in ORS 344.530(1)(b) and 344.600; and

(3) Clarify how these regulations incorporate and supplement other applicable federal and state laws and regulations

Stat. Auth.: ORS 344

Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730

Hist.: VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f. & cert. ef. 3-12-04

582-030-0005
Definitions

The following definitions apply to each Rule in Division 30 unless otherwise indicated.

(1) "Administrator" means the Administrator of the Office of Vocational Rehabilitation Services.

(2) "Client" means any person who has provided information to OVRS as part of his or her application process for OVRS services or subsequent to an application. "Client" includes former clients.

(3) "Client Information" means any personally identifiable information acquired or developed by OVRS, its staff or its representatives or that identifies an individual as a client of OVRS.

(4) "Client's Representative" means any person identified by the client as being authorized to speak or act on behalf of the client or to assist the client in any matter pertaining to services of OVRS, unless a representative has been appointed by a court to represent the client, in which case the court-appointed representative is the client's representative.

(5) "Cooperative Agreement" means a written agreement between OVRS and another agency or organization which includes terms protecting confidentiality of OVRS client information in keeping with the statutory and regulatory requirements of all parties to the agreement.

(6) "HIPAA" refers to Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq, and the federal regulations adopted to implement this Act.

(7) "HIV/AIDS Information" is any information covered by ORS 433.045(3) or that is likely to identify, directly or indirectly, that a client has been tested for the HIV virus or has HIV infection, antibodies to HIV, AIDS (Acquired Immunodeficiency Syndrome) or related infections or illnesses.

(8) "Informed Written Consent" means, after receiving a thorough explanation and understanding of the purposes, limitations, recipients, and specific information to be released, a client or, if appropriate, client's representative completes and signs a Department of Human Services Form 2098 (Authorization for Use and Disclosure of Non-Health Information) or DHS Form 2099 (Authorization for Use and Disclosure of Health Information), or the successors to these forms or other sufficient written authorization, releasing personal information from or to OVRS.

(9) "Parent or Guardian" means a person or persons having legal responsibility for the overall welfare and well-being of a client under age 18 or a client who, if over age 18, is adjudicated legally incompetent.

(10) "Parent Locator Service" means a service authorized by 42 USC 653 seeking information for the purpose of establishing parentage or establishing, setting, modifying or enforcing child support.

(11) "Public Officer Privilege" means, as provided in ORS 40.270, a public officer shall not be examined as to public records determined to be exempt from disclosure under ORS 192.502(8) and (9).

(12) "Subpoena" means a written order for a witness to appear and give testimony and/or deliver named material issued.

(13) "Substance Abuse Information" means any information regulated under 42 CFR 2.1 - 2.67.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 344
Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730
Hist.: VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f.& cert. ef. 3-12-04

582-030-0008
Billing Policy and Procedures

(1) A client or client's representative may request a copy of information from their files at no cost once every 12 months. If the client requests another copy of the same information, written summary, or explanation more frequently than once every 12 months, then OVRS may impose a reasonable, cost-based fee.

(2) If an agency or organization requests client records, fees may be assessed for accessing stored records, extracting filed matter, duplication of records and/or other costs necessary to releasing requested information.

(3) OVRS may establish additional, reasonable fees to cover extraordinary costs of duplicating records, making extensive searches, or preparing written summaries of records.

(4) All moneys received shall be handled and recorded under approved state accounting procedures.

(5) At the option of the office or unit that processes the requested material, fee assessment may be waived.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 344
Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730
Hist.: VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f.& cert. ef. 3-12-04

582-030-0010
Program Uses and Disclosures by OVRS

(1) All individually identifiable information regarding a client that is obtained, generated by, or made available to OVRS, its representative or employees, shall be protected, held confidential, and is the property of OVRS and may only be used and disclosed as permitted by OAR chapter 582, division 30. Such information may not be used or disclosed in violation of any of the following laws where those laws are applicable:

(a) Oregon Administrative Rules, chapter 410, division 14, concerning Privacy of Protected Information for clients of the Department of Human Services and concerning the implementation of HIPAA;

(b) ORS 179.505 concerning written treatment records;

(c) Federal laws concerning substance abuse information as set out in 42 CFR part 2;

(d) State laws concerning HIV information as set out in ORS 433.045;

(e) State laws concerning DNA and genetic information as set out in ORS 192.537 and 192.539.

(2) Client information may be used and disclosed by OVRS for purposes directly connected with the administration of the vocational rehabilitation program unless prohibited by law. Except for purposes directly connected with the administration of vocational rehabilitation or as required by law, OVRS will not use or disclose any list of or names of, or any information concerning persons applying for or receiving vocational rehabilitation services. Permitted disclosures under ORS 344.600 and OAR 582-030-0010 shall include disclosures made with informed written consent of the client for the purpose of assisting the financial capacity of OVRS or the client to pay for the rehabilitation of the client.

(3) Except as directed by the client under informed written consent, client information will not be disclosed outside OVRS unless:

(a) Required by federal or state law, including the exceptions to written consent requirements described in OAR 582-030-0040;

(b) Ordered by a judge, magistrate or other authorized judicial officer; or

(c) Authorized by these rules.

(4) Any information about a crime committed by any individual, or suspected abuse or neglect, or that poses a threat to the safety of the client or others is not confidential except as provided by law.

(5) Identifiable personal information may not be shared with advisory or other bodies that do not have official responsibility for administration of the program, unless the client gives written consent.

(6) Each affected OVRS client shall be informed that discussion of work related client information with potential employers, in connection with the job placement of a client, is considered to be within the scope of the administration of the vocational rehabilitation program and such information may be used or disclosed to the extent allowed by law. Such information shall be limited to that which the counselor determines to be necessary to the placement process and directly related to the client's abilities to perform, retain, or acquire the skills to perform, specific employment.

(7) Unless prohibited by law, OVRS client information may be released to other agencies which have cooperative agreements with OVRS without the written consent of the client only if providing such information has a bearing on administration of the OVRS program and/or the provision of OVRS services. At time of application and at other times that client information is being collected, OVRS shall inform the client about situations where information is routinely released and identify the involved agencies.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 344
Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730
Hist.: VRD 22, f. & ef. 3-5-76; VRD 3-1981, f. & ef. 12-1-81; VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f. & cert. ef. 3-12-04

582-030-0020
Release of Information to Other Agencies, Organizations, Authorities or Individuals

(1) DHS Form 2098 Authorization for Use and Disclosure of Non-Health Information or Form 2099 Authorization for Use and Disclosure of Health Information, or the equivalent, shall be utilized to obtain client permission to release or obtain client information. Before the client or client's representative signs this form it must be completed so as to indicate informed consent, involved parties and timelines for obtaining or releasing specified information. For a client who has been adjudicated legally incapacitated, the parent or legal guardian must also sign the form.

(2) Each page of any document, record, or report containing OVRS client information released to any other agency, organization or person shall be imprinted with a statement that reads:

CONFIDENTIAL

This information cannot be released to any other person, agency, or organization without the prior written approval of the Office of Vocational Rehabilitation Services.

(3) Release to other agencies or programs. Upon receiving the informed written consent of the client, OVRS may release client information to another agency or organization to assist with vocational rehabilitation services or administration — including the financial capacity of OVRS or the client to pay for the rehabilitation of the client. OVRS may restrict disclosure of client information believed to be harmful if released directly to an OVRS client until OVRS secures written agreement from the requester that the information will be used only for the purposes authorized and will not be further released to the client.

(4) Release for audit, evaluation, or research. Client information may be released to an organization, agency, or individual engaged in audit, evaluation, or research only for purposes directly connected with the administration of the vocational rehabilitation program, or for purposes which would significantly improve the quality of life for individuals with disabilities and only when OVRS is assured that:

(a) The information will be used only for the purposes authorized;

(b) The information will be released only to persons officially connected with the authorized activity;

(c) The information will not be released to the involved client;

(d) The information will be managed in a manner to safeguard confidentiality; and

(e) The final product will not reveal the identity of any involved client without his/her, or his/her representative's written consent.

[Publications: Publications referenced are available from the agency.]

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 344

Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730

Hist.: VRD 22, f. & ef. 3-5-76; VRD 3-1981, f. & ef. 12-1-81; VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f. & cert. ef. 3-12-04

582-030-0025
Subpoenas

(1) The Administrator of OVRS is the official custodian of all client records for OVRS. Any subpoena for release of an OVRS client record must be directed to the Administrator of OVRS at OVRS Central Administration Offices in Salem.

(2) A subpoena generated or authorized by an OVRS client or client's attorney to testify or release client information is deemed to be an informed written consent from the client, except as prohibited by law.

(3) Upon verification that a client's attorney is authorized to issue the subpoena on behalf of the client, OVRS employees may communicate with the client's attorney within the scope of the request to the extent provided under OAR 582-030-0030.

(4) Without a valid written authorization from the client or an order issued by a judge, magistrate or other authorized judicial officer, OVRS employees may not provide client information in response to a subpoena not generated by or authorized by a client or his/her attorney.

(5) Any OVRS employee who appears in response to a subpoena not generated by or authorized by the client or his/her attorney and without a valid written client authorization must read the following statement at the start of the appearance instead of providing client documents or testifying about an OVRS client: "Confidentiality policy imposed by state law, including ORS 344.600, and federal regulation requires OVRS to invoke public officer privilege under ORS 40.270 — Evidence Rule 509, with respect to the release of client information or provision of testimony not requested or authorized by the client or the client's representative." If after making this statement to a judge, magistrate or other authorized judicial officer, the judge, magistrate or other judicial officer issues an order, the OVRS employee shall comply with the order, including providing any documents or testimony within the scope of the order.

Stat. Auth.: ORS 344.530

Stats. Implemented: ORS 344.530, 344.540(1), 344.600

Hist.: VRS 3-2004, f. & cert. ef. 3-12-04

582-030-0030
Release to Clients, Parents, Guardians and Legal Representatives

(1) Upon written request using DHS Form 2093, its equivalent, or its successor, the requested information from the OVRS case file shall be released to an OVRS client or, as appropriate, the client's representative, in a timely manner, with the following exceptions:

(a) Treatment records, psychological evaluations, and case file information obtained from another public organization may only be released under the conditions established by the treatment provider or source of the records or under the conditions established by agreement between OVRS and the treatment provider or source of the records.

(b) If a client or (as appropriate) a parent, guardian, or other representative presents a written request to review medical or psychological reports from the client's OVRS file and the counselor believes direct release of such information to any of the above persons may be harmful to the client, the following procedures must be followed:

(A) The counselor will contact the practitioner(s) who wrote the report(s) to request an opinion as to whether the practitioner believes direct release of the information would be harmful to the client; or, if a practitioner is unavailable;

(B) The counselor will obtain an opinion from the appropriate office medical or psychological consultant as to whether the consultant believes direct release of the information would be harmful to the client; the consultant is to record his/her opinion on the Medical/Psychological Review Record in the medical jacket (R-114);

(C) If the practitioner or consultant states that direct release would not be harmful, the counselor will release the requested OVRS information directly to the client or (as appropriate) to the client's parent, guardian, or designated representative;

(D) If the practitioner or consultant states that direct release would be harmful, the counselor will request but not require the client to designate an appropriate and qualified physician or psychologist of the client's choosing for the purpose of reviewing and interpreting the contents of the report(s) to the client. If the client agrees, the counselor will schedule the appointment, mail copies of the report(s) to the practitioner, and if the client so requests, execute an Authorization for Purchase to pay the practitioner for an office visit at the OVRS current approved rate of payment.

(E) Medical, psychological, or other information that OVRS determines may be harmful to the individual may not be released directly to the individual, but if release is allowed under these rules, must be provided to the individual through a third party chosen by the individual, which may include, among other, an advocate, a family member, a qualified medical or mental health professional, unless a representative has been appointed by court to represent the individual in which case the information must be released to the court-appointed representative.

(2) Informed written consent from the client is required for the release of mental health or substance abuse information to a parent or guardian for any client age 14 or over.

(3) Informed written consent from the client is required for the release of general medical information to a parent or guardian for any client age 15 or over.

(4) Informed written consent from the client is required for the release of any information about sexually transmitted diseases or birth control to a parent or guardian for any client regardless of age.

Stat. Auth.: ORS 344

Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730

Hist.: VRD 22, f. & ef. 3-5-76; VRD 3-1981, f. & ef. 12-1-81; VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f. & cert. ef. 3-12-04

582-030-0040
Exceptions to Written Consent Requirements

(1) Required Reporting and Response to Investigations:

(a) OVRS employees must report to the appropriate authorities abuse of individuals age 65 and over, ORS 124.060, under the age of 18, ORS 419B.010, individuals 18 age or over with developmental disabilities or mental illness, ORS 430.765, and residents of long-term care facilities, ORS 441.640;

(b) OVRS must release client information if required by federal law or in response to investigations in connection with law enforcement, fraud or abuse (unless expressly prohibited by federal or state laws or regulations, such as OAR 410-014-0020(2)(j) which identifies limits on disclosures of protected health information to law enforcement) or in response to an order issued by a judge, magistrate or other authorized judicial officer.

(2) Response to Child Support Enforcement. A person authorized under federal law may access information for the Federal Parent Locator Service under ORS 25.265.

(3) OVRS may release client information to protect the individual or others when the individual poses a threat to his or her safety or to the safety of others.

(4) For Deceased Persons:

(a) Vital Statistics. These rules do not restrict the disclosure of OVRS client identifying information relating to the death of a client under laws

requiring the collection of such vital statistics or permitting inquiry into the cause of death;

(b) Consent by Personal Representative. Other requirements of these rules notwithstanding, if written consent to such disclosure is required, that consent may be given by an executor, administrator or other personal representative appointed under applicable state law. If there is no such appointment, consent may be given by the spouse or other responsible member of the client's family.

(6) Participation in State Agency Information Exchange: OVRS will participate in the State Shared Information System (SIS) or Performance Reporting Information System (PRISM), and DHS information sharing to the extent allowed by and consistent with state and federal law and/or regulations. Where client authorization is required, OVRS may obtain informed written consent using forms specific to these information exchanges.

(7) OVRS may disclosure the minimum information necessary for internal OVRS administrative purposes to the Department of Human Services; federal Rehabilitation Services Administration; or other state or federal agencies with regulatory authority over OVRS or administrative responsibilities necessary for OVRS services.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 344
Stats. Implemented: ORS 344.511 - 344.690 & 344.710 - 344.730
Hist.: VRD 4-1991, f. & cert. ef. 12-13-91; VRD 2-1993, f. & cert. ef. 9-15-93; VRS 3-2004, f. & cert. ef. 3-12-04

• • • • • • • • • •

Department of Justice
Chapter 137

Adm. Order No.: DOJ 6-2004
Filed with Sec. of State: 2-19-2004
Certified to be Effective: 4-1-04
Notice Publication Date: 11-1-03
Rules Amended: 137-025-0020, 137-025-0160, 137-025-0180
Subject: 1. Amends rules to clarify what awards to bingo players may be offered as "prizes" and that consolation awards are not permitted.

2. Amends rule to clarify that 2 simultaneous bingo games may be operated at one location, but only by separate licensees.
Rules Coordinator: Carol Riches—(503) 378-6313

137-025-0020
Definitions

For purposes of these rules, the following definitions shall apply:

(1) The "Department" means the Oregon Department of Justice.

(2) "Bingo" means a game played on a printed form or card containing a grid bearing horizontal and vertical lines of numbers. Each card must include the same number of numbers. The numbers may be pre-printed or completed by the players. Numbers are drawn from a receptacle containing no more than 90 numbers, until there are one or more winners. A winner(s) is determined by the player(s) to first cover or uncover the selected numbers in a designated combination, sequence or pattern as they appear on the player's card. The progress toward a "bingo" of the non-winning players shall be irrelevant in determining the prize payout for the winner(s). A "blackout" (i.e., covering all squares on the grid) shall qualify as a designated sequence or pattern. Games which do not qualify as bingo include, but are not limited to, games marketed as "quick shot bonanza," "pick X" bingo, and "pick-8" bingo in the format utilizing a 40 square grid.

(3) "Pull Tab" means a single folded or banded ticket or card, the face of which is initially covered or otherwise hidden from view to conceal a number, symbol or set of symbols, a few of which numbers or symbols out of every set of pull tabs have been designated in advance and at random as prize winners.

(4) "Raffle" means a form of a lottery in which each participant buys a ticket for an article or money designated as a prize and where the winner is determined by a random drawing. A raffle includes the elements of consideration, chance and a prize. Consideration is presumed to be present unless it is clearly and conspicuously disclosed to prospective participants that tickets to the drawing may be acquired without contributing something of economic value.

(5) "Door Prize Drawing" means a drawing held by a nonprofit organization at a meeting of the organization where both the sale of tickets and the drawing(s) occur during the meeting and the total value of the prize(s) does not exceed $500.

(6) "Handle" means the total amount of money and other things of value bet on the bingo, lotto or raffle games, the value of raffle chances sold or the total amount collected from the sale of imitation money during Monte Carlo events.

(7) "Responsible Officials of the Organization" means the officers of the organization and the board of directors, if any.

(8) "Bingo Game Manager" means any person who is responsible for the overall conduct of bingo games of a charitable, fraternal or religious organization.

(9) "Regular Bingo Game" means a bingo game where players use hard cards or paper cards from a packet which have been purchased for a package price and may be used by players during more than one game of a session.

(10) "Special Bingo Game" means a bingo game where players must purchase individual paper cards where use is limited to a specific bingo game.

(11) "Concessions" means the sale of food, beverages, related bingo supplies, such as daubers, glue and other retail items using a bingo theme sold to bingo players.

(12) "Management or Operation" means supervising the games.

(13) "Administration or Operation" means supervising the games.

(14) "Supervise" means to direct, oversee and inspect the work of others; to exercise authority with respect to decision-making or the implementing of decisions; and responsibility for the performance of functions integral to the operation of bingo and raffles, including operation of the games and operation of the facility used to conduct the games.

(15) "Drawing" means an approved random selection process for determining winners in a raffle. To be random, each number in the drawing must have an equal chance of selection.

(16) "Monte Carlo event" means a gambling event at which wagers are placed with imitation money upon contests of chance in which players compete against the house. As used in this subsection, "imitation money" includes imitation currency, chips or tokens.

(17) "Monte Carlo equipment supplier" means a person or organization who leases equipment to a non-profit tax exempt organization for operation of a Monte Carlo event.

(18) "Monte Carlo event contractor" means a Monte Carlo event supplier who is employed to operate a Monte Carlo event on behalf of a non-profit tax exempt organization.

(19) "Monte Carlo event licensee" means any organization which has obtained a Monte Carlo event license pursuant to OAR 137-025-0410.

(20) "Related party" means an officer, director or bingo game manager of the licensed organization. Related party includes the family of such an individual. Family shall include a spouse, domestic partner, brothers and sisters (whether by the whole or half blood), ancestors and lineal descendents. Related party also includes corporations wherein the preceding individuals directly, or indirectly, own 50% or more of the capital interest and a trust in which the preceding individuals serve as fiduciaries or are named beneficiaries.

(21) "Sleeper Bingo" — A bingo game where the licensee adopts a house rule providing that a bingo prize may be shared between player(s) announcing a qualifying bingo on the last number called and player(s) who achieved a qualifying bingo as a result of a previously called number.

Stat. Auth.: ORS 167.117(10)(12), 464.250(1), 914
Stats. Implemented: HB 3009, 1997
Hist.: JD 8-1987, f. 10-30-87, ef. 11-1-87; JD 1-1989, f. & cert. ef. 3-1-89; JD 1-1991, f. 2-1-91, cert. ef. 3-1-91; JD 2-1993, f. 6-21-93, cert. ef. 7-1-93; JD 7-1997(Temp), f. 12-31-97, cert. ef. 1-1-98 thru 6-20-98; DOJ 5-1998, f. 6-19-98, cert. ef. 6-20-98; DOJ 13-2001, f. 12-28-01, cert. ef. 1-1-02; DOJ 6-2004, f. 2-19-04, cert. ef. 4-1-04

137-025-0160
Conduct of Bingo in General

(1) No employee of the licensee involved in the conduct of bingo games may receive a prize or participate as a player at a bingo game session in which the employee is actually involved in the conduct of the bingo games.

(2) All prizes awarded in connection with bingo games, whether in cash or merchandise, and all rules by which such prizes may be won, including costs to a participant, shall be disclosed to each participant prior to that participant taking part in the activity or paying for the opportunity to take part in the activity. Disclosures shall be made by conspicuously posting or displaying upon the premises where the activity is operated a complete description of the rules of the activity, an explanation of how each prize can be won, and the cost to participate in the activity.

(3) The numbers for bingo shall be physically selected from a container, and players shall be able to view the selection process, including an unobstructed view of the container or blower chamber. Immediately following the drawing of each number in the bingo game, the caller shall dis-

play the letter and number for viewing by the participants. Numbers shall not be selected by electronic equipment, such as by computer.

(4) All prizes, or script redeemable for prizes, paid to the winner(s) shall be paid by the licensee; no prizes or script shall be transferred from non-winners to the winner(s).

(5) Bingo cards may not be purchased or played other than at the approved location of the licensee's game; a player must be present to win.

(6) Except for the conduct of "bonanza" bingo described in section (7) of this rule, the numbers shall be drawn and announced during the play of the game; each player covers the corresponding number, if present on the bingo card, as each number is called.

(7) A licensee may play "bonanza" bingo by drawing a predesignated quantity of bingo numbers before the actual playing of the bonanza bingo game only if the licensee complies with the following procedures:

(a) Bonanza bingo cards shall remain sealed until such time as they are sold to the players;

(b) The balls drawn in advance of the bonanza bingo game shall be drawn during a bingo session in the presence of the players; and

(c) The quantity of numbers drawn in advance shall be fewer than the number which would produce a probable instant winner, based upon the rules of the game and the expected number of players.

(8) No operator shall engage in any act, practice, or course of operation as would operate as a fraud to affect the outcome of any bingo game.

(9) Cages or blowers used to mix and select bingo numbers shall be designed and constructed in such a manner which reasonably provides a thorough mix of the numbers and random selection. Cages and blowers shall be cleaned and maintained in good repair so as to prevent damage to the bingo numbers.

(10) Bingo numbers shall be periodically inspected, cleaned and maintained in good condition by the licensee. No bingo numbers may be used in play which are defective, cracked, broken, illegible, out of round or damaged in such a manner that would interfere with or affect the random selection process. Only sequentially complete sets of bingo numbers shall be placed in play; there shall be no duplication of numbers.

(11) No person shall tamper with, mutilate, weight, or otherwise alter a bingo number in any manner that would interfere with or affect the random selection process.

(12) The Department may immediately remove any bingo number or set of bingo numbers from play if a violation is found. The number or number set shall not be returned to play until the violation is corrected. The Department may require that any bingo number or number set be replaced or tested for compliance if a violation is found or suspected.

(13) With the exception of "sleeper bingos", a prize may be awarded only to the bingo player(s) who first covers or uncovers the selected numbers in a designated combination, sequence or pattern. Multiple prizes may be awarded in the course of a game if each prize is given to the first player to achieve a designated pattern, such as those offered in "work up" games. No awards, including consolation awards, such as "monitor bingos", shall be made to players other than the prizes described above.

Stat. Auth.: ORS 464.250(1) & 464
Stats. Implemented: ORS 464.250(7)
Hist.: JD 7-1987, f. 10-30-87, ef. 1-1-88; JD 1-1991, f. 2-1-91, cert. ef. 3-1-91; JD 2-1993, f. 6-21-93, cert. ef. 7-1-93; DOJ 6-2004, f. 2-19-04, cert. ef. 4-1-04

137-025-0180
Bingo Operating Limits

(1) Unless excepted by the Department, a licensee shall not operate bingo games for more than 15 hours nor more than three days in any one calendar week. However, a Class C or D licensee may operate without restriction as to number of days or hours per week if its total operations are limited to no more than 12 consecutive days during its license year. All bingo games must be conducted at a single physical location. No more than two bingo games may be operated simultaneously at a location. One licensee may not operate simultaneous games. Simultaneous games occur when numbers are pulled from more than one container/blower at the same time.

(2) A licensee shall not award prizes exceeding $2,500 in value in any one game except a licensee may award prizes not to exceed $10,000 per game up to 2 times during the license year. On the licensee report as provided by OAR 137-025-0140, the licensee shall record the dates(s) and amount(s) of any prizes awarded exceeding $2,500 per game. A licensee shall not offer a prize in excess of $2,500 unless the licensee has such funds available in an account with a financial institution or has evidence that it has purchased current insurance from a surety/insurance company providing for payment if such a prize is won by one or more of the licensee's players. Any such prize won by a player shall be paid by a corporate or cashier's check no later than the close of the second business day after the prize is won.

(3) The "operating expenses" of all bingo and raffle games, conducted by the licensee as defined in ORS 167.117(14), excluding prizes and money paid to players, shall not exceed 18 percent of the total of the annual handle of those games:

(a) If expenses are related to both the bingo operations and the nonbingo operations of a licensee (such as rent, utilities and employee salaries), a reasonable allocation shall be made between the bingo and nonbingo activities. Employee salaries shall be allocated based upon hours spent in bingo and nonbingo activities;

(b) All leasehold improvements and improvements to bingo facilities owned by the licensee may be reasonably amortized;

(c) No salary of an employee of the licensee shall be considered an operating expense for purposes of this subsection, if less than 20 percent of the employee's time is devoted to activities directly related to the games;

(d) Fees paid to the Department are not operating expenses for purposes of this subsection;

(e) If a licensee subleased its space or equipment to one or more additional licensees, the licensee may pro rate its rental expenses based on proportional use of the property; the pro rate shall be based on the actual hours of use by that licensee compared to the total hours of use of the other licensees.

Stat. Auth.: ORS 464.250(1)
Stats. Implemented: HB 3009, 1997
Hist.: JD 7-1987, f. 10-30-87, ef. 1-1-88; JD 2-1993, f. 6-21-93, cert. ef. 7-1-93; DOJ 5-1998, f. 6-19-98, cert. ef. 6-20-98; DOJ 13-2001, f. 12-28-01, cert. ef. 1-1-02; DOJ 6-2004, f. 2-19-04, cert. ef. 4-1-04

• • • • • • • • • •

Department of Transportation
Chapter 731

Adm. Order No.: DOT 2-2004
Filed with Sec. of State: 2-23-2004
Certified to be Effective: 2-23-04
Notice Publication Date:
Rules Amended: 731-001-0005
Subject: This rule adopts the Attorney General's Model Rules of Procedure. The amendment adopts the model rules in effect January 1, 2004.
Rules Coordinator: Brenda Trump—(503) 945-5278

731-001-0005
Model Rules of Procedure

Pursuant to ORS 183.341, the Oregon Transportation Commission adopts the following portions of Oregon Administrative Rules chapter 137 as in effect on January 1, 2004 as the general administrative procedural rules for the Oregon Transportation Commission and the Oregon Department of Transportation: division 1, division 2, division 3 excluding OAR 137-003-0001 through 137-003-0092, division 4 and division 5.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the Attorney General or Department of Transportation.]
Stat. Auth.: ORS 183.341, 184.616 & 184.619
Stats. Implemented: ORS 183.341
Hist.: HC 1207, f. & ef. 10-9-69; HC 1245, f. & ef. 2-12-71; HC 1276, f. & 3-3-72, ef. 3-15-72; 1 OTC 1(Temp), f. & ef. 7-18-73; 1 OTC 2, f. & ef. 9-26-73; 1 OTC 3, f. 10-15-73, ef. 11-25-73; 1 OTC 68, f. & ef. 1-23-76; 1 OTC 3-1978, f. & ef. 3-29-78; 1 OTC 3-1980(Temp), f. & ef. 1-16-80; 1 OTC 7-1980, f. & ef. 3-28-80; 1 OTC 4-1981, f. & ef. 11-24-81; 1 OTC 1-1984, f. & ef. 1-6-84; 1 OTC 3-1986, f. & ef. 4-28-86; DOT 1-1988, f. & ef. 8-22-88; DOT 4-1990, f. & cert. ef. 8-14-90; DOT 1-1992, f. & cert. ef. 5-12-92; DOT 2-1994, f. & cert. ef. 3-17-94; DOT 2-1995, f. 11-21-95, cert. ef. 1-1-96; DOT 2-1997, f. & cert. ef. 12-23-97; DOT 2-2000, f. & cert. ef. 6-8-00; DOT 1-2002, f. & cert. ef. 1-17-02; DOT 2-2004, f. & cert. ef. 2-23-04

• • • • • • • • • •

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

Adm. Order No.: DMV 4-2004
Filed with Sec. of State: 2-23-2004
Certified to be Effective: 2-23-04
Notice Publication Date: 12-1-04
Rules Amended: 735-064-0220
Rules Repealed: 735-064-0220(T)
Subject: ORS 809.605 requires DMV to adopt rules specifying which traffic offenses count for the purpose of determining that a person is a habitual offender under ORS 809.600(2). By administrative rule, those offenses are used to determine who qualifies for DMV's

Driver Improvement programs, and whether a person has violated the terms of a hardship or probationary permit or has committed a serious traffic violation while operating a commercial motor vehicle. OAR 735-064-0220 specifies those traffic offense convictions DMV will use for the above described purposes. The 2003 Legislature enacted several bills that create new traffic offenses or amend current traffic offense statutes. The amendments to OAR 735-064-0220 revise the list of traffic offenses to implement these legislative changes. Section (3) of the rule is amended to clarify that DMV may use the AAMVAnet Code Dictionary (ACD) code when posting convictions received from other states or jurisdictions and updates the references of equivalent Oregon traffic offenses based upon the new legislation.

Rules Coordinator: Brenda Trump—(503) 945-5278

735-064-0220

Traffic Offenses Used in Habitual Offender, Driver Improvement, CMV Serious Violations and Hardship/Probationary Driver Permit Programs

(1) A conviction for an offense listed in this rule counts toward:

(a) The Habitual Offender Program pursuant to ORS 809.600(2);

(b) The Provisional and Adult Driver Improvement Programs outlined in Oregon Administrative Rule chapter 735, division 72;

(c) Motor vehicle traffic control violations connected to a fatal accident as defined in ORS 801.477(9) that can lead to a suspension of commercial motor vehicle driving privileges;

(d) Revocation of a probationary driver permit pursuant to ORS 807.270(7); and

(e) Revocation of a hardship permit pursuant to OAR 735-064-0100 and 735-064-0110.

(2) This section lists the offenses and the statutory citations for Oregon offenses used in the programs identified in section (1) of this rule: [Table not included. See ED. NOTE.]

(3) The following offenses are a result of laws passed by the 2003 Legislature and become effective January 1, 2004. [Table not included. See ED. NOTE.]

(4) Offenses from other states may be posted to driver records using an AAMVAnet Code Dictionary (ACD) code. This section identifies the code that appears on the driver record, a description of the offense and the ORS reference covering an equivalent offense(s) for Oregon: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 184.616, 184.619, 809.480 & 809.605

Stats. Implemented: ORS 807.240, 807.270, 809.480, 809.600(2) & 809.605

Hist.: MV 17-1986, f. & ef. 10-1-86; MV 33-1987, f. & ef. 11-2-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0180; MV 32-1989, f. & cert. ef. 10-3-89; MV 7-1990, f. & cert. ef. 5-16-90; MV 18-1991, f. 9-18-91, cert. ef. 9-29-91; MV 26-1991, f. & cert. ef. 11-18-91; DMV 8-1995, f. & cert. ef. 6-19-95; DMV 5-1997, f. & cert. ef. 2-20-97; DMV 8-1998, f. & cert. ef. 6-19-98; DMV 27-2001(Temp), f. 12-14-01, cert. ef. 1-1-02 thru 6-29-02; DMV 11-2002, f. 6-24-02, cert. ef. 6-30-02; DMV 33-2003(Temp), f. 12-15-03 cert. ef. 1-1-04 thru 6-28-04; DMV 4-2004, f. & cert. ef. 2-23-04

• • • • • • • • • •

Department of Transportation, Highway Division
Chapter 734

Adm. Order No.: HWD 2-2004
Filed with Sec. of State: 2-18-2004
Certified to be Effective: 3-1-04
Notice Publication Date: 7-1-03
Rules Adopted: 734-051-0085, 734-051-0105
Rules Amended: 734-051-0010, 734-051-0020, 734-051-0040, 734-051-0070, 734-051-0080
Rules Repealed: 734-051-0130, 734-051-0140, 734-051-0150, 734-051-0160, 734-051-0170, 734-051-0180, 734-051-0220, 734-051-0330, 734-051-0340, 734-051-0350, 734-051-0410, 734-051-0420, 734-051-0480
Rules Ren. & Amended: 734-051-0030 to 734-051-0020, 734-051-0050 to 734-051-0035, 734-051-0060 to 734-051-0035, 734-051-0090 to 734-051-0070, 734-051-0100 to 734-051-0070, 734-051-0110 to 734-051-0045, 734-051-0120 to 734-051-0095, 734-051-0190 to 734-051-0115, 734-051-0200 to 734-051-0125, 734-051-0210 to 734-051-0145, 734-051-0230 to 734-051-0175, 734-051-0235 to 734-051-0225, 734-051-0240 to 734-051-0195, 734-051-0250 to 734-051-0185, 734-051-0260 to 734-051-0165, 734-051-0270 to 734-051-0205, 734-051-0280 to 734-051-0215, 734-051-0290 to 734-051-0245, 734-051-0300 to 734-051-0265, 734-051-0310 to 734-051-0255, 734-051-0320 to 734-051-0135, 734-051-0360 to 734-051-0155, 734-051-0370 to 734-051-0285, 734-051-0380 to 734-051-0275, 734-051-0390 to 734-051-0345, 734-051-0400 to 734-051-0355, 734-051-0430 to 734-051-0295, 734-051-0440 to 734-051-0305, 734-051-0450 to 734-051-0315, 734-051-0460 to 734-051-0325, 734-051-0470 to 734-051-0335
Subject: The amendments cover the process for applications for approaches to state highways and clarify the parameters for management of access on state highways. The amendments will increase the level of predictability for applicants when requesting an approach to a state highway and will promote consistency within ODOT when permitting public and private approaches. Additionally, the amendments: • Provide for a less complex rule, in a more logical order that is easier to understand through the consolidation and renumbering of rules. • Clarify that ODOT may require such approach to be located in the safest possible location. • Clarify the criteria used by ODOT in determining reasonable access and require the Department to consider additional criteria in determining whether alternate access to a property is reasonable. • Clarify the approval criteria for development on multiple parcels, parcels with double frontage, and the effect of easements. • Allow approval of applications for approaches to expressways where no alternate access exists or where the applicant shows that a benefit to the highway system will result. • Allow the Department to consider incremental improvements for approaches in areas where redevelopment or infill development occurs. • Increase ODOT's engineering staff's ability to recommend sound, workable solutions on a site by site basis. • Clarify when the department may approve an application for a temporary approach. • Allow the Department to approve a restricted-use (emergency vehicle) approach.
Rules Coordinator: Brenda Trump—(503) 945-5278

734-051-0010

Authority for Rules

Division 51 rules are adopted under the Director's authority contained in ORS 374.310(1).

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345, 374.990; Ch. 974 OL 1999; Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04

734-051-0020

Purpose and Applicability of Rules

The purpose of division 51 rules is to provide a safe and efficient transportation system through the preservation of public safety, the improvement and development of transportation facilities, the protection of highway traffic from the hazards of unrestricted and unregulated entry from adjacent property, and the elimination of hazards due to highway grade intersections. These rules establish procedures and criteria used by the Department to govern highway approaches, access control, spacing standards, medians and restriction of turning movements in compliance with statewide planning goals and in a manner compatible with acknowledged comprehensive plans and consistent with Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR), and the 1999 Oregon Highway Plan (OHP).

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999; Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0030

734-051-0035

Administration of Rules

(1) Approaches in existence and applications filed after March 1, 2004 are governed by these rules.

(2) Division 51 rules do not affect existing rights of owners of grandfathered approaches.

(3) Consistent with ORS 374.312 the Department and local governments may enter into intergovernmental agreements allowing local governments to process applications and issue Construction Permits and Permits to Operate for private approaches to regional and district highways, includ-

ing highways routed over city streets where the local government owns the right of way.

(4) Approval of a property for a particular use is the responsibility of city, county, or other governmental agencies, and an applicant must obtain appropriate approval from city, county, or other governmental agencies having authority to regulate land use. Approval of an application or issuance of a Construction Permit or a Permit to Operate is not a finding of compliance with statewide planning goals or an acknowledged comprehensive plan.

(5) Any notice or other communication by the Department is sufficient if mailed by first class mail to the person at the address on the application or where property tax statements for the property are sent. Any notice of an appealable decision is sufficient if sent by certified mail to the person at the address on the application or where property tax statements for the property are sent. The notice date is the date of mailing.

(6) Pursuant to ORS 374.310(3), the division 51 rules may not be exercised so as to deny any property adjoining the highway reasonable access and ORS 374.312(1)(c) requires adoption of rules establishing criteria for reasonable access consistent with ORS 374.310(3) criteria. These rules address "reasonable access" solely in the context of the issuance of approach permits. "Reasonable access" under these rules does not affect whether access may be reasonable for other purposes or under other reviews.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 347.345 & 374.990; Ch. 974, OL 1999; Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0050 & 734-051-0060

734-051-0040
Definitions

The following definitions apply to division 51 rules:

(1) "1999 Oregon Highway Plan" means the 1999 Oregon Highway Plan and all amendments approved by the Commission as of the adoption of this rule.

(2) "Access Control" means no right of access exists between a property abutting the highway and the highway. The right of access may have been acquired by the Department or eliminated by law.

(3) "Access Management Strategy" means a project delivery strategy that identifies the location and type of approaches and other necessary improvements to the highway and that is intended to improve current conditions of the section of highway by moving in the direction of the access management spacing standards.

(4) "Access Management Plan" means a plan for a designated section of highway that identifies the location and type of approaches and necessary improvements to the state highway or local roads and that is intended to improve current conditions of the section of highway by moving in the direction of the access management spacing standards. Both the Department and the appropriate local jurisdiction must adopt the Access Management Plan, and the plan should be included in a Transportation System Plan.

(5) "Access Mitigation Proposal" means a proposal offered by an applicant that identifies the location and type of approaches and necessary improvements to the highway and that is intended to improve current conditions of the section of highway by moving in the direction of the access management spacing standards by combining or removing approaches resulting in a net reduction of approaches to that section of highway. An Access Mitigation Proposal must be approved by the Department, agreed to by all affected property owners, and real property interests must be recorded.

(6) "Alternate Access" means the physical existence of other means to access a property than the proposed approach, such as an existing public right of way, another location on the subject state highway, an easement across adjoining property, a different highway, a service road, or an alley, including singularly or as a joint approach, but without a conclusive determination that the alternate access is "reasonable" as defined in section (51) of this rule.

(7) "Appealable decision" means a decision by the Department that may be appealed through a Region Review as set forth in OAR 734-051-0345 or a Contested Case Hearing as set forth in OAR 734-051-0355. An appealable decision includes a decision to deny an application or to deny a deviation or approval of an application with mitigation measures.

(8) "Applicant" means a person, firm or corporation, or other legal entity that applies for an approach or deviation including an owner or lessee, or an option holder of a property abutting the highway, or their designated agent.

(9) "Application" means a completed form Application for State Highway Approach including any required documentation and attachments necessary for the Department to determine if the application can be deemed complete.

(10) "Approach" means a legally constructed, approach road or private road crossing, recognized by the Department as grandfathered or existing under a valid Permit to Operate.

(11) "Approach road" means a legally constructed, public or private connection, providing vehicular access to and/or from a highway and an adjoining property.

(12) "Classification of highways" means the Department's state highway classifications defined in the 1999 Oregon Highway Plan.

(13) "Commission" means the Oregon Transportation Commission.

(14) "Construction Permit" means a Permit to Construct a State Highway Approach including all attachments, required signatures, and conditions and terms.

(15) "Crash history" means at least the three most recent years of crash data recorded by the Department's Crash Analysis and Reporting Unit.

(16) "Day" means calendar day, unless specifically stated otherwise.

(17) "Deemed complete" means an application and all required supplemental documentation necessary for the Department to review and assess the application and determine if a Construction Permit or a Permit to Operate may be issued.

(18) "Department" or "ODOT" means the Oregon Department of Transportation.

(19) "Deviation" means a departure from the access management spacing standards.

(20) "Division 51" means Oregon Administrative Rules (OAR) 734-051-0010 through 734-051-0560 and Tables 1, 2, 3, 4, 5, 6, 7 and 8 adopted and made a part of division 51 rules and Figures 1, 2, 3 and 4 adopted and made a part of division 51 rules.

(21) "Double-Frontage Property" means a property with a right of access to more than one state highway.

(22) "Executive Deputy Director" means the Executive Deputy Director for Highway Division of the Oregon Department of Transportation.

(23) "Expressway" means a segment of highway defined in the 1999 Oregon Highway Plan and classified by the Oregon Transportation Commission.

(24) "Fair Market Value" means the amount in cash, or on terms reasonably equivalent to cash, for which in all probability the property would be sold by a knowledgeable owner willing but not obligated to sell to a knowledgeable purchaser who desired but is not obligated to buy.

(25) "Freeway or Expressway ramp" means all types, arrangements, and sizes of turning roadways for right or left turning vehicles that connect two or more legs at an interchange and the components of a ramp area terminal at each leg and a connection road, usually with some curvature and on a grade.

(26) "Grandfathered approach" means a legally constructed approach existing prior to 1949. A property owner has the burden to prove an approach is grandfathered based upon existence prior to 1949. For purposes of this Division, grandfathered approaches also include approaches presumed in compliance as set forth in OAR 734-051-0285(1), and approaches intended to remain open that were improved in conjunction with a Department project prior to the effective date of this Division, April 1, 2000, as set forth in OAR 734-051-0285(9).

(27) "Grant of Access" means the conveyance or evidence of the conveyance from the Department of a specific right of access at a location where an abutting property currently does not have that specific right of access.

(28) "Highway mobility standards" mean the established standards for maintaining mobility as defined in the 1999 Oregon Highway Plan.

(29) "Highway segment designations" mean the four categories of designations, Special Transportation Area, Commercial Centers, Urban Business Areas, and Urban, defined in the 1999 Oregon Highway Plan.

(30) "Indenture of Access" means a deeded conveyance that changes the location, width, or use restrictions of an existing reservation of access.

(31) "Infill" means development of vacant or remnant lands passed over by previous development, and that is consistent with zoning.

(32) "Influence area of an interchange" means the area 1320 feet from an interchange ramp terminal measured on the crossroad away from the mainline.

(33) "Interchange" means a system of interconnecting roadways in conjunction with one or more grade separations that provides for the move-

ment of traffic between two or more roadways or highways on different levels.

(34) "Interchange Area Management Plan" means a plan similar to an Access Management Plan or an Access Management Plan for an Interchange developed to plan for and manage grade-separated interchange areas to ensure safe and efficient operation between connecting roadways and to protect the functional integrity, operations, and safety of the influence area of an interchange. Interchange Area Management Plans typically include analysis of the relationships between existing local land uses, zoning and long range plans and the state and local roadway network within a designated study area around an existing or planned interchange, and identify necessary improvements to approach roads and the local street network to support the long-term safety and efficiency of the interchange.

(35) "Intersection" means an area where two or more highways or an approach and a highway join or cross at grade.

(36) "Land Use Action" means an action by a local government or special district concerning the adoption, amendment or application of the statewide planning goals, a comprehensive plan provision, or a land use regulation including zoning or subdivision ordinance.

(37) "Median" means the portion of the roadway separating opposing traffic streams.

(38) "Mitigation Measures" mean conditions, improvements, modifications, and restrictions set forth in OAR 734-051-0145 and required by the Department or initiated by an applicant for approval of a deviation or an application.

(39) "Move in the direction of" means that changes in the approach(es) to a property abutting the highway would bring a site closer to conformance with existing highway standards including where existing approaches to the highway or expressway are combined or eliminated resulting in a net reduction in the number of approaches to the highway or expressway, improvements in spacing of private approaches or public approaches, or improvements to intersection sight distance.

(40) "Peak hour" means the highest one-hour volume observed on an urban roadway during a typical or average week or the 30th highest hourly traffic volume on a rural roadway typically observed during a year.

(41) "Permit to Construct" means a Permit to Construct a State Highway Approach including all attachments, required signatures, conditions and terms, and performance bonds or insurance.

(42) "Permit to Operate" means a Permit to Operate, Maintain and Use a State Highway Approach including all required signatures and attachments, and conditions and terms.

(43) "Permitee" means a person, firm or corporation, or other entity holding a valid Permit to Operate including the owner or lessee of the property abutting the highway or their designated agent.

(44) "Permitted approach" means a legally constructed approach existing under a valid Permit to Operate.

(45) "Planned" means not currently existing but anticipated for the future when referring to items such as a roadway or utility connection shown in a Corridor Plan, or Comprehensive Plan, or Transportation System Plan.

(46) "Private approach" means an approach serving one or more properties and is not a public approach as defined in section (50) of this rule.

(47) "Private road crossing" means a legally constructed, privately owned road designed for use by trucks which are prohibited by law from using state highways, county roads, or other public highways.

(48) "Professional Engineer" means a person registered and holding a valid certificate to practice engineering in the State of Oregon, as provided in ORS 672.002 through 672.325, with expertise in traffic engineering, as provided in OAR 820-040-0030.

(49) "Project Delivery" means the allocation of resources to plan and construct new highways or modify and improve existing highways.

(50) "Public approach" means an approach serving multiple properties, owned and operated by a public entity, and providing connectivity to the local road system.

(51) "Reasonable Access" means the ability to access a property in a manner that meets the criteria under ORS 374.310(3).

(52) "Redevelopment" means the act or process of changing existing development including replacement, remodeling, or reuse of existing structures to accommodate new development that is consistent with current zoning.

(53) "Region Access Management Engineer" means a professional engineer employed by the Department who by training and experience has comprehensive knowledge of the Department's access management rules, policies, and procedures, or as specified in an Intergovernmental Agreement delegating permitting authority as set forth in OAR 734-051-0035(3).

(54) "Region Manager" means the person in charge of one of the Department's Transportation Regions or designated representative.

(55) "Reservation of Access" means a limitation of a common law right of access to a specific location where the Department has acquired access control subject to restrictions that are designated in a deed. A reservation of access may include a use restriction limiting the right of access to a specified use or restriction against a specified use. A use restriction included in a reservation of access does not restrict turning movements nor does the absence of a use restriction allow unrestricted turning movements. A reservation of access affords the right to apply for an approach but does not guarantee approval of an Application for State Highway Approach or the location of an approach.

(56) "Restricted Use Approach" means an approach that is intended to provide vehicular access for a specific use and for a limited volume of traffic. Such uses are determined by the Department and may include emergency services, government, and utility uses. A mitigation required as a part of approach permit approval or a condition on a construction permit does not by itself create a "restricted use approach."

(57) "Right of access" means the right of ingress and egress to the roadway and includes a common law right of access, reservation of access, or grant of access.

(58) "Right of way" means real property or an interest in real property owned by the Department as defined in the 1999 Oregon Highway Plan.

(59) "Rural" means the area outside the urban growth boundary, the area outside a Special Transportation Area in an unincorporated community, or the area outside an Urban Unincorporated Community defined in OAR 660-022-0010(9).

(60) "Safety factors" include the factors identified in OAR 734-051-0080(9).

(61) "Signature" means the signature of the specific individual or an authorized officer of the corporation or partnership and must include the name of the corporation or partnership licensed as set forth in ORS 60.111, and which maintains a registered agent and registered office in this state.

(62) "Spacing Standards" mean Access Management Spacing Standards as set forth in OAR 734-051-0115 and specified in Tables 2, 3, and 4, adopted and made a part of division 51 rules and Access Management Spacing Standards for Approaches in an Interchange Area as set forth in OAR 734-051-0125 and specified in Tables 5, 6, 7, and 8 and Figures 1, 2, 3, and 4, adopted and made a part of Division 51 rules.

(63) "Temporary approach" means an approach that is constructed, maintained, and operated for a specified period of time not exceeding two years, and removed at the end of that period of time.

(64) "Traffic Impact Study" means a report prepared by a professional engineer that analyzes existing and future roadway conditions resulting from the applicant's development.

(65) "Trip" means a one-way vehicular movement. A vehicle entering a property and later exiting that property has made two trips.

(66) "Urban" means the area within the urban growth boundary, within a Special Transportation Area of an unincorporated community, or within an Urban Unincorporated Community defined in OAR 660-022-0010(9). For purposes of these rules, the Region Access Management Engineer may apply the "urban" standards in OAR 734-051-0080 to infill or redevelopment projects in an otherwise rural area on commercial or industrial zoned land where the land has been developed into an urban block pattern including a local street network, and the posted highway speed is at or below 45 miles per hour.

(67) "Vehicle trips per day" means the total of all one-direction vehicle movements with either the origin or destination inside the study site that includes existing, primary, pass by, and diverted linked trips and is calculated in accordance with the procedures contained in the Institute of Traffic Engineers' Trip Generation Report. Adjustments to the standard Institute of Traffic Engineers' rates for mode split may be allowed if calculated in accordance with Transportation Planning Rule and the Institute of Traffic Engineers' Trip Generation Report procedures. Adjustments to the standard Institute of Traffic Engineer's rates for multi-use internal site trips may be allowed if calculated in accordance with the Institute of Traffic Engineers' procedures and if the internal trips do not add vehicle movements to the approaches to the highway.

(68) "Vehicular Access" means access by motorized vehicles to a property from a street, roadway, highway, easement, service road, or alley including singular or joint access.

(69) "Work Day" means Monday through Friday and excludes holidays.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 and Ch. 974, OL 1999
Stats. Implemented: ORS 374.305 to 374.345 & 374.990; Ch. 974, OL 1999; Ch. 371, OL 2003
Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0010; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04

734-051-0045
Change of Use of an Approach

(1) This rule applies to private approaches existing under a valid Permit to Operate and private grandfathered approaches.

(2) A change of use of an approach occurs, and an application must be submitted, when an action or event identified in subsection (a) of this section, results in an effect identified in subsection (b) of this section.

(a) The Department may review an approach at the time of an action such as:

(A) Zoning or plan amendment designation changes;

(B) Construction of new buildings;

(C) Floor space of existing buildings increase;

(D) Division or consolidation of property boundaries;

(E) Changes in the character of traffic using the approach;

(F) Internal site circulation design or inter-parcel circulation changes; or

(G) Reestablishment of a property's use after discontinuance for two years or more.

(b) An application must be submitted when an action in subsection (a) of this section may result in any of the following:

(A) Site traffic volume generation increases by more than 250 average daily trips or 25 peak hour trips (external trip generation for multi-use developments).

(B) Operational problems occur or are anticipated.

(C) The approach does not meet sight distance requirements.

(D) The approach is not consistent with the safety factors set forth in OAR 734-051-0080(9).

(E) Use of the approach by vehicles exceeding 20,000 pound gross vehicle weight increases by 10 vehicles or more per day.

(c) An effect in subsection (b) of this section may be determined by:

(A) Field counts;

(B) Site observation;

(C) Traffic Impact Study;

(D) Field measurement;

(E) Crash history;

(F) Institute of Transportation Engineer Trip Generation Manual; or

(G) Information and studies provided by the local jurisdiction.

(3) The following actions do not constitute a change of use:

(a) Modifications in advertising, landscaping, general maintenance, or aesthetics not affecting internal or external traffic flow or safety; or

(b) Buildout or redevelopment of an approved site plan or multi-phased development within the parameters of a Traffic Impact Study that is less than five years old or where within parameters of the future year analysis of the Traffic Impact Study, whichever is greater, and that is certified by a Professional Engineer.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999
Stats. Implemented: ORS 374.305 to 374.345 and 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003
Hist.: 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0065; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0110

734-051-0070
Application Procedure and Timelines

(1) The Department shall document decisions made under Division 51 rules with written findings and shall provide written notice to applicants:

(a) Written findings shall be provided to the applicant upon request;

(b) Materials submitted by the applicant become the property of the Department;

(c) The Region Manager may waive requirements for information and documentation required from an applicant depending on the nature of the application and on the sufficiency of other information available to the Department for its evaluation of an application;

(d) Where necessary to comply with the permitting criteria under Division 51 rules, approval of an application may be conditioned upon significant changes to a proposed site plan including relocation of buildings, parking, circulation, reduction of intensity of use, or variances from local jurisdictions; and

(e) Approval of an application may require mitigation measures set forth in OAR 734-051-0145.

(2) The Department, applicant, or local government may request a pre-application meeting to discuss the approach application process.

(3) An application is required:

(a) For a new approach to a state highway;

(b) When a change of use occurs as set forth in OAR 734-051-0045;

(c) For a temporary approach to a state highway; or

(d) For a restricted use approach to a state highway.

(4) An application accompanied by a site plan, and the administrative fee as set forth in Table 1, must be submitted for each approach requested. All of the following apply to an application:

(a) The Department shall not accept an application for an approach to a freeway, a freeway ramp, or an expressway ramp, or where an approach would be aligned opposite a freeway or expressway ramp terminal.

(b) The Department shall require written evidence of concurrence by the owner where an applicant is not the property owner.

(c) The Department may refuse to accept an application that is incomplete or contains insufficient information to allow the Department to determine the correct administrative fee, to determine if supplemental documentation is required or otherwise determine that the application may be deemed complete.

(d) All of the following apply to administrative fees and fee adjustments for incorrect charges, refunds, and waivers:

(A) The application, site plan and check for the administrative fee will be returned if the application is not accepted.

(B) The Department may refund 75% of the administrative fee where the Department determines that no right of access exists and the application cannot be deemed complete as set forth in section (5) of this rule.

(C) The administrative fee will be calculated based upon the land uses proposed for the site as early in the application process as is reasonably possible, and the application will not be considered complete until the full amount is received.

(D) The Executive Deputy Director or the Region Manager, not a designee, may waive the administrative fee requirements if a local jurisdiction requests a new approach or modification of an existing approach during project delivery. The reasons for the fee waiver must be documented in writing.

(E) Where the department determines that mitigation measures are required as set forth in OAR 734-051-0145 and those mitigation measures are for the benefit of a local jurisdiction, or where a local government proposes relocation or modification of a public approach to improve safety or spacing, the Executive Deputy Director or the Region Manager, not a designee, may waive the administrative fee requirements. The reasons for the fee waiver must be documented in writing.

(F) Where a development proposes two or more approaches, no administrative fee for an "additional approach" as specified in Table 1, will be added for any shared approach located to serve two or more separate developments when the total number of approaches to the highway does not increase by more than one approach.

(G) An administrative fee is not required for a permit for construction or reconstruction of an approach by the Department or its contractor as part of road improvement, highway or interchange construction, or reconstruction, modernization, or other roadway or interchange project.

(H) An administrative fee is not required for a name change on a Permit to Operate, Maintain and Use an Approach, including issuing an operation permit for a public approach when the applicant is a private entity, when both the original permitee and the proposed new permitee document their concurrence with the change.

(I) Administrative fees are calculated based upon a methodology developed by the Department based upon proposed land uses, and consistent with Table 1.

(J) The Department's decision concerning administrative fees and fee adjustments for incorrect charges, refunds, and waivers is not an appealable decision.

(5) The Department shall determine if an application is deemed complete:

(a) Within 30 days of accepting an application when the full administrative fee has been received and section (6) of this rule does not require supplemental documentation; or

(b) When the full administrative fee and supplemental documentation are received and the Department determines that the supplemental documentation is sufficient to evaluate the application, if section (6) of this rule requires supplemental documentation.

(6) The Department may require supplemental documentation before an application is deemed complete, and the Region Manager:

(a) May conduct an on-site review to determine the need for supplemental documentation before an application is deemed complete. The on-site review area includes both sides of the highway in the vicinity of the proposed approach including:

(A) The site frontage;

(B) All approaches; and

(C) The nearest public intersections within a distance less than the applicable spacing standard distance.

(b) May meet with the applicant to discuss the supplemental documentation including definition and degree of specification;

(c) Shall notify an applicant, within 30 days of accepting an application, of the supplemental documentation necessary for an application to be deemed complete;

(d) Shall notify an applicant, within 30 days of accepting an application, that an application may not be deemed complete where no right of access exists; and

(A) An applicant may apply for an Application for a Grant of Access or Application for an Indenture of Access;

(B) An application for a Grant of Access or Application for an Indenture of Access must be submitted concurrently with an Application for State Highway Approach;

(C) OAR 734-051-0295 through 734-051-0335 govern modification of access rights:

(i) To state highways and other public roads from property where the Department has access control; and

(ii) To state highways from property owned or controlled by cities or counties where the Department has access control where a public road connection is requested.

(D) Submittal of an Application for a Grant of Access or Application for an Indenture of Access stays the 120-day timeline in section (8) of this rule;

(E) The timeline for processing an Application for a Grant of Access and completing the appraisals and property transactions may be up to 365 days depending on the complexity of the request; and

(F) The timeline for processing an Application for an Indenture of Access may be up to 60 days depending on the complexity of the request.

(e) May require a Traffic Impact Study for:

(A) Proposed developments generating vehicle trips that equal or exceed 600 daily trips or 100 hourly trips; or

(B) Proposed zone changes or comprehensive plan changes;

(f) Shall require a Traffic Impact Study for proposed developments or land use actions where the on-site review indicates that operational or safety problems exist or are anticipated; and

(g) Shall notify the applicant that required supplemental documentation, including an application for a grant of access or indenture of access, must be submitted within 60 days of the date of notice of supplemental documentation or the application expires.

(7) All of the following apply when a Traffic Impact Study is required:

(a) A Professional Engineer employed by the Department shall determine the scope of the study and shall review and comment on the study.

(b) Future year analyses apply to both public and private approaches and include year of each phase opening and future year beyond build out, based on vehicle trips per day and type of land use action, but not greater than the year of planning horizon for transportation system plans or 15 years, whichever is greater.

(c) A Professional Engineer must prepare the study in accordance with methods and input parameters approved by the Department.

(d) The scope and detail of the study must be sufficient to allow the Department to evaluate the impact of the proposal and the need for roadway capacity, operational, and safety improvements resulting from the approach.

(e) The study must identify the data and the application of data in the analysis.

(f) The study may be sufficient to satisfy the requirements of this rule without being adequate to satisfy local government requirements or the Transportation Planning Rule.

(8) When necessary to comply with the permitting criteria of division 51 Rules the Department shall evaluate an application that is deemed complete and shall approve or deny that application within 120 days including a final order as set forth in OAR 734-051-0355:

(a) The final 60 days of the 120 days are reserved for the Contested Case Hearing process set forth in OAR 734-051-0355;

(b) The Department shall use division 51 and ORS Chapter 374 and may use other applicable statutes, administrative rules, or manuals to evaluate and act on an application;

(c) If an application is approved, the Department shall issue a Construction Permit or a Permit to Operate as set forth in sections (10) through (13) of this rule; and

(d) Denial of an application is an appealable decision.

(9) If approval of an approach requires a deviation from access management spacing standards or access management spacing standards for approaches in an interchange area, a Traffic Impact Study may be required and the Department may approve or deny the deviation as set forth in OAR 734-051-0135:

(a) Approval of a deviation may be conditioned upon changes to a proposed site plan including relocation of buildings, changes to parking or circulation, reduction of the intensity of use, or variances from local jurisdiction regulations; and

(b) Denial of a deviation from spacing standards is an appealable decision.

(10) If a land use action is pending, including an appeal of a final land use decision or a limited land use decision, for a property for which an application has been submitted, the application may be accepted and processed:

(a) Approval will be conditioned on the Department receiving notice of approval of the land use action shown on the application.

(b) A Construction Permit may be issued while the local land use action is pending. A deposit may be required, to be determined in the manner used for a Temporary Approach in OAR 734-051-0095(2), to ensure that the approach will be removed if the land use is not approved.

(c) A Permit to Operate shall not be issued until the applicant provides the Department with written proof of final land use decision.

(11) To obtain a Construction Permit an applicant must submit construction drawings and plans within 60 days of notice of approval of an application when use of the Department's standard drawings is not appropriate. The Region Manager determines the acceptability of submitted construction plans. If plans are not submitted within the 60 days and no request for extension is received within that time, the approval will be void.

(12) The Department shall issue a Construction Permit as set forth in OAR 734-051-0175 upon approval of an application and approval of construction drawings and plans where required; and

(a) An approach approved by a Construction Permit must be constructed as required by OAR 734-051-0175 through 734-051-0245; and

(b) An applicant must have insurance, bonds, and deposits in place before construction begins and must provide 30 days written notice of cancellation or intent not to renew insurance coverage as set forth in OAR 734-051-0215.

(13) The Department shall issue a Permit to Operate as set forth in OAR 734-051-0245.

(14) An applicant may request a Region Review of an appealable decision within 21 days of notice of that decision as set forth in OAR 734-051-0345:

(a) An applicant may request a collaborative discussion within the Region Review process; and

(b) The Region Review process stays the 120-day timeline for approval or denial of an application.

(c) An applicant may request a Contested Case Hearing following a Region Review and the hearing will be on the original decision.

(15) An applicant may request a Contested Case Hearing of an appealable decision within 21 days of notice of that decision, or within 21 days of notice of a Region Review decision, as set forth in OAR 734-051-0355.

(16) Division 51 timelines may be extended if the applicant and the Department agree in writing before the applicable deadline, as specified in these rules. Any agreement to extend a timeline shall include a new deadline date and shall state the reason for the extension. Applications for which an extension of time has been issued will expire on the deadline date specified in the extension letter if no new extension has been agreed to and the activities for which the deadline was extended have not been completed.

(17) An application will expire after 120 days of inactivity on the part of the applicant if the Department sends a reminder letter to notify the applicant that 90 days have passed with no activity, and advising that the application will expire in 30 days if the application continues to be inactive. Submittal of any information after the date of expiration will be processed as a new application, requiring submittal of a new application and fee.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; 2HD 13-1981, f. & ef. 10-2-81; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0015; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0090 & 734-051-0100

734-051-0080
Criteria for Approving an Application for an Approach

(1) The following apply to all applications:

(a) Existence of a recorded easement does not by itself establish a right of access and does not guarantee the approval of an application or the location of an approach.

(b) If an application is for a double-frontage property the approach must be located on the lower classification highway except where the Region Access Management Engineer determines that an approach to the higher classification highway would better meet the approval criteria in sections (2) through (11) of this rule.

(c) Where a development includes multiple parcels, the development is evaluated in its entirety, regardless of the number of individual parcels or ownership contained within the development, and applications will not be accepted for individual parcels or ownership.

(2) For a private approach with no alternate access to the property the Region Manager shall approve an application if the applicant demonstrates that section (10) of this rule is met.

(3) For a private approach in a rural area and on a statewide, regional, or district highway or an expressway or within the influence area of an expressway interchange or freeway interchange, with alternate access to the property, the Region Manager shall approve an application if the applicant demonstrates that:

(a) Either:

(A) The alternate access cannot be made reasonable as set forth in section (8) of this rule; or

(B) The proposal is for infill or redevelopment and approval of the proposal will result in a net reduction of approaches on the highway or the net result improves safety for any remaining approaches; and

(b) Section (10) of this rule is met.

(4) For a private approach in an urban area and on a statewide, regional, or district highway or within the influence area of an expressway interchange or freeway interchange, with alternate access to the property, the Region Manager shall approve an application, even where the Department has evidence that the alternate access is reasonable, if the applicant provides substantial evidence that demonstrates that:

(a) The alternate access is not reasonable as set forth in section (8) of this rule; and

(b) Section (10) of this rule is met.

(5) For a private approach in an urban area and on a statewide, regional, or district highway or within the influence area of an expressway interchange or freeway interchange, with alternate access to the property, the Region Manager shall approve an application if the applicant demonstrates that:

(a) The alternate access is reasonable as set forth in section (8) of this rule; and

(b) Section (10) and section (11) of this rule are met.

(6) For a public or private approach in an urban area and on an expressway, with alternate access to the property, the Region Manager shall approve an application if the applicant demonstrates that:

(a) The alternate access cannot be made reasonable as set forth in section (8) of this rule, and section (10) and section (11) of this rule are met; or

(b) The approach provides an immediate and long-term benefit to the state highway system, as set forth in OAR 734-051-0085, regardless of any required safety or operations mitigation measures, and section (10) of this rule is met.

(7) For a public approach on a statewide, regional, or district highway or an expressway the Region Manager shall approve an application if:

(a) The applicant demonstrates that the approach enhances connectivity consistent with, and is included in, the jurisdiction's adopted comprehensive plan, corridor plan, or transportation system plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055;

(b) The applicant demonstrates that section (10) and subsections (11)(a) and (b) of this rule are met; and

(c) The Permit to Operate is issued to the local jurisdiction.

(8) Which approval criteria will be applied to an application (sections (2) through (7) of this rule) depends in part upon whether alternate access to the site is or can be made reasonable, which is determined based upon the following:

(a) The Department determines that alternate access to the property is sufficient to allow the authorized uses for the property identified in the acknowledged local comprehensive plan.

(b) The Department determines that the type, number, size and location of approaches are adequate to serve the volume and type of traffic reasonably anticipated to enter and exit the property, based on the planned uses for the property.

(c) The Department may require mitigation measures are set forth in OAR 734-051-0145:

(A) Including where the applicant or the local jurisdiction commits proportional shares for the cost of removal or mitigation of geographic, safety, or physical restrictions on the property or local street network; and

(B) Neither a lack of commitment by a local government to share the cost of mitigation nor the cost of mitigation alone is determinative in evaluating whether the access is or could be made reasonable.

(d) Consideration of factors including:

(A) Legal restrictions;

(B) Geographic restrictions;

(C) Historical or cultural resources;

(D) Safety factors; and

(E) Physical considerations such as planned streets, roadway width, and weight and size restrictions.

(e) Where a significant difference exists between an existing and planned local road network, a phased method addressing access may be considered:

(A) Where a planned public street or road network cannot be provided at the time of development, an application may be approved with conditions requiring connection when such connection becomes available;

(B) The approach permit may be revoked and the approach removed, or the approach permit may be modified and mitigation required when the planned street or road network becomes available; and

(C) An agreement with the local government regarding the planned street or road network may be an intergovernmental agreement.

(9) For purposes of division 51, safety factors include:

(a) Roadway character;

(b) Traffic character;

(c) Geometric character;

(d) Environmental character; and

(e) Operational character.

(10) As required by sections (2) through (7) of this rule an applicant must demonstrate, consistent with Division 51 rules, that:

(a) The approach is consistent with safety factors in section (9) of this rule;

(b) Spacing standards are met or a deviation is approved as set forth in OAR 734-051-0135; and

(c) The effect of the approach meets traffic operations standards, signals, or signal systems standards in OAR 734-020-0400 through 734-020-0500 and 734-051-0115 and 734-051-0125.

(11) As required by sections (5) through (7) of this rule the Department may require an applicant to demonstrate that:

(a) Highway mobility standards are met on state highways;

(b) The approach is consistent with an Access Mitigation Proposal, Access Management Strategy, or Access Management Plan for the segment of highway abutting the property, if applicable;

(c) The site plan shows that the site circulation does not require vehicles, once on site, to reenter the highway to access parking or other portions of the development; and

(d) More than one approach to the highway is necessary to accommodate traffic reasonably anticipated to the site if multiple approaches are requested.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 to 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04

734-051-0085
Benefit to the State Highway System

(1) For the purposes of this rule a benefit to the state highway system:

(a) Will be found only where an applicant demonstrates that an approach will provide an immediate and long-term benefit to the state highway system;

(b) Is evaluated for no less than 20 years;

(c) For an Application for a Grant of Access, must exceed any mitigation of impacts related to the development regarding safety and operations; and

(d) Is a determination requiring the professional judgment of a professional engineer employed by the Department.

(2) For an Application for State Highway Approach or for an Application for a Grant of Access the Department may determine a benefit to the state highway system exists if the requirements of subsections (a) and (b) of this section are met:

(a) The applicant demonstrates better management of access as a result of either controlling or combining approach locations, or eliminating existing or planned approaches by improving:

(A) Access management spacing standards;

(B) Public approach spacing; or

(C) Intersection sight distance.

(b) The applicant demonstrates with no degradation of the criteria in paragraphs (A) through (E) of this subsection, that any of the following occur:

(A) Highway mobility standards improve.

(B) Safety improves on the section of highway where the approach is located.

(C) Safety problems in the general vicinity are eliminated because of closure of an existing approach.

(D) Operations in the general vicinity improve as a result of connectivity, traffic diversions, or other traffic engineering techniques.

(E) The applicant demonstrates that off-system connectivity improves and reduces demand to the state highway system without creating operational or safety problems elsewhere:

(i) Off-system connectivity must occur immediately; or

(ii) Off-system connectivity must be committed for construction as evidenced by the local government's adopted Capital Improvement Plan.

(F) The Department determines that other circumstances result in a benefit to the state highway system.

(3) For an Application for State Highway Approach, for a private or public approach in an urban area and to an expressway, the Department may presume that a benefit to the state highway system exists if the requirements of subsection (a) of this section are met, or the requirements of subsections (b) and (c) of this section are met:

(a) Where a change of use occurs, approaches to the expressway are combined or eliminated resulting in a net reduction in the number of approaches to the expressway, and the applicant demonstrates an improvement of:

(A) Access management spacing standards;

(B) Public road intersection spacing; or

(C) Intersection sight distance.

(b) The Department determines that an improvement in safety occurs on the section of expressway where an approach is requested and both paragraphs (A) and (B) of this subsection are met:

(A) Only one approach to the expressway is requested and:

(i) Where a new approach is requested, no approach to the site currently exists; or

(ii) Where a change of use occurs, only one private approach to the site currently exists; and

(B) An improvement in safety occurs on the expressway primarily and on other state highways secondarily and includes:

(i) A decrease in the number of existing conflict points;

(ii) Elimination of existing left turns;

(iii) Elimination of an existing overlap of left turn movements;

(iv) The addition of a left turn lane where existing conditions meet the Department's installation criteria; or

(v) Provision of adequate sight distance at the alternate approach or the subject approach where existing sight distance is deficient.

(c) The Region Access Management Engineer determines that the approach results in a benefit to the state highway system due to other circumstances.

(4) A benefit to the state highway system is determined by:

(a) The Region Access Management Engineer when an Application for State Highway Approach is submitted for a private approach in an urban area and on an expressway; or

(b) The Department's Technical Services Manager when an Application for a Grant of Access is submitted.

Stat. Auth.: ORS 184.616. 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 347.345 & 374.990; Ch. 974, OL 1999; Ch. 371, OL 2003

Hist.: HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04

734-051-0095

Temporary Approaches

(1) The Region Manager may approve an application for a temporary approach where:

(a) The approach is consistent with safety factors;

(b) Conditions such as signing or flagging are identified on the Construction Permit and the Permit to Operate and are enforced during construction and operation; and

(c) A closure date is specified on the Permit to Operate.

(2) A deposit of not less than $1000 per temporary approach is required prior to issuance of a Construction Permit and a Permit to Operate a Temporary Approach to guarantee its removal by the applicant:

(a) The appropriate District office will determine the amount of the deposit;

(b) If the Department incurs no expense in the removal of the temporary approach, the entire deposit is refunded to the applicant; and

(c) If the Department incurs any expenses in the removal of the approach, the applicant will be billed for the amount in excess of the amount deposited or refunded the difference if the expense is less than the amount deposited.

(3) The Region Manager may extend the time period for a temporary approach where extenuating circumstances beyond the control of the applicant or permitee exist.

(4) Existence of a recorded easement does not by itself establish a right of access and does not guarantee the approval of an application for a temporary approach or the location of a temporary approach.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, O L 1999, Ch. 371, OL 2003

Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0060; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0120

734-051-0105

Restricted Use Approaches

(1) The Region Manager may approve an application for a restricted use approach where the approach is consistent with safety factors.

(2) The Department shall require restricted use approaches:

(a) To be restricted from general use by physical means such as a gate or other design approved by the Department; and

(b) May require special design considerations such as reinforced sidewalks, curb design options, and landscaping considerations.

(3) The Region Manager may require mitigation measures to be incorporated into a Construction Permit and a Permit to Operate a Restricted Use Approach.

(4) Existence of a recorded easement does not by itself establish a right of access and does not guarantee the approval of an application for a restricted use approach or the location of a restricted use approach.

Stat. Auth.: ORS 184.616, 814.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 to 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04

734-051-0115

Access Management Spacing Standards for Approaches

(1) Access management spacing standards for approaches to state highways:

(a) Are based on the classification of the highway and highway segment designation, type of area, and posted speed;

(b) Apply to properties abutting state highways, highway or interchange construction and modernization projects, and planning processes involving state highways or other projects determined by the Region Manager; and

(c) Do not apply to approaches in existence prior to April 1, 2000 except where any of the following occur:

(A) These standards will apply to private approaches at the time of a change of use.

(B) If infill development or redevelopment occurs, spacing and safety factors will improve by moving in the direction of the access management spacing standards, with the goal of meeting or improving compliance with the access management spacing standards.

(C) For a highway or interchange construction or modernization project or other roadway or interchange project determined by the Region Manager, the project will improve spacing and safety factors by moving in the direction of the access management spacing standards, with the goal of

meeting or improving compliance with the access management spacing standards.

(2) Spacing standards in Tables 2, 3, and 4, adopted and made a part of this rule, identify the spacing standards.

(3) An applicant may provide evidence to support a determination that an approach is located in a commercially zoned area that has the characteristics established in the Oregon Highway Plan for a Special Transportation Area (STA) or for an Urban Business Area (UBA), in which case the spacing standards for such segment designation may be applied to the application. A decision by local government or by the Oregon Transportation Commission to either designate or not designate an STA and/or UBA makes this provision unavailable. This provision may not be applied where a management plan would be required for an STA or a UBA under the provisions of the Oregon Highway Plan

(4) Deviations must meet the criteria in OAR 734-051-0135.

(5) Location of traffic signals on state highways must meet the criteria of OAR 734-020-0400 through 734-020-0500.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04 cert. ef. 3-1-04, Renumbered from 734-051-0190

734-051-0125

Access Management Spacing Standards for Approaches in an Interchange Area

(1) Access management spacing standards for approaches in an interchange area:

(a) Are based on classification of highway and highway segment designation, type of area, and posted speed;

(b) Apply to properties abutting state highways, highway or interchange construction and modernization projects, planning processes involving state highways, or other projects determined by the Region Manager; and

(c) Do not apply to approaches in existence prior to April 1, 2000 except where any of the following occur:

(A) These standards will apply to private approaches at the time of a change of use.

(B) If infill development or redevelopment occurs, spacing and safety factors will improve by moving in the direction of the access management spacing standards, with the goal of meeting or improving compliance with the access management spacing standards.

(C) For a highway or interchange construction or modernization project or other roadway or interchange project determined by the Region Manager, the project will improve spacing and safety factors by moving in the direction of the access management spacing standards, with the goal of meeting or improving compliance with the access management spacing standards.

(2) Spacing standards in Tables 5, 6, 7, and 8 and Figures 1, 2, 3, and 4, adopted and made a part of this rule, identify the spacing standards for approaches in an interchange area.

(3) When the Department approves an application:

(a) Access management spacing standards for approaches in an interchange area must be met or approaches must be combined or eliminated resulting in a net reduction of approaches to the state highway and an improvement of existing interchange management areas spacing standards; and

(b) The approach must be consistent with any applicable access management plan for an interchange.

(4) Deviations must meet the criteria in OAR 734-051-0135 .

(5) Location of traffic signals within an interchange management area must meet the criteria of OAR 734-020-0400 through 734-020-0500.

(6) The Department should acquire access control on crossroads around interchanges for a distance of 1320 feet. In some cases it may be appropriate to acquire access control beyond 1320 feet.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0200

734-051-0135

Deviations from Access Management Spacing Standards

(1) A deviation will be considered when an approach does not meet spacing standards and the approach is consistent with safety factors in OAR 734-051-0080(9). The information necessary to support a deviation must be submitted with an application or with the supplemental documentation as set forth in OAR 734-051-0070(5) and (6).

(2) For a private approach with no reasonable alternate access to the property, as identified in OAR 734-051-0080(2), spacing standards are met if property frontage allows or a deviation is approved as set forth in this section. The Region Manager shall approve a deviation for a property with no reasonable alternate access if the approach is located:

(a) To maximize the spacing between adjacent approaches; or

(b) At a different location if the maximized approach location:

(A) Causes safety or operational problems; or

(B) Would be in conflict with a significant natural or historic feature including trees and unique vegetation, a bridge, waterway, park, archaeological area, or cemetery.

(3) The Region Access Management Engineer shall approve a deviation if:

(a) Adherence to spacing standards creates safety or traffic operation problems;

(b) The applicant provides a joint approach that serves two or more properties and results in a net reduction of approaches to the highway;

(c) The applicant demonstrates that existing development patterns or land holdings make joint use approaches impossible;

(d) Adherence to spacing standards will cause the approach to conflict with a significant natural or historic feature including trees and unique vegetation, a bridge, waterway, park, archaeological area, or cemetery;

(e) The highway segment functions as a service road;

(f) On a couplet with directional traffic separated by a city block or more, the request is for an approach at mid-block with no other existing approaches in the block or the proposal consolidates existing approaches at mid-block; or

(g) Based on the Region Access Management Engineer's determination that:

(A) Safety factors and spacing significantly improve as a result of the approach; and

(B) Approval does not compromise the intent of these rules as set forth in OAR 734-051-0020.

(4) When a deviation is considered, as set forth in section (1) of this rule, and the application results from infill or redevelopment:

(a) The Region Access Management Engineer may waive the requirements for a Traffic Impact Study and may propose an alternative solution where:

(A) The requirements of either section (2) or section (3) of this rule are met; or

(B) Safety factors and spacing improve and approaches are removed or combined resulting in a net reduction of approaches to the highway; and

(b) Applicant may accept the proposed alternative solution or may choose to proceed through the standard application review process.

(5) The Region Access Management Engineer shall require any deviation for an approach located in an interchange access management area, as defined in the Oregon Highway Plan, to be evaluated over a 20-year horizon from the date of application and may approve a deviation for an approach located in an interchange access management area if:

(a) A condition of approval, included in the Permit to Operate, is removal of the approach when reasonable alternate access becomes available;

(b) The approach is consistent with an access management plan for an interchange that includes plans to combine or remove approaches resulting in a net reduction of approaches to the highway;

(c) The applicant provides a joint approach that serves two or more properties and results in a net reduction of approaches to the highway; or

(d) The applicant demonstrates that existing development patterns or land holdings make utilization of a joint approach impracticable.

(6) The Region Access Management Engineer may approve a deviation for a public approach that is identified in a local comprehensive plan and provides access to a public roadway if:

(a) Existing public approaches are combined or removed; or

(b) Adherence to the spacing standards will cause the approach to conflict with a significant natural or historic feature including trees and unique vegetation, a bridge, waterway, park, archaeological area, or cemetery.

(7) The Region Access Management Engineer may require that an access management plan, corridor plan, transportation system plan, or comprehensive plan identifies measures to reduce the number of approaches to the highway to approve a deviation for a public approach.

(8) The Region Access Management Engineer shall not approve a deviation for an approach if any of the following apply:

(a) Spacing standards can be met even though adherence to spacing standards results in higher site development costs.

(b) The deviation results from a self-created hardship including:

(A) Conditions created by the proposed site plan, building footprint or location, on-site parking, or circulation; or

(B) Conditions created by lease agreements or other voluntary legal obligations.

(c) The deviation creates a significant safety or traffic operation problem.

(9) The Region Access Management Engineer shall not approve a deviation for an approach in an interchange access management area where reasonable alternate access is available and the approach would increase the number of approaches to the highway.

(10) Where section (2), (3), (4), (5) or (6) of this rule cannot be met, the Region Manager, not a designee, may approve a deviation where:

(a) The approach is consistent with safety factors; and

(b) The Region Manager identifies and documents conditions or circumstances unique to the site or the area that support the development.

(11) Approval of a deviation may be conditioned upon mitigation measures set forth in OAR 734-051-0145.

(12) Denial of a deviation is an appealable decision.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0320

734-051-0145

Mitigation Measures

(1) The Department may require mitigation measures on the state highway or the subject property to comply or improve compliance with the division 51 rules for continued operation of an existing approach or construction of a new approach.

(2) Unless otherwise set forth in division 51 rules, the cost of mitigation measures is the responsibility of the applicant, permitee, or property owner as set forth in OAR 734-051-0205.

(3) Mitigation measures may include:

(a) Modifications to an approach;

(b) Modifications of on-site storage of queued vehicles;

(c) Installation of left turn or right turn channelization or deceleration lanes;

(d) Modifications to left turn or right turn channelization or deceleration lanes;

(e) Modifications required to maintain intersection sight distance;

(f) Modification or installation of traffic signals or other traffic control devices;

(g) Modification of the highway;

(h) Modification or installation of curbing;

(i) Consolidation of existing approaches or provisions for joint use accesses;

(j) Installation of raised medians;

(k) Restriction of turn movements for circumstances including:

(A) The proximity of existing approaches or offset of opposing approaches;

(B) Approaches within an Interchange Management Area;

(C) Approaches along an Expressway;

(D) Areas of insufficient decision sight distance for speed;

(E) The proximity of railroad grade crossings;

(F) Approaches with a crash history involving turning movements;

(G) The functional area of an intersection; and

(H) Areas where safety or traffic operation problems exist.

(l) Installations of sidewalks, bicycle lanes, or transit turnouts;

(m) Development of reasonable alternate access; and

(n) Modifications of local streets or roads along the frontage of the site.

(4) Mitigation measures are directly related to the impacts of the particular approach on the highway and the scale of the mitigation measures will be directly proportional to those impacts, as follows:

(a) Where safety standards can be met by mitigation measures located entirely within the property controlled by the applicant or within existing state right of way, that will be the preferred means of mitigation.

(b) Where safety standards cannot be met with measures located entirely within the property controlled by the applicant or within existing state right of way, ODOT will make an effort to participate in negotiations between the applicant and other affected property owners or assist the applicant to take necessary actions.

(c) When cumulative effects of existing and planned development create a situation where approval of an application would require mitigation measures that are not directly proportional to the impacts of the proposed approach, the Region Manager may allow mitigation measures to mitigate impacts as of the day of opening and defer mitigation of future impacts to ODOT project development provided the applicant conveys any necessary right of way to ODOT prior to development of the subject approach.

(5) Mitigation to an alternate access may be more significant where the property fronts a higher classification of highway than where the property fronts a lower classification of highway.

(6) An applicant may propose an Access Mitigation Proposal or an Access Management Plan to be implemented by the applicant or the local jurisdiction.

(7) The Department will work with the local jurisdiction and the applicant to establish mitigation measures and alternative solutions including:

(a) Changes to on-site circulation;

(b) On-site improvements; and

(c) Modifications to the local street network.

(8) Where mitigation measures include traffic controls:

(a) The applicant bears the cost of the controls and constructs required traffic controls within a timeframe identified by the Department or reimburses the Department for the cost of designing, constructing, or installing traffic controls; and

(b) An applicant that is a lessee must provide evidence of compliance with required traffic controls and must identify the party responsible for construction or installation of traffic controls during and after the effective period of the lease.

(9) Traffic signals are approved in the following priority:

(a) Traffic signals for public approaches.

(b) Private approaches identified in a Transportation System Plan to become public.

(c) Private approaches.

(10) Traffic signals are approved with the following requirements:

(a) A signalized private approach must meet spacing standards for signalization relative to all planned future signalized public road intersections; and

(b) The effect of the private approach must meet traffic operations standards, signals, or signal systems standards in OAR 734-020-0400 through 734-020-0500 and 734-051-0115 and 734-051-0125.

(11) All highway improvements within the right of way resulting from mitigation constructed by the permitee, and inspected and accepted by the Department, become the property of the Department.

(12) Approval of an application with mitigation measures is an appealable decision.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0210

734-051-0155

Access Management Plans, Access Management Plans for Interchanges, and Interchange Area Management Plans

(1) The Department encourages the development of Access Management Plans, Access Management Plans for Interchanges, and Interchange Area Management Plans to maintain highway performance and improve safety by improving system efficiency and management before adding capacity consistent with the 1999 Oregon Highway Plan.

(2) Access Management Plans and Access Management Plans for Interchanges are developed for a designated section of highway with priority placed on facilities with high volumes or providing important statewide or regional connectivity where:

(a) Existing developments do not meet spacing standards;

(b) Existing development patterns, land ownership patterns, and land use plans are likely to result in a need for deviations; or

(c) An access management plan would preserve or enhance the safe and efficient operation of a state highway.

(3) Access Management Plans and Access Management Plans for Interchanges may be developed:

(a) By the Department;

(b) By local jurisdictions; or

(c) By consultants.

(4) Access Management Plans and Access Management Plans for Interchanges comply with all of the following:

(a) Are prepared for a logical segment of the state highway and include sufficient area to address highway operation and safety issues and development of adjoining properties including local access and circulation.

(b) Describe the roadway network, right-of-way, access control, and land parcels in the analysis area.

(c) Are developed in coordination with local governments and property owners in the affected area.

(d) Are consistent with any applicable adopted Transportation System Plan, Local Comprehensive Plan, Corridor Plan, or Special Transportation Area or Urban Business Area designation, or amendments to the Transportation System Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055.

(e) Are consistent with the 1999 Oregon Highway Plan.

(f) Contain short, medium, and long-range actions to improve operations and safety and preserve the functional integrity of the highway system.

(g) Consider whether improvements to local street networks are feasible.

(h) Promote safe and efficient operation of the state highway consistent with the highway classification and the highway segment designation.

(i) Consider the use of the adjoining property consistent with the comprehensive plan designation and zoning of the area.

(j) Provide a comprehensive, area-wide solution for local access and circulation that minimizes use of the state highway for local access and circulation.

(k) Are approved by the Department through an intergovernmental agreement and adopted by the local government, and adopted into a Transportation System Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055.

(l) Are used for evaluation of development proposals.

(m) May be used in conjunction with mitigation measures.

(5) The Department encourages the development of Interchange Area Management Plans to plan for and manage grade-separated interchange areas to ensure safe and efficient operation between connecting roadways:

(a) Interchange Area Management Plans are developed by the Department and local governmental agencies to protect the function of interchanges by maximizing the capacity of the interchanges for safe movement from the mainline facility, to provide safe and efficient operations between connecting roadways, and to minimize the need for major improvements of existing interchanges;

(b) The Department will work with local governments to prioritize the development of Interchange Area Management Plans to maximize the operational life and preserve and improve safety of existing interchanges not scheduled for significant improvements; and

(c) Priority should be placed on those facilities on the Interstate system with cross roads carrying high volumes or providing important statewide or regional connectivity.

(6) Interchange Area Management Plans are required for new interchanges and should be developed for significant modifications to existing interchanges consistent with the following:

(a) Should be developed no later than the time an interchange is designed or is being redesigned;

(b) Should identify opportunities to improve operations and safety in conjunction with roadway projects and property development or redevelopment and adopt strategies and development standards to capture those opportunities;

(c) Should include short, medium, and long-range actions to improve operations and safety in the interchange area;

(d) Should consider current and future traffic volumes and flows, roadway geometry, traffic control devices, current and planned land uses and zoning, and the location of all current and planned approaches;

(e) Should provide adequate assurance of the safe operation of the facility through the design traffic forecast period, typically 20 years;

(f) Should consider existing and proposed uses of the all property in the interchange area consistent with its comprehensive plan designations and zoning;

(g) Are consistent with any adopted Transportation System Plan, Corridor Plan, Local Comprehensive Plan, or Special Transportation Area or Urban Business Area designation, or amendments to the Transportation System Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055;

(h) Are consistent with the 1999 Oregon Highway Plan; and

(i) Are approved by the Department through an intergovernmental agreement and adopted by the local government, and adopted into a Transportation System Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 to 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0360

734-051-0165
Design of Approaches

(1) Approach design must conform to standards in the 2002 Oregon Highway Design Manual and allow movement to and from the highway of vehicles reasonably expected to utilize the approach without undue conflict with other traffic.

(2) Design of an approach may require mitigation measures as set forth in OAR 734-051-0145.

(3) No person may place curbs, posts, signs, or other structures on the highway right of way without written approval of the Region Manager.

(4) An applicant is responsible for the cost of accommodating drainage from the property.

(5) Approaches that are private road crossings must be constructed by grade separation except where the Technical Services Manager determines that grade separation is not economically feasible. Where no grade separation is required, the applicant shall install signing, signalization, or other traffic safety devices the Technical Services Manager determines necessary:

(a) The Department may construct the approach and additional facilities in accordance with the plans and specifications approved by the Department; or

(b) The applicant may be required to install the approach and additional facilities, other than signalization, in accordance with plans and specifications approved by the Region Manager, where installation can be completed adequately and safely.

Stat. Auth.: ORS 184.616, 184.619, 374.305, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch.371, OL 2003

Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0035; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0260

734-051-0175
Issuance of Construction Permits

(1) The Region Manager shall issue a Construction Permit when construction plans, if required, and all other required documents are received and approved.

(2) Receipt of the Construction Permit by the applicant constitutes acceptance of the special provisions, mitigation measures, conditions, or agreements, consistent with and identified and approved through the application process, unless the applicant provides written notification to the Department that the special provisions, mitigation measures, conditions, or agreements are not accepted within 21 days of the date of mailing Construction Permit.

(3) If the applicant does not accept the special provisions, mitigation measures, conditions, or agreements the Construction Permit will be void.

(4) The applicant must provide the Department with proof of liability insurance and bond or deposit in lieu of bond as required by OAR 734-051-0215 within 60 days from the date of transmittal or the Construction Permit and approval of the application are void.

(5) No work on highway right of way may begin until an applicant obtains a valid Construction Permit, approved and signed by the Region Manager.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0230

734-051-0185
Construction of Approaches

(1) An applicant must notify the Region Manager at least two work days prior to beginning construction.

(2) Construction must conform to the terms of the Construction Permit including any special provisions, mitigation measures, conditions, or agreements, and the applicant must notify the Region Manager when construction is complete.

(3) Upon inspection of the approach the Department shall notify the applicant if construction deficiencies exist:

(a) The applicant must correct all deficiencies within 60 days of notification that deficiencies exist and notify the Region Manager; and

(b) The Region Manager shall re-inspect the approach.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0040; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0250

734-051-0195

Effective Period of Construction Permits

(1) A Construction Permit is effective for the time period specified on the permit. The Region Manager shall extend the time period of a Construction Permit for good cause shown.

(2) If an applicant fails to comply with the terms and conditions of the Construction Permit the Department may, at the applicant's expense:

(a) Reconstruct or repair the approach; or

(b) Cancel the Construction Permit and remove the approach.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0240

734-051-0205

Allocation of Costs for Construction and Maintenance of Approaches

(1) Except as otherwise provided in the Division 51 rules, the applicant or permitee is responsible for the cost of mitigation measures and the cost of construction of an approach including the cost of materials, labor, signing, signals, structures, equipment, traffic channelization, and other permit requirements.

(2) The Department may be responsible for the cost of mitigation measures and the cost of construction of an approach where the costs are a part of the terms and conditions of a right of way acquisition obligation or other contractual agreement.

(3) The Department is responsible for the cost of removal or relocation of a permitted or grandfathered approach during project delivery unless the removal or relocation is at the request of a permitee or owner of a grandfathered approach.

(4) The applicant, permitee, or owner of a grandfathered approach is responsible for the cost of maintenance of an approach from the outside edge of the highway pavement, shoulder, or curb-line to the right of way line, and any portion of the approach on the applicant's property required to be maintained as part of the permit.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Chapter 371, OL 2003

Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0020; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0270

734-051-0215

Liability and Control for Construction and Maintenance, Repair, Operation and Use of Approaches

(1) An applicant or permitee assumes responsibility for damage or injury to any person or property resulting from the construction, maintenance, repair, operation, or use of an approach for which a Construction Permit or a Permit to Operate is issued and where the applicant may be legally liable.

(2) An applicant or permitee indemnifies and holds harmless the State of Oregon, the Commission, the Department, and all officers, employees or agents of the Department against damages, claims, demands, actions, causes of action, costs, and expenses of whatsoever nature which may be sustained by reasons of the acts, conduct, or operation of the applicant, his agents, or employees in connection with the construction, maintenance, repair, operation, or use of an approach.

(3) Construction of an approach may not begin until the applicant provides the Department with evidence of insurance in the following minimum amounts:

(a) $50,000 for property damage resulting from any single occurrence, or $500,000 combined single limit; and

(b) $200,000 for the death or injury of any person, subject to a limit of $500,000 for any single occurrence.

(4) Insurance policies must include as named as insured the State of Oregon, the Commission, and the Department, its officers, agents and employees, except as to claims against the applicant, for personal injury to any members of the Commission or the Department and its officers, agents, and employees or damage to any of its or their property.

(5) Construction of an approach may not begin until a copy of the insurance policy or a certificate showing evidence of insurance is filed with the Department.

(6) An applicant or permitee shall provide 30 days written notice to the Department of intent to cancel or intent not to renew insurance coverage. Failure to comply with notice provisions does not affect coverage provided to the State of Oregon, the Commission, or the Department, its officers, agents and employees.

(7) If the highway surface or highway facilities are damaged by the applicant or the applicant's contractor, the applicant must replace or restore the highway or highway facilities to a condition satisfactory to the Department.

(8) The applicant or permitee must furnish, in an amount specified by the Region Manager and for the time period necessary to install the approach, a cash deposit or a bond issued by a surety company licensed to do business in the State of Oregon to ensure that any damage to the highway has been corrected to the Department's satisfaction; and no construction is performed until a deposit or bond is filed with the Department.

(9) The applicant or permitee is responsible for relocating or adjusting any utilities located on highway right of way when required for accommodation of the approach, and no construction may be performed until the applicant furnishes evidence to the Department that satisfactory arrangements have been made with the owner of the affected utility facility.

(10) The applicant or permitee is responsible for erosion control during construction of the approach.

(11) Where warning signs are required by the Construction Permit, other regulations, or the Region Manager, the Department furnishes, places, and maintains the signs at the applicant's or permitee's expense, and unauthorized signs are not allowed on any portion of the right of way.

(12) The work area during any construction or maintenance performed under a Construction Permit or a Permit to Operate is protected in accordance with the Manual on Uniform Traffic Control Devices adopted under OAR 734-020-0005.

(13) An applicant or permitee shall provide true and complete information, and if any required fact that is material to the assessment of the approach's impact upon traffic safety, convenience or the legal or property rights of any person (including the State of Oregon) is false, incorrect or omitted, the Region Manager may:

(a) Deny or revoke the Construction Permit; and

(b) At the applicant's or permitee's expense:

(A) Require the applicant or permitee to remove the approach and restore the area to a condition acceptable to the Region Manager;

(B) Require the applicant or permitee to provide additional safeguards to protect the safety, convenience, and rights of the traveling public and persons (including the State), if such safeguards are adequate to achieve these purposes, as a condition of the continued validity of the Permit to Operate;

(C) Reconstruct or repair the approach; or

(D) Remove the approach.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 724-050-0025; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0280

734-051-0225

Post-Decision Review Procedure

(1) An applicant may request a post-decision review to modify a Construction Permit if:

(a) Ambiguities or conflicts exist in the Construction Permit;

(b) New and relevant information concerning the approach or the Construction Permit is available; or

(c) Requirements of local governments or state agencies are relevant to the modification of the Construction Permit.

(2) The Region Manager shall determine if a request for a post-decision review meets the criteria in section (1) of this rule.

(3) The Region Manager may conduct a post-decision review and may modify the Construction Permit.

(4) A post-decision review does not stay the time period to request a Region Review or Contested Case Hearing.

(5) A post-decision review decision is an appealable decision.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003
Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0235

734-051-0245
Issuance of a Permit to Operate, Maintain and Use an Approach

(1) The Department shall issue a Permit to Operate upon approval of an application, where no Construction Permit is required, or upon notification by the applicant that construction is complete and when the approach conforms to the terms and conditions of the Construction Permit.

(2) Use of an approach is legal only after a Permit to Operate is issued.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999
Stats. Implemented: ORS 374.305 to 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003
Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00 HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0290

734-051-0255
Maintenance of Approaches

(1) An applicant, permitee, or owner of a grandfathered approach must obtain approval and necessary permits prior to performing maintenance on an approach that interferes with or interrupts traffic on or along a highway.

(2) Where traffic signals are required, signal maintenance is performed by the Department or as assigned by a Cooperative Cost Agreement.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999
Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003;
Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0045; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0310

734-051-0265
Effective Period of Permit to Operate, Maintain and Use an Approach

(1) Except as otherwise provided a Permit to Operate is effective unless:

(a) Revoked by mutual consent;

(b) Revoked for failure to abide by the terms and conditions;

(c) A change of use occurs as set forth in OAR 734-051-0045;

(d) Safety or operational problems exist as set forth in OAR 734-051-0275;

(e) The highway facility is significantly improved to meet classification of the highway, highway mobility standards, spacing standards, and safety criteria that are inconsistent with the approach; or

(f) By other operation of law.

(2) The Permit to Operate is binding on successors and assignors including successors in interest to the property being served by the approach.

(3) The operation, maintenance, and use of an approach are subject to the control of the legislature over the state highway system.

(4) A Permit to Operate should not be construed to be beyond the power or authority of the legislature to control the state highway system.

(5) Acceptance of a Permit to Operate is acceptance of all special provisions, mitigation measures, conditions, or agreements, identified and approved through the application process and acknowledgment that all rights and privileges may be changed or relinquished by legislative action.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999
Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003
Hist.: 1 OTC 43, f. 11-26-74, ef. 12-1-74; 1 OTC 20-1980, f. & ef. 10-22-80; TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0050; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0300

734-051-0275
Removal of Approaches

(1) The Department may revoke a Permit to Operate and may remove an approach:

(a) If current or potential safety or operational problems exist that are verified by an engineering analysis;

(b) If an applicant or permitee fails to comply with any terms or conditions of a Permit to Operate; or

(c) During project delivery as set forth in OAR 734-051-0285.

(2) The Department shall provide written notification of the intent to remove an approach under section (1) of this rule as required by ORS 374.305, 374.307, and 374.320.

(3) The Region Manager may determine that an approach identified for removal as described in section (1) of this rule may remain open if mitigation measures are required as set forth in OAR 734-051-0145:

(a) The Department shall provide written notification of the intent to remove the approach unless mitigation measures are taken; and

(b) The applicant must agree to comply with mitigation measure and to bear the cost of the mitigation measures.

(4) An applicant, permitee, or property owner is responsible for the expense of removing an approach except as set forth in OAR 734-051-0205 and 734-051-0285.

(5) Removal of a permitted or grandfathered approach is an appealable decision.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999
Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003
Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0380

734-051-0285
Project Delivery

(1) This rule applies to construction of new highways and interchanges, highway or interchange modernization projects, highway and interchange preservation projects, highway and interchange operations projects, or other highway and interchange projects. Access Management Strategies, Access Management Plans, and Access Management Plans for Interchanges are developed during project delivery to maintain highway performance and improve safety by improving system efficiency and management before adding capacity, as provided by this rule and consistent with the 1999 Oregon Highway Plan. All approaches identified to remain open in an area that is not access controlled in an Access Management Strategy, Access Management Plan, or Access Management Plan for an Interchange Area are presumptively found to be in compliance with Division 51 rules once any measures prescribed for such compliance by the plan are completed, and subsequent changes will be measured from that status. However, that status does not convey a grant of access.

(2) This rule does not create an obligation that the Department apply documentation requirements in OAR 734-051-0070(1) or the standards and criteria in OAR 734-051-0080, 734-051-0115, 734-051-0125, 734-051-0275 or 734-051-0295 through 734-051-0335.

(3) The Region Manager shall develop Access Management Strategies for modernization projects, projects within an influence area of an interchange where the project includes work along the crossroad, or projects on an expressway and may develop Access Management Strategies for other highway projects.

(4) Except where the Region Manager documents the reasons why an Access Management Plan is not appropriate, the Region Manager shall develop an Access Management Plan for modernization projects and an Access Management Plan for an Interchange for modernization projects where the project includes work along the crossroad.

(5) The Region Manager may require modification, mitigation, or removal of approaches within project limits:

(a) Pursuant to either:

(A) An Access Management Plan or an Access Management Plan for an Interchange adopted by the Department; or

(B) An approved Access Management Strategy; and

(b) If necessary to meet the classification of highway or highway segment designation, mobility standards, spacing standards, or safety factors; and

(c) If a property with an approach to the highway has multiple approaches and if a property with an approach to the highway has alternate access in addition to the highway approach.

(d) The determination made under subsections (a) through (c) of this section must conclude that the net result of the project including closures, modification and mitigations will be that access will remain adequate to serve the volume and type of traffic reasonably anticipated to enter and exit the property, based on the planned uses for the property.

(6) Access Management Strategies comply with all of the following:

(a) Are developed for the project limits, a specific section of the highway within the project limits, or to address specific safety or operational issues within the project limits.

(b) Must improve access management conditions to the extent reasonable within the limitation, scope, and strategy of the project and consistent with design parameters and available funds.

(c) Promote safe and efficient operation of the state highway consistent with the highway classification and the highway segment designation.

(d) Provide for reasonable use of the adjoining property consistent with the comprehensive plan designation and zoning of the area.

(e) Are consistent with any applicable adopted Access Management Plan, Transportation System Plan or Corridor Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055.

(7) Access Management Plans comply with all of the following:

(a) Must include sufficient area to address highway operation and safety issues and the development of adjoining properties including local access and circulation.

(b) Must improve access management conditions to the extent reasonable within the limitation and scope of the project and be consistent with design parameters and available funds.

(c) Describe the roadway network, right-of-way, access control, and land parcels in the analysis area.

(d) Are developed in coordination with local governments.

(e) Are consistent with any applicable adopted Transportation System Plan, corridor plan, or Special Transportation Area or Urban Business Area designation, or amendments to the Transportation System Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055.

(f) Are consistent with the 1999 Oregon Highway Plan.

(g) Contain short, medium, and long-range actions to improve operations and safety and preserve the functional integrity of the highway system.

(h) Consider whether improvements to local street networks are feasible.

(i) Promote safe and efficient operation of the state highway consistent with the highway classification and the highway segment designation.

(j) Consider the use of the adjoining property consistent with the comprehensive plan designation and zoning of the area.

(k) Provide a comprehensive, area-wide solution for local access and circulation that minimizes use of the state highway for local access and circulation.

(l) Are approved by the Department through an intergovernmental agreement and adopted by the local government, and adopted into a Transportation System Plan unless the jurisdiction is exempt from transportation system planning requirements under OAR 660-012-0055.

(8) In the event of a conflict between the access management spacing standards and the access management spacing standards for approaches in an interchange area the more restrictive provision will prevail. These spacing standards are used to develop Access Management Plans for Interchanges and where appropriate:

(a) Support improvements such as road networks, channelization, medians, and access control, with an identified committed funding source, and consistent with the 1999 Oregon Highway Plan;

(b) Ensure that approaches to cross streets are consistent with spacing standards on either side of the ramp connections; and

(c) Support interchange designs that consider the need for transit and park-and-ride facilities and the effect of the interchange on pedestrian and bicycle traffic.

(9) Notwithstanding other provisions of this Division, the Region Manager, not a designee, may recognize an approach to be in compliance where there is no Access Control, and where construction details for a Department project show the intention to preserve the approach as a part of that project, as documented by plans dated before the original effective date of Division 51, April 1, 2000.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0370

734-051-0295
Grants of Access

(1) A grant of access establishes a right of access; and

(a) For a grant of access approved prior to April 1, 2000, the grant of access does not guarantee approval of an Application for State Highway Approach or issuance of a Construction Permit or Permit to Operate; and

(b) Subsequent to April 1, 2000, the Department may approve an Application for a Grant of Access only where an Application for State Highway Approach or a Construction Permit or Permit to Operate may be approved.

(2) The applicant for a grant of access must be the owner of the property abutting the highway right of way or the owner's designated agent.

(3) The Department shall not approve an Application for a Grant of Access for a private approach:

(a) On a freeway, freeway mainlines, or freeway ramp;

(b) On an expressway or expressway ramp;

(c) Opposite a freeway or expressway ramp terminal; or

(d) In an Interchange Management Area.

(4) The Department may approve an Application for a Grant of Access to private property abutting a state and local facility where all of the following conditions are met:

(a) An applicant submits an Application for State Highway Approach as set forth in OAR 734-051-0070 and concurrently submits an Application for a Grant of Access, as set forth in OAR 734-051-0305.

(b) An applicant meets the requirements for issuance of a Construction Permit, as set forth in OAR 734-051-0175.

(c) The applicant agrees in writing to meet any mitigation measures, terms, and conditions placed on the Construction Permit and the Permit to Operate.

(d) The grant of access is consistent with the 1999 Oregon Highway Plan.

(e) One of the following occurs:

(A) The Department determines that access control is no longer needed at the location specified in the Application for a Grant of Access as set forth in section (7) of this rule; or

(B) The applicant establishes that the grant of access will benefit the state highway system as set forth in OAR 734-051-0085(1) and (2).

(f) Alternate access to the property is not and cannot be made reasonable as set forth in OAR 734-051-0080(8).

(g) The property owner must agree to deed restrictions to ensure that future development intensity and trip generation can be safely accommodated by the state transportation system.

(h) The application is approved by the Region Manager and reviewed by the State Traffic Engineer, and approved by the Technical Services Manager.

(5) The Department shall not approve an Application for a Grant of Access for a public approach:

(a) On a freeway, freeway mainlines, or freeway ramp;

(b) On an expressway ramp;

(c) Opposite a freeway or expressway ramp terminal; or

(d) In an Interchange Management Area.

(6) The Department may approve an Application for a Grant of Access for a public approach to a state highway where all of the following conditions are met:

(a) An applicant submits an Application for State Highway Approach, as set forth in OAR 734-051-0070 and concurrently submits an Application for a Grant of Access, as set forth in OAR 734-051-0305.

(b) The applicant meets the requirements for issuance of a Construction Permit, as set forth in OAR 734-051-0175.

(c) The applicant agrees in writing to meet any mitigation measures, terms, and conditions placed on the Construction Permit and the Permit to Operate.

(d) The grant of access is consistent with the 1999 Oregon Highway Plan, the adopted State Highway Corridor Plan, and local transportation system plan, or in the absence of an adopted corridor plan or transportation system plan, a grant of access may be considered where the applicant has explored all possible alternatives to the connection, including parallel streets, and the purchase of additional right of way.

(e) One of the following occurs:

(A) The Department determines that access control is no longer needed at the location specified in the Application for a Grant of Access as set forth in section (7) of this rule; or

(B) The applicant establishes that the grant of access will benefit the state highway system as set forth in OAR 734-051-0085; and

(i) The Department may determine that a benefit to the state highway system exists where the proposed connection is a public facility with a functional classification of collector or higher and is identified in an adopted Transportation System Plan, consistent with OAR 660-012-0000 through 660-012-0070; and

(ii) The Department shall require supporting documentation of sufficient detail to determine that a benefit to the state highway system exists, as set forth in OAR 734-051-0085(1) and (2), to be included in the Transportation System Plan; and

(iii) The Department shall determine if the supporting documentation is sufficient to meet the requirements in subparagraph (ii) of this paragraph.

(f) The Department and the local jurisdiction requesting a grant of access for a public approach:

(A) Shall enter into an intergovernmental agreement that details the responsibility for construction, maintenance, operation and cost of the public approach; and

(B) May enter into an intergovernmental agreement that addresses transportation plan and land use amendments or modifications to ensure that planned development intensities and trip generation can be safely supported on the state transportation system.

(g) The application is approved by the Region Manager and reviewed by the State Traffic Engineer, and approved by the Technical Services Manager.

(7) For the purposes of sections (4) and (6) of this rule, the Department shall consider the following factors in determining whether access control is still needed at the location specified in an application for a grant of access:

(a) Classification of the highways and highway segment designations;

(b) Spacing Standards;

(c) Highway mobility standards;

(d) State and Local Transportation System Plans;

(e) Comprehensive Plan and land uses in the area; and

(f) Safety factors.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003;

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0430

734-051-0305
Application Procedure for Grants of Access

(1) An Application for a Grant of Access to a state highway must be made on the standard state form, and the processing fee must accompany the Application for a Grant of Access as set forth in OAR 734-051-0335.

(2) The Department may refuse to accept an Application for a Grant of Access if the application is:

(a) Incomplete;

(b) Not accompanied by an Application for State Highway Approach and all required documentation;

(c) Not accompanied by a current preliminary title report covering the property to be served by the approach, showing any access easements appurtenant to the property; or

(d) From anyone other than the owner of the abutting property or a designated agent.

(3) Upon acceptance of an Application for a Grant of Access and any required attachments, the Department shall use division 51, ORS Chapter 374, and any other applicable state statutes, administrative rules, and Department manuals for evaluating and acting upon the application for a grant of access.

(4) The Region Manager shall review the Application for a Grant of Access, determine if the Application for a Grant of Access meets the requirements of division 51 and Department policy, and shall:

(a) Forward the Application for a Grant of Access to the State Traffic Engineer; or

(b) Deny the Application for a Grant of Access.

(5) When the Application for a Grant of Access is forwarded to the State Traffic Engineer, the State Traffic Engineer, with the assistance of Department staff, shall:

(a) Evaluate the Application for a Grant of Access;

(b) Notify the applicant of any additional information required; and

(c) Make a recommendation to the Technical Services Manager.

(6) The Technical Services Manager shall approve or deny the Application for a Grant of Access and notify the applicant.

(7) If the Application for Grant of Access is approved, the Department shall:

(a) Appraise the abutting property to determine the fair market value of the grant of access;

(b) Notify the applicant of the value of the grant of access; and

(c) Provide the applicant with instructions for payment.

(8) After payment of fair market value is received by the Department:

(a) The grant of access will be executed and recorded; and

(b) A copy of the grant of access will be sent to the Region Manager so that a Construction Permit may be issued in accordance with OAR 734-051-0175.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0440

734-051-0315
Indentures of Access

(1) The Department may approve an Application for Indenture of Access to a property abutting a state or local facility where all of the following conditions are met:

(a) An applicant submits an Application for State Highway Approach as set forth in OAR 734-051-0070 and concurrently submits an Application for Indenture of Access as set forth in OAR 734-051-0325;

(b) The applicant meets the requirements for issuance of a Construction Permit, as set forth in OAR 734-051-0175;

(c) The applicant agrees in writing to meet any mitigation measures, conditions, and terms placed on the Construction Permit and the Permit to Operate;

(d) The Region Manager approves the Application for Indenture of Access; and

(e) The property owner agrees to the closure of one or more existing reservations of access.

(2) All of the property owners that have a right of access at and are currently being served by the existing reservation of access must be applicants for any Application for Indenture of Access.

(3) A request for removal of farm crossing or farm access restrictions requires a grant of access as set forth in OAR 734-051-0295 and 734-051-0305.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0450

734-051-0325
Application Procedure for Indentures of Access

(1) An Application for Indenture of Access to a state highway must be made on the standard state form and the appropriate processing fee must accompany the Application for Indenture of Access as set forth in OAR 734-051-0335 except where the Region Manager, not a designee, waives the processing fee and documents in writing the reasons for the waiver.

(2) The Department may refuse to accept an Application for Indenture of Access if the application is:

(a) Incomplete;

(b) Not accompanied by an Application for State Highway Approach and all required documentation;

(c) Not accompanied by a current preliminary title report covering the property to be served by the approach showing any access easements appurtenant to the property; or

(d) From anyone other than the owner of the abutting property or a designated agent.

(3) The Department shall use division 51, ORS Chapter 374, and any other applicable state statutes, administrative rules, and Department manuals for evaluating and acting upon the Application for Indenture of Access.

(4) The Region Manager shall approve or deny the Application for Indenture of Access and shall notify the applicant.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0460

734-051-0335
Administration of Grants and Indentures of Access

(1) A processing fee must be submitted with the Application for Indenture of Access.

(2) A processing fee must be submitted with the Application for a Grant of Access. The processing fee is based on the actual documented costs incurred by the Department plus a 10 percent charge for general administration:

(a) The processing fee includes the cost to secure an appraisal of the fair market value of the grant of access;

(b) An initial deposit, applied towards the processing fee, must accompany the Application for a Grant of Access; and

(c) The Department shall determine the amount of the initial deposit based on the complexity of the request and the anticipated cost of obtaining an appraisal of the grant of access.

(3) The applicant shall pay all costs incurred by the Department in processing the Application for a Grant of Access.

(4) Upon approval of an Application for a Grant of Access and prior to issuance of the Construction Permit, payment must be made to the

Department in an amount equal to the appraised value of the grant of access. This payment is in addition to the processing fee.

(5) The Department may waive payment of the appraised value of the grant of access when:

(a) An application for a grant of access is for a public approach and the applicant has demonstrated that the public approach will benefit the State highway system as set forth in OAR 734-051-0085(1) and (2); and

(b) The benefit to the State highway system is a direct and immediate result of the public approach.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: 1 OTC 19-1980, f. & ef. 10-22-80, TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; Renumbered from 734-050-0085; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0470

734-051-0345
Region Review Process and Collaborative Discussion Option

(1) The Region Review process is an optional process that falls outside the 120-day timeline in OAR 734-051-0070(8) and applies to appealable decisions.

(2) To request a Region Review, an applicant must submit a written request to the Region Manager within 21 days of the mailing date of notice of an appealable decision and identify documentation to be presented at the Region Review.

(3) A Region Review Committee includes members with expertise in:

(a) Access Management policies;

(b) Roadway design standards;

(c) Right-of-way;

(d) Traffic engineering; and

(e) At least one Professional Engineer with experience in the issues being reviewed.

(4) The Department may invite a representative from the affected local jurisdiction with land use or transportation knowledge to provide input to the Region Review Committee.

(5) The applicant or permitee may present additional information in writing or in person to the Region Review Committee.

(6) The Region Review Committee shall meet, consider information presented, and provide written findings to the Region Manager.

(7) The Region Manager shall review the Committee's findings and approve, modify, or reverse the original decision; and

(a) Shall notify the applicant in writing within 21 days of the committee meeting;

(b) Shall include information on the applicant's right to request a contested case hearing on the original decision; and

(c) May include mitigation measures, conditions and terms to be incorporated into the Construction Permit or Permit to Operate.

(8) An applicant may request a collaborative discussion within the Region Review process:

(a) Both the applicant and the Department must agree to the collaborative discussion.

(b) The collaborative discussion:

(A) Will be conducted under the Alternative Dispute Resolution model in ORS 183.502; and

(B) Will include a time limit of 45 days, or longer if the Department and the applicant agree, in the Agreement to Collaborate.

(c) The Region Manager is the final agreement authority and may make a binding decision for the Department.

(d) Any agreement made by the Region Manager:

(A) Shall be documented in writing;

(B) May require conditions or limitations to be incorporated into the Construction Permit or Permit to Operate; and

(C) Shall include information on the applicant's right to request a contested case hearing on the original decision.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0390

734-051-0355
Contested Case Hearings

(1) An applicant may request a contested case hearing as provided by the Administrative Procedures Act (ORS Chapter 183):

(a) The request for a hearing and the hearing are governed by OAR 137-003-0501 through 137-003-0700;

(b) The request for a hearing must evidence an intent to request a hearing and must be submitted to and received by the Office of Administrative Hearings within 21 days of the mailing date of the notice of an appealable decision by the Department;

(c) The hearings process falls within the 120-day timeline in OAR 734-051-0070(8) unless the Department and the applicant agree to a time extension:

(A) Time extensions fall outside the 120-day timeline; and

(B) Filing of exceptions falls outside the 120-day timeline.

(2) The Department is authorized to use agency representatives in access management contested case hearings as set forth in OAR 137-003-0545.

(3) The Department and the applicant may present additional information in writing or in person at the contested case hearing.

(4) An Administrative Law Judge will review the Region Manager's decision, conduct a hearing, and may approve, reverse, or modify the decision. The Administrative Law Judge:

(a) Shall issue a proposed order as set forth in OAR 137-003-0645; and

(b) May require conditions or limitations to be incorporated into the Construction Permit or the Permit to Operate.

(5) The Executive Deputy Director shall issue a final order or may adopt as final the proposed order issued by the Administrative Law Judge.

Stat. Auth.: ORS 184.616, 184.619, 374.310, 374.312 & 374.345; Ch. 972 & Ch. 974, OL 1999

Stats. Implemented: ORS 374.305 - 374.345 & 374.990; Ch. 974, OL 1999, Ch. 371, OL 2003

Hist.: TO 4-2000, f. 2-14-00, cert. ef. 4-1-00; HWD 2-2004, f. 2-18-04, cert. ef. 3-1-04, Renumbered from 734-051-0400

• • • • • • • • • •

Adm. Order No.: HWD 3-2004
Filed with Sec. of State: 2-25-2004
Certified to be Effective: 2-25-04
Notice Publication Date: 12-1-03
Rules Adopted: 734-082-0080
Subject: Current over-dimensional variance permit rules do not establish criteria for emergency issuance of authority when an emergency occurs requiring the movement of an oversize load at a time when a written permit cannot be issued. Such movements may occur on a weekday after hours, a weekend or a holiday. The rule is adopted to establish a process to ensure that when an emergency does exist, issuance of authority is handled in a consistent manner, authorization is clearly documented, and there is a follow-up by the motor carrier to order the written permit on the next business day.
Rules Coordinator: Brenda Trump—(503) 945-5278

734-082-0080
Emergency Verbal Authorization

(1) When a motor carrier learns of the need to use an oversize vehicle, or transport an oversize load, to respond to an emergency at a time (weekday after business hours, weekends or holidays) when the motor carrier cannot obtain a written variance permit, the motor carrier may request verbal authorization in lieu of a written permit.

(2) A motor carrier seeking verbal authorization must:

(a) Telephone the Motor Carrier Transportation Division Over-Dimensional Permit Unit (ODPU) at (503) 588-9610, provide the ODPU with any information requested regarding the movement, and receive the authorization before operating the oversize vehicle or transporting the oversize load; and

(b) On the first business day following the authorization, telephone the ODPU to confirm that the emergency movement occurred and request the written permit.

(3) ODPU will determine if the request constitutes an emergency move, and if approved will:

(a) Inform the motor carrier of the terms and conditions of the authorization;

(b) Remind the motor carrier of their obligation to obtain, on the first business day following the authorization, the written permit for the emergency movement; and

(c) Create and retain a written record of the authorization, that includes:

(A) The date and time of the authorization;

(B) The route; and

(C) Any terms and conditions of the authorization.

(4) Nothing in this rule relieves the motor carrier from its obligation to comply with all requirements related to oversize movements.

Stat. Auth.: ORS 184.616, 184.619 & 818.220
Stat. Implemented: ORS 818.200 & 818.220
Hist,: HWD 3-2004, f. & cert. ef. 2-25-04

• • • • • • • • • •

Department of Veterans' Affairs
Chapter 274

Adm. Order No.: DVA 3-2004
Filed with Sec. of State: 2-24-2004
Certified to be Effective: 2-24-04
Notice Publication Date: 2-1-04
Rules Amended: 274-020-0388
Rules Repealed: 274-020-0388(T)
Subject: This rule supersedes and repeals the Temporary OAR filed on January 15, 2004 and effective January 15, 2004 through July 13, 2004.

This rule is being amended to include the option that will allow the borrower of a daily simple loan, with an interest rate of less than 7%, to request that the Director advance funds for the payment of property taxes on loans.

The language in this rule is also being amended to modify the requirement that a borrower must have 30% equity in the security before they are allowed to directly pay their own property taxes and insurance. The revision shall require that the borrower need only have 20% equity prior to requesting to directly pay their own property taxes.

Rules Coordinator: Herbert D. Riley—(503) 373-2055

274-020-0388
Property Tax Amortization and Escrow Accounting

(1) Except as otherwise provided herein, payments required on all loans shall include an amount, which represents advances, for taxes paid by the Director of Veterans' Affairs (director) on the security:

(a) The amounts shall be determined each year by dividing the amount advanced by the number of loan payments due during the year, increased to the next whole dollar;

(b) The amounts so determined shall be added to and become part of the loan payment unless full payment of the advance is made pursuant to subsection (c) or (d) of this section;

(c) As soon as possible after taxes are paid on November 15th of each year, the director may notify each borrower by mail of the amount of the tax advance. If full payment of the tax advance is made to the director, the amount determined in subsection (a) of this section shall be deleted from the loan payments. Upon such payment the borrower shall be credited with prior loan payments made to the extent of the amounts contained therein that represent repayment of the tax advance;

(d) If for any reason the taxes cannot be paid on November 15th, the director will send the notice as provided in subsection (c) of this section as soon as possible after the taxes are paid;

(e) Effective with taxes paid in November of 1990 (1990-91 taxes) through November of 2003 (2003-2004 taxes), the director generally did not advance funds for the payment of taxes on property that was security for a loan being charged less than seven percent interest unless an escrow account had been established on the loan for the payment of taxes. The interest rate charged was the "loan rate" or "composite rate" where more than one loan (with different interest rates) is secured by the property;

(f) Effective with taxes (including delinquent taxes) to be paid in November of 2004 (2004-2005 taxes), the director may approve a borrower's request to advance funds for the payment of taxes on property that is security for a loan unless an escrow account had been established on the loan for the payment of taxes. The interest rate being charged is the "loan rate" or "composite rate" where more than one loan (with different interest rates) is secured by the property;

(g) Notwithstanding the provisions of subsection (1)(e) and (1)(f) of this rule, the director may advance funds for the payment of taxes on property that is security for a loan under the provisions of the Servicemembers Civil Relief Act. In addition, the director may advance funds to pay property taxes if sufficient funds are not available in the escrow account, by overdrawing the escrow account balance.

(2) The director may allow owners of the security to directly pay the taxes and/or hazard insurance due on the security, subject to the following conditions:

(a) For existing accounts or qualified assumptions of existing accounts, the owner of the property must make written application to the director on a form prescribed by the director. Said application also must conform with the following:

(A) The application must be submitted by September 1st of the year application is made;

(B) At the time of application, payments on the loan must be current and the applicant's credit history must be satisfactory as determined by the director at his sole discretion and,

(C) The loan balance, including any accruals, at the time of application must not be more than 80 percent of the "real market value" of the security as shown by the county tax assessor.

(D) If a request is approved, any funds the director holds in an applicable escrow account, which are not scheduled for disbursement will be returned to the borrower and the borrower will be responsible for any future disbursements.

(b) For new loan applications, the applicant must make written request to the director. Said application also must conform with the following:

(A) The loan-to-value ratio must be 80 percent or less of the net appraised value;

(B) The loan must have no restrictions by virtue of FHA mortgage insurance or private mortgage insurance that the lender pay taxes and/or insurance.

(3) All applications, for permission to pay taxes and/or hazard insurance directly, will receive a written approval or disapproval from the director. If the application is approved, the applicant will be advised of the date when the director will discontinue making disbursements, if applicable and the date the loan payment will be adjusted, if necessary.

(4) The director may revoke any permission granted concerning the payment of taxes and/or hazard insurance on the security by giving the owner of the security 30 days written notice of the revocation, except as otherwise provided herein. If the director advances funds to pay unpaid taxes and/or hazard insurance, any advance by the director for such a shortage/deficiency also will constitute immediate revocation by the director of permission for the owner to pay directly any taxes and/or hazard insurance due on the security, and the account will revert to the last signed agreement between the director and borrower for the payment of taxes, hazard insurance and other obligations. Any advances by the director, including any interest and fee, shall be paid back within the remaining payment/escrow year. The borrower may not change this obligation without prior written approval from the director.

(5) Sections (1), (2), (3) and (4) of this rule are not applicable to payments made under contracts for the purchase of state-owned property. Contract purchaser(s) may prepay the current year's property taxes in a lump sum and have the tax portion removed from the following year's payment(s).

(6) Monthly simple interest home improvement loans are handled as follows:

(a) If the borrower has an existing account with ODVA the taxes will continue to be paid per the terms of that account;

(b) When an existing account is paid in full and the loan-to-value ratio (LTV) is 80 percent or less of the net appraised value, the borrower may at the Director's discretion pay their own taxes directly to the county and the borrower may at the Director's discretion pay their own hazard insurance;

(c) If the borrower does not have an existing account and the LTV is greater than 80 percent, the borrower must pay their taxes and hazard into an escrow account as part of their standard payment.

(7) Pursuant to the provisions of ORS 407.169, beginning November 1, 1990, escrow accounts are available for the prepayment of estimated property taxes and insurance. All borrowers with loans, and all purchasers buying property from the director on a land sale contract, based on a daily simple interest calculation, may make prepayments of estimated property taxes into an escrow account, subject to the following conditions:

(a) The owner of the property must make written application to the director on a form prescribed by the director;

(b) Applicants will have the option of either repaying the previous year's tax advance as provided by section (1) of this rule, or of permitting said tax advance to remain part of the principal balance on the loan with the payments of said loan adjusted to repay the tax advance with interest over the remaining life of the loan.

(8) On monthly simple interest loans with escrow accounts, the required escrow payment may be based, inter alia, on the preceding year's disbursements for such items as property taxes, fire and extended coverage premiums, other required insurance premiums, condominium/homeowners

dues, and bancrofted amounts. In cases of unassessed new construction, the estimate may be based, inter alia, on the assessment of comparable residential property in the market area.

(9) The director will pay interest on the escrow account as provided by ORS 86.245(1).

(10) Effective May 24, 1995, all escrow accounts on monthly simple interest loans and tax escrows on daily simple interest loans will be administered in the following manner:

(a) The director may require a cushion that shall be no greater than 1/6 of the estimated total annual disbursements from the escrow account. Estimated disbursements may be modified by an amount not exceeding the most recent year's change in the national Consumer Price Index for all urban consumers (CPI, all items);

(b) At the end of an escrow account computation year, an aggregate analysis will be completed on each escrow account to determine the borrower's escrow account payment(s) for the new payment year. The borrower will be notified of any shortage, deficiency, or surplus in the escrow account and the amount of escrow account payment to be included in the loan payment;

(c) If the loan is two months or more delinquent in payments an analyzes will not be done until the loan is brought current.

(d) If the analysis determines there is not sufficient money in the escrow account to pay the required disbursements, the shortage/deficiency may be advanced by the director. The required escrow payments on the loan will be increased to recover any interest, fee and/or advance by the director for such a shortage/deficiency, or the borrower may repay the advance, interest and/or fee in a lump sum;

(e) If the analysis determines there is a surplus in the escrow account equal to or greater than $25, the entire surplus shall be refunded to the borrower. If the surplus is less than $25, this amount will be retained in the escrow account and credited against the next year's escrow payments;

(f) A statement itemizing all escrow account activity, (annual escrow statement) will be provided to the borrower each year.

(11) The following definitions apply to section 10 above:

(a) "Aggregate analysis" — to analyze the escrow account by calculating the sufficiency of escrow funds as a whole, as opposed to calculating components separately.

(b) "Cushion" — funds that the director may require a borrower to pay into an escrow account to cover unanticipated disbursements or disbursements made before the borrower's payments are available in the account.

(c) "Deficiency" — the amount of a negative balance in an escrow account.

(d) "Escrow account" — any account that the director establishes or controls on behalf of a borrower to pay taxes, insurance premium, or other charges, as applicable.

(e) "Escrow account computation year" — a 12-month period that the director establishes for the escrow account.

(f) "Shortage" — an amount by which a current escrow account balance falls short of the target balance at the time of escrow analysis.

(g) "Surplus" — an amount by which the current escrow account balance exceeds the target balance of the account.

(h) "Target balance" — the estimated month end balance in an escrow account that is just sufficient to cover the remaining disbursements from the escrow account in the escrow account computation year, taking into account the remaining scheduled periodic payments, and a cushion.

Stat. Auth.: ORS 86.240, 86.245, 406.030, 407.115, 407.169 & 407.275

Stats. Implemented: ORS 406.030 & 407.275

Hist.: DVA 26-1982(Temp), f. & ef. 10-1-82; DVA 3-1983, f. 1-14-83, ef. 1-15-83 and Suspended by DVA 4-1983(Temp); DVA 4-1983(Temp), f. & ef. 2-1-83; DVA 10-1983, f. 9-8-83, ef. 2-1-84; DVA 13-1983, f. & ef. 11-1-83; DVA 10-1984, f. 10-8-84, ef. 10-15-84; DVA 9-1985, f. 6-20-85, ef. 7-1-85; DVA 2-1989, f. & cert. ef. 6-1-89; DVA 2-1990, f. & cert. ef. 2-1-90; DVA 1-1991, f. & cert. ef. 5-1-91; DVA 7-1993, f. 5-18-93, cert. ef. 5-21-93; DVA 5-1995, f. 5-23-95, cert. ef. 5-24-95; DVA 11-1995, f. 9-11-95, cert. ef. 9-22-95; DVA 12-1995, f. & cert. ef. 9-22-95; DVA 5-2001, f. & cert. ef. 7-23-01; DVA 1-2004(Temp), f. & cert. ef. 1-15-04 thru 7-13-04; DVA 3-2004, f. & cert. ef. 2-24-04

• • • • • • • • • •

Health Licensing Office, Sanitarians Registration Board
Chapter 338

Adm. Order No.: SRB 1-2004(Temp)
Filed with Sec. of State: 2-27-2004
Certified to be Effective: 3-1-04 thru 7-27-04
Notice Publication Date:
Rules Amended: 338-010-0015, 338-010-0025, 338-010-0030, 338-010-0035, 338-010-0050

Subject: Emergency rules are being filed, while concurrently undergoing the full rulemaking process, to eliminate the oral examination requirement to mitigate the necessity for individuals to sit for an oral examination on April 9, 2004, in order to qualify for registration as an environmental health specialist. The oral examination was eliminated from statutory requirement following passage of HB 2325 by the 2003 Legislature, which became effective January 1, 2004.
Rules Coordinator: Patricia C. Allbritton—(503) 378-8667, ext. 4322

338-010-0015
Application Requirements

(1) Individuals applying for registration to practice environmental sanitation or waste water sanitation must meet requirements of OAR 331-030-0000 and 331-030-0020, in addition to the requirements of subsections (2) through (4) of this rule, that are applicable to the specific field of practice and qualification pathway for which registration is being sought.

(2) Applicants must submit a completed application form prescribed by the agency, which must be accompanied by payment of the appropriate fees. The completed application must contain the information listed in OAR 331-030-0000(5), and include the following:

(a) Signed and completed "Background Information Fact Sheet" which contains information on educational and work experience;

(b) Official transcripts from college, university and post-graduate records;

(c) Evidence of prescribed educational and work experience as required by ORS 700.030, 700.053, and OAR 338-010-0025.

(3) Reciprocity: Applications for registration based on reciprocity as defined in Oregon Laws 2003, chapter 547, section 101 and OAR 338-005-0020(21) must meet the requirements listed in subsections (1) and (2) of this rule. Documentation must include a copy of the current registration and describe the type of examination completed for registration in another state or country.

(4) All documentation and payment of fees must be complete and received by the agency to be eligible and scheduled to take the examination.

Stat. Auth.: ORS 700.030, 700.053, 700.090 & 700.240

Stats. Implemented: ORS 700.030, 700.053, 700.090 & 700.240

Hist.: SRB 2, f. 4-7-72, ef. 5-1-72; SRB 4(Temp), f. & ef. 7-1-75 thru 10-28-75; SRB 5, f. 10-14-75, ef. 11-11-75; SRB 1-1985, f. & ef. 11-1-85; SRB 2-1996, f. 5-31-96, cert. ef. 6-1-96; SRB 1-1998, f. 4-29-98, cert. ef. 5-1-98; SRB 1-2004(Temp), f. 2-27-04, cert. ef. 3-1-04 thru 7-27-04

338-010-0025
General Requirements for Registration; Requirements for Reciprocity

(1) Applicants for registration must submit satisfactory evidence to the Board that they have completed the prescribed education and work experience requirements as listed in one of the following areas:

(a) Environmental health specialist: ORS 700.030;

(b) Waste water specialist: ORS 700.053;

(c) Trainee — environmental health specialist: ORS 700.035; or

(d) Trainee — waste water specialist: ORS 700.062.

(2) Applicants for registration by reciprocity must provide evidence satisfactory to the Board that they have passed an examination equivalent to the examination required at the time of application for Oregon registration, and that they have the education and work experience equivalent to that required for an applicant for registration by examination in Oregon.

(3) Credits will be allowed toward work experience requirements for activities directly related to Environmental Sanitation and Waste Water Sanitation, and which were experienced in the military, industrial, special agency, or other situation, and will be credited at the rate of one time unit of experience for each time unit of related work provided supervision occurred by a qualified person as determined by the Board.

Stat. Auth.: ORS 700.030, 700.035, 700.053 & 700.062

Stats. Implemented: ORS 700.030, 700.035, 700.053 & 700.062

Hist.: SRB 2, f. 4-7-72, ef. 5-1-72; SRB 1-1985, f. & ef. 11-1-85; SRB 2-1996, f. 5-31-96, cert. ef. 6-1-96; SRB 1-1998, f. 4-29-98, cert. ef. 5-1-98; SRB 1-2004(Temp), f. 2-27-04, cert. ef. 3-1-04 thru 7-27-04

338-010-0030
Examination

(1) Notwithstanding subsection (8) of this rule, the agency will administer an examination to qualified applicants. 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 in advance.

(2) Applicants will qualify for examination upon compliance with all applicable provisions of OAR 338-010-0015, 338-010-0017 and 338-010-0025. Applicants will not be allowed to sit for the examination if documentation is incomplete or incorrect.

(3) Applicants must present photographic identification, such as a driver's license, and their original Social Security card to the examination proctor.

(4) In order to qualify for registration, the applicant must receive a passing score of at least 68 percent on the written examination.

(5) **EXAMINATION CONDUCT**: Examinations are conducted in a designated area with restricted access. Examination conduct differs between an environmental health specialist and a waste water specialist. Authorization for bringing any written material or electronic equipment or devices is subject to approval of the Board. Taking unauthorized items into the examination area may invalidate the examination and result in forfeiture of the examination and fees.

(6) **EXAMINATION DISQUALIFICATION**: An examination applicant will be immediately disqualified during or after the examination for conduct that interferes with the examination. Such conduct includes:

(a) Giving or attempting to give assistance to others in answering questions during the examination;

(b) Receiving or attempting to receive assistance during the examination, including assistance from other individuals, from notes, books or devices to answer questions;

(c) Removing or attempting to remove any secure examination-related information, notes, or materials from the examination site;

(d) Failing to follow directions relative to the conduct of the examination;

(e) Exhibiting behavior which impedes the normal progress of the examination; and

(f) Endangering the health or safety of a person involved in the examination.

(7) Disqualification will invalidate the examination and result in forfeiture of the examination and fees. The applicant will be required to reapply, submit additional examination fees, and request in writing to schedule another examination. Reexamination will be scheduled at a date, time and place determined by the Director following the date of disqualification.

(8) Satisfactory passage of the National Environmental Health Association examination, administered by an approved entity meeting NEHA requirements, will be recognized. The agency will accept verification directly from NEHA of a passing score as meeting Oregon examination requirements.

(9) Applicants taking the examination from a NEHA approved test provider are responsible for payment of any fees incurred.

Stat. Auth.: ORS 700.050, 700.059 & 700.240
Stats. Implemented: ORS 700.050, 700.059 & 700.240
Hist.: SRB 2, f. 4-7-72, ef. 5-1-72; SRB 1-1985, f. & ef. 11-1-85; SRB 1-1993, f. & cert. ef. 3-18-93; SRB 2-1996, f. 5-31-96, cert. ef. 6-1-96; SRB 1-1998, f. 4-29-98, cert. ef. 5-1-98; SRB 1-2003(Temp), f. & cert. ef. 4-25-03 thru 10-17-03; SRB 2-2003, f. 9-24-03, cert. ef. 10-1-03; SRB 1-2004(Temp), f. 2-27-04, cert. ef. 3-1-04 thru 7-27-04

338-010-0035
Registration Issuance; Exemption

(1) Pursuant to ORS 700.020, a person shall not practice environmental sanitation or waste water sanitation or claim to be an environmental health specialist or waste water specialist, including that a person shall not display a sign or in any way advertise or purport to be a registrant or to be engaged in the field of environmental sanitation or waste water sanitation without first obtaining a registration under ORS Chapter 700.

(2) Registrants are subject to provisions of OAR 331-030-0010 regarding issuance and renewal of a registration, and to provisions of OAR 331-030-0020 regarding authorization to practice, identification, and requirements for issuance of a duplicate authorization.

(3) Notwithstanding other exemptions listed in ORS 700.025(6), registration is not required for persons who provide recommendation or advice to clients, when advice is solely for the purpose of installation of an approved septic tank or cesspool system, and is not related to counseling or consulting in connection with the duties of waste water sanitation as defined in OAR 338-005-0020(29).

Stat. Auth.: ORS 700.100 & 700.240
Stats. Implemented: ORS 700.100 & 700.240
Hist.: SRB 2, f. 4-7-72, ef. 5-1-72; SRB 1-1985, f. & ef. 11-1-85; SRB 2-1996, f. 5-31-96, cert. ef. 6-1-96; SRB 1-1998, f. 4-29-98, cert. ef. 5-1-98; SRB 1-2004(Temp), f. 2-27-04, cert. ef. 3-1-04 thru 7-27-04

338-010-0050
Trainee Registration

(1) An environmental health specialist trainee or waste water specialist trainee registration will be issued to individuals when all qualifications have been met and payment of the registration fee is received. The registration will be valid for a period of two years, expiring on the last day of the month two years from the date of issuance. The original two-year trainee registration fee will not be prorated.

(2) The trainee registration will state the registrant's name, address, registration number, expiration date, and bear the signature of the registrant.

(3) The trainee registration will not be extended beyond a two-year period unless the cumulative hours of work experience total less than 3,840 clock hours. In the event the trainee has acquired less than 3,840 clock hours, the registration may be extended for an additional period of time in increments of six months based on projected completion date of work experience. The extension fee will be prorated at $50 per six-month period.

(4) The registrant must complete the Certificate form and obtain a supervisor's signature, attesting to the following information:

(a) Trainee name;

(b) Work location;

(c) Date(s) work experience started and if applicable, ended;

(d) Total hours of work experience recorded as of the date of certification;

(e) Disclosure as to whether the work experience is based on full time or part time employment;

(f) Activity performed and clock hours recorded for work experience per activity.

(5) Holding a trainee registration does not prevent a registrant from taking the board prescribed examination for registration as an environmental health specialist or waste water specialist before completion of the required work experience. The trainee must satisfactorily complete prescribed work experience and the written examination within the two-year registration period or within a 3,840 total clock hour limitation.

(6) All registered trainees must obtain 1.0 credit or 10 contact hours of continuing education training every year as a condition of holding the registration.

(7) Persons who previously held a trainee registration, which expired without attainment of permanent registration or fulfillment of the two-year or 3,840-clock hour limitation, may be issued an extension to their trainee registration subject to the following conditions:

(a) Submission of the Certification of Work Experience form documenting previous hours of work experience attained while in trainee status;

(b) Submission of satisfactory evidence that the trainee is or will be working in the field of environmental sanitation and will be under the direct supervision of an Oregon registered environmental health specialist or other person possessing equivalent credentials approved by the Board;

(c) Submission of continuing education required in subsection (6) of this rule and in accordance with provisions of OAR 338-020-0030. Documentation must meet the requirements of OAR 338-020-0050(3).

(8) The trainee registration issued will be valid only for the remaining period of time from those hours previously accumulated for a maximum cumulative total of two years or 3,840 clock hours.

(9) Trainees who fail to meet requirements of subsection (7)(a) through (c) will not be eligible for a registration extension until all qualifications have been met.

(10) An individual who holds a trainee registration that has been expired for more than three years, and who has not yet completed the 3,840 required hours of training, will be required to reapply and meet all registration requirements in accordance with ORS 700.100(4). Trainee registrations that are extended under this rule will only be valid for the time remaining to complete an aggregate 3,840 hours of training or six months, whichever occurs first.

Stat. Auth.: ORS 700.035
Stats. Implemented: ORS 700.035
Hist.: SRB 1-1998, f. 4-29-98, cert. ef. 5-1-98; SRB 1-2004(Temp), f. 2-27-04, cert. ef. 3-1-04 thru 7-27-04

• • • • • • • • • •

Oregon Department of Aviation
Chapter 738

Adm. Order No.: AVIA 1-2004
Filed with Sec. of State: 2-17-2004
Certified to be Effective: 2-17-04
Notice Publication Date: 11-1-03

Rules Amended: 738-001-0001, 738-001-0006, 738-001-0025, 738-001-0030, 738-015-0015, 738-025-0001, 738-025-0010, 738-090-0030, 738-090-0040, 738-100-0010
Rules Repealed: 738-030-0005, 738-030-0010, 738-030-0015, 738-030-0020, 738-030-0025, 738-110-0010, 738-110-0020, 738-110-0030, 738-110-0040, 738-110-0050
Subject: These technical amendments occurred as a first phase of voluntary periodic rule review that focused on careful synthesis of existing administrative rules governing the practices of Oregon Department of Aviation. No requests for public hearings were forthcoming; no comments were received from members of the public. The amendments are summarized as follows:

• Proposed amendments to OAR 738-001 update outdated statutory references and dates referring to the State Attorney General's Model Rules of Procedures; some rule numbers referenced in this section have also been updated.

• Amendments to OAR 738-015 eliminate unnecessary verbiage that complicates clear understanding of the rule.

• An important statutory reference was added to OAR 738-025, as well as one key word that aids in interpreting this rule in the context of the State Fire Marshal's Administrative Rules.

• The citation to land use laws in OAR 738-090 has been updated to cite key administrative rules more recently adopted by the Department of Land Conservation and Development following original adoption of OAR 738-090. In addition, the information formerly contained in Exhibits 1 and 2 has now been formatted to fit into the text of the administrative rule, for ease of access by the general public.

• Amendments to OAR 738-100 consist only of references to newly adopted administrative rules.

• OAR 738-030 is repealed since this rule has been replaced by OAR 738-035 Operating Minimum Standards for State-Owned Airports.

• OAR 738-110 is repealed because this rule dates back a specific window in history (1989) when Legislative Counsel renumbered all Oregon Revised Statutes, requiring amendment of all OAR citations in OARs. This rule is no longer needed.

Rules Coordinator: Carolyn R. Bolton—(503) 378-4880, ext. 223

738-001-0001
Notice of Proposed Rules

In accordance with ORS 183.341, to provide a reasonable opportunity for interested persons to be notified of proposed actions, prior to the adoption, amendment or repeal of any rule, the Oregon Department of Aviation shall give notice of the proposed adoption, amendment or repeal:

(1) In the Secretary of State's Bulletin referred to in ORS 183.360 and in accordance with ORS 183.335.

(2) By mailing a copy of the notice to persons on the Oregon Department of Aviation mailing lists for specific interest areas established pursuant to ORS 183.335(8)).

(3) By mailing a copy of the notice to legislators as provided in ORS 183.335(15).

(4) By mailing a copy of the notice to the following:

(a) Associated Press;

(b) Northwest Labor Press;

(c) Associated Oregon Industries;

(d) Capitol Press Room; and

(e) Statesman-Journal newspaper.

Stat. Auth.: ORS 835.112
Stats. Implemented: ORS 183.335 & 183.341
Hist.: AVIA 1-2000, f. & cert. ef. 12-26-00; AVIA 1-2004, f. & cert. ef. 2-17-04

738-001-0006
Model Rules of Procedure

Pursuant to ORS 183.341, the Oregon Department of Aviation adopts the following portions of Oregon Administrative Rules Chapter 137 as in effect on October 3, 2001.as the general administrative procedural rules for the Oregon Department of Aviation: Division 1, Division 2, Division 3 excluding OAR 137-003-0001 through 137-003-0092, Division 4 and Division 5.

Stat. Auth.: ORS 835.112
Stats. Implemented: ORS 183.341
Hist.: AVIA 1-2000, f. & cert. ef. 12-26-00; AVIA 1-2004, f. & cert. ef. 2-17-04

738-001-0025
Selection and Hiring of Consultants

The Oregon Department of Aviation adopts OAR 125-025-0000 through OAR 125-025-0110 (effective October 23, 1999), the Department of Administrative Services Rules, Consultant Selection Procedures: Architect, Engineers and Related Professional Consultants. The Model Rules adopted by the Attorney General under ORS 279.049 (OAR 137-035) shall not apply to the Oregon Department of Aviation.

Stat. Auth: ORS 835.112 & 279.712
Stats. Implemented: ORS 279.049
Hist.: 1 OTC 3-1981, f. & ef. 4-21-81; AVIA 1-2000, f. & cert. ef. 12-26-00; AVIA 1-2004, f. & cert. ef. 2-17-04

738-001-0030
Model Public Contract Rules

OAR 137-030, Public Procurement Rules, and 137-040, Public Improvement Contracts, from the Attorney General's Model Public Contract Rules as amended March 20, 2002, are hereby adopted by reference as the procedural rules of the Oregon Department of Aviation.

Stat. Auth.: ORS 835.112 & 279.049
Stat. Implemented: ORS 279.049(4)
Hist.: AVIA 1-2000, f. & cert. ef. 12-26-00; AVIA 1-2004, f. & cert. ef. 2-17-04

738-015-0015
ODA Review of Application for Commercial Aeronautical Lease

(1) The Department shall review the lease application for commercial aeronautical activities of the prospective Lessee and the financial responsibility documentation, and determine whether to approve or deny the application. The decision shall be conveyed in writing to the prospective Lessee.

(2) The Department may deny any prospective Lessee's application if it is determined that:

(a) The proposed commercial aeronautical activities, operation, and/or construction would create a safety hazard at the airport or surrounding community;

(b) The prospective Lessee, for any reason, does not fully meet the qualifications, standards, and requirements of the Airport Operating Minimum Standards;

(c) The granting of the lease application will require the Department to expend funds, or supply labor or materials in connection with the proposed activity and/or construction, that the Department is unwilling or unable to spend, or the proposed activity and/or construction will result in a financial loss or hardship to the airport;

(d) No adequate space is available or no buildings exist at the State-owned airport that would accommodate the proposed commercial operation at the time of the application, nor is such contemplated within a reasonable time frame;

(e) The proposed operation, development, and/or construction does not comply with the Airport Master Plan and/or the Airport Layout Plan in effect at that time, or those plans anticipated to be in effect within the time frame proposed by the prospective Lessee;

(f) The development or use of the area requested by the prospective Lessee is likely to result in congestion of aircraft or airport buildings, or will unduly interfere with operations or activities of any present Lessee at the airport, or will prevent adequate access to the assigned Lease area of any present Lessee;

(g) The prospective Lessee has failed to make full disclosure or has misrepresented or omitted material facts in its application or in supporting documents;

(h) The prospective Lessee, or a principal of the prospective Lessee, has a record of violating the rules, regulations, statutes, ordinances, laws, or orders of any airport, or any civil air regulations, FAA regulations, or any other rules, regulations, statues, ordinances, laws, or orders applicable to airports;

(i) The prospective Lessee, or a principal of the prospective Lessee, has defaulted at any time in the performance of any other agreement with the State;

(j) On the basis of current financial information, the prospective Lessee does not, in the discretion of ODA, exhibit adequate financial responsibility or capability to undertake the proposed operation and activities;

(k) The prospective Lessee cannot or will not provide a performance bond or applicable insurance in the amounts and type required the Department for the proposed commercial aeronautical activity; or

(l) It is determined that the prospective Lessee's activities or operations could be detrimental in any way whatsoever to the State-owned airport.

Stat. Auth.: ORS 835.035, 835.040, 835.112
Stats. Implemented: ORS 935.035, 935.040, 835.112, 836.055
Hist.: AVIA 1-2002, f. & cert. ef. 9-3-02; AVIA 1-2004, f. & cert. ef. 2-17-04

738-025-0001
Purpose of Rule

The purpose of this rule is to establish a procedure for permitting non-retail facilities that dispense aviation fuels at airports.

Stat. Auth.: ORS 835.112, 480.390
Stats. Implemented: ORS 480.390
Hist: AVIA 1-2001(Temp), f. & cert. ef. 6-5-01 thru 11-30-01; AVIA 2-2001, f. & cert. ef. 10-24-01; AVIA 1-2004, f. & cert. ef. 2-17-04

738-025-0010
Permit Process

(1) Before starting construction or installation of a nonretail (card-lock) facility to dispense aviation fuels at an airport the owner or operator of the proposed facility shall submit to the Department an application for a facility permit.

(a) The Department shall specify the form of the application.

(b) The airport owner shall sign the application.

(c) The Department shall consider the airport owner's signature on the application as proof that the airport owner has permitted the construction or installation of the facility.

(2) Following receipt of the signed application the Department shall issue a permit to the owner or operator of the proposed facility:

(a) The permit shall state that the airport owner has given permission for the construction or installation of the facility;

(b) The Director of the Department shall sign the permit; and

(c) The signed permit shall be returned to the applicant.

(3) The application and permit specified in (1) and (2) of this rule are in addition to any other applications, permits or other requirements of additional federal, state or local authorities with jurisdiction over such facilities.

Stat. Auth.: ORS 835.112
Stats. Implemented: SB 106, eff. 06-04-01
Hist: AVIA 1-2001(Temp), f. & cert. ef. 6-5-01 thru 11-30-01; AVIA 2-2001, f. & cert. ef. 10-24-01; AVIA 1-2004, f. & cert. ef. 2-17-04

738-090-0030
Airport Listings

(1) The list of airports required by ORS 836.610(1) is as follows:

(a) Publicly owned airports registered, licensed or otherwise recognized by the Department on or before December 31, 1994, that in 1994 were the base for three or more aircraft, are as follows: [List not included. See ED. NOTE.]

(b) Privately owned, public use airports that provide important links in air traffic in this state; provide essential safety or emergency services; or are of economic importance to the county where the airport is located, are as follows: [List not included. See ED. NOTE.]

(2) Information to be considered in determining whether the criteria listed in subsection (1)(b) of this rule have been met are in OAR 738-090-0050.

(3) The Department will, at least every five years, review and update the listings of airports in this rule to add or remove airports from the listings as required by ORS 836.610(3). The Board will consider applications by airport sponsors for inclusion on the list, outside of the five-year review and update, as provided in OAR 738-090-0040.

[ED. NOTE: List referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619 & 836.610
Stats. Implemented: ORS 836.610
Hist.: AERO 1-1999, f. & cert. ef. 3-25-99; AVIA 4-2002, f. 11-27-02, cert. ef. 12-1-02; AVIA 1-2004, f. & cert. ef. 2-17-04

738-090-0040
Procedure for Adding an Airport to Listings

(1) The procedure for adding a publicly owned airport to OAR 738-090-0030(1)(a) is as follows:

(a) The airport sponsor shall submit a written request to the Department, to add an airport to the list;

(b) The request shall include documentation that:

(A) The airport is publicly owned;

(B) The airport was registered, licensed or otherwise recognized by the Department on or before December 31, 1994; and

(C) The airport was the base for three or more aircraft in 1994.

(c) The Department shall submit a copy of the airport sponsor's written request to the local government(s) that may be impacted by the change and request written comments on the request. If no comments are received from a local government within 60 days of mailing of the airport sponsor's request, it will be assumed that the local government has no comments on the request. Any comments received by the Department shall be forwarded to the airport sponsor;

(d) The Department shall evaluate the airport sponsor's written request and make a recommendation to the Board whether the proposed addition should be approved or denied;

(e) Upon approval of the Board, the airport shall be added to OAR 738-090-0030(1)(a) upon filing of formal amendment to the rules; and

(f) If the Board denies the airport sponsor's application, the airport may not be considered for inclusion on the list for at least two years.

(2) The procedure for adding a privately owned airport to OAR 738-090-0030(1)(b)is as follows:

(a) The airport sponsor shall apply to the Department for site approval as a public use airport on a site approval application form, Form 802-7611, provided by the Department;

(b) The airport sponsor shall submit an application to the FAA on an **FAA Form 7480-1**, with a proposal to place the airport into a public use category. If the airport currently has a public use airport status, this step is not necessary. (FAA Part 157.5, Notice of Intent);

(c) The Department shall submit a copy of the site approval application to the local government(s) that may be impacted by this change and request written comments on the application. If no comments are received from a local government within 60 days of mailing of the airport sponsor's application, it shall be assumed that the local government has no comments on the application. Any comments received by the Department shall be forwarded to the airport sponsor;

(d) The Department shall request the addresses of all affected property owners from the local governments. "Affected property owners" are those whose property is within 500 feet of an airport boundary, within an approach corridor, or whose use of their property may be directly affected, if the proposed airport is listed, by the requirements of the Land Conservation and Development's rules, OAR 660-013. The local government shall be responsible for determining which property owners will be affected by the proposed listing of an airport. This address list shall be submitted to the Department within 21 days of a written request from the Department. Failure of the local government to provide this list within the above time lines eliminates the responsibility of the Department to provide notice under this subsection. Upon receipt of the address list, the Department shall provide notice to the affected property owners, at least 20 days but no more than 40 days before the date of the public hearing, sufficient to tell the property owners generally of the effect of including the proposed airport on the list and the opportunity for public comment. The Department shall conduct a public hearing and receive testimony in each county where an airport is located. If more than one airport in a county is proposed for listing, one hearing shall be sufficient to meet this requirement.

(e) The Department shall evaluate the proposal based upon criteria in ORS 836.610(1)(b) and comments received from the airport sponsor, local governments and testimony taken at a public hearing;

(f) The Department shall make a recommendation to the Board whether the proposed action should be approved or denied;

(g) Upon approval of the Board, the airport shall be added to OAR 738-090-0030(1)(b) upon filing of formal amendment to the rules; and

(h) If the Board denies the airport sponsor's application, the airport may not be considered for inclusion on the list for at least two years.

(3) The Department will comply with the administrative rulemaking requirements in ORS Chapter 183 and its State Agency Coordination Program rule in OAR chapter 731, division 15 when adding airports to the lists in sections (1) and (2) of this rule.

[ED. NOTE: Form referenced are available from the agency.]
Stat. Auth.: ORS 184.616, 184.619 & 836.610
Stats. Implemented: ORS 836.610
Hist.: AERO 1-1999, f. & cert. ef. 3-25-99; AVIA 4-2002, f. 11-27-02, cert. ef. 12-1-02; AVIA 1-2004, f. & cert. ef. 2-17-04

738-100-0010
Purpose

(1) Except as provided in section (2) of this rule, notice of a public hearing on a land-use permit or a zone change and notice of a decision on a land-use permit pursuant to ORS 215.223, 215.416 and 227.175 shall be provided to owners of public-use airports by the respective city and county planning authorities if:

(a) The name and address of the airport owner has been provided by the Oregon Department of Aviation (Department) to the appropriate city or county planning authority;

(b) The property subject to the land-use permit or zone change is:

(A) Within 5,000 feet of the sides or ends of a runway determined by the Department to be a "visual airport"; or

(B) Within 10,000 feet of the sides or ends of the runway of an airport determined by the Department to be an "instrument airport".

(2) Notice of a public hearing on a land-use permit or zone change or notice of a decision on a land-use permit need not be provided as set forth in section (1) of this rule if that land-use permit or zone change would only allow a structure of less than 35 feet in height and the property is located outside the runway "approach surface", as defined in OAR 738-070-0120, or on property controlled by the airport.

(3) The failure of an airport owner to receive notice, which was mailed, shall not invalidate any land-use permit or zone change.

(4) This rule shall define terms used in Chapter 106, Oregon Laws 1987 and specify the dimensions of the approach surfaces for the various classifications of airports.

(5) In addition to the owner of a public-use airport, a copy of any notice of a land-use action for any affected airport shall, at the same time, be sent to the Oregon Department of Aviation, 3040 25th Street S.E., Salem, OR 97302-1125.

Stat. Auth.: ORS 184
Stats. Implemented: ORS 836.325
Hist.: AERO 4-1987, f. & ef. 12-15-87; AVIA 4-2002, f. 11-27-02, cert. ef. 12-1-02; AVIA 1-2004, f. & cert. ef. 2-17-04

• • • • • • • • • •

Oregon Department of Education
Chapter 581

Adm. Order No.: ODE 4-2004(Temp)
Filed with Sec. of State: 3-5-2004
Certified to be Effective: 3-5-04 thru 9-1-04
Notice Publication Date:
Rules Adopted: 581-001-0120
Subject: This rule was developed to clearly outline and codify the process by which the Oregon Department of Education will solicit and award intergovernmental agreements to school districts, education service districts, and community colleges.

If you have questions regarding this rule, please contact Bret West at (503) 378-3600, ext. 4446 or e-mail bret.west@state.or.us. For a copy of this rule, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us.
Rules Coordinator: Debby Ryan—(503) 378-3600, ext. 2348

581-001-0120
Administration of Intergovernmental Agreements

(1) For purposes of the rule:

(a) "Agreement to Agree" (ATA) is a written agreement between the Department and a public entity that contains contractual provisions, which can be used in certain future Intergovernmental Agreements between the parties through either incorporation by reference or attachment. Examples of an Agreement to Agree include, but are not limited to:

(A) A non-binding Price Agreement between the Department and a public entity under which the Department may issue purchase orders that create a binding agreement; and

(B) A document of understanding between the Department and a public entity, which identifies potential tasks or services the Department may request the public entity to perform, but are not specifically identified until the Department issues a purchase order or work order that creates a binding agreement.

(b) "Department" means the Oregon Department of Education.

(c) "Direct services" are services provided directly to children.

(d) "Local services" are those delivered within the boundaries of a school district, education service district, or community college district. Current examples include early intervention/early childhood, education of children in hospital programs, and educating children in long-term care or treatment programs.

(e) "Non-direct services" are all other services provided by school districts, education service districts, and community college districts that are not direct services.

(f) "Non-geographic services" are those delivered across more than one region but not across the entire state. Current examples include TESA and Early Intervention/Early Childhood Special Education.

(g) "Regional services" are those delivered within the four zones Education Service Districts they have established as the communications network. Current examples include educating children with disabilities in regional programs.

(h) "Request for Proposals" (RFP) is a solicitation document issued by the Department calling for proposals on specific activities.

(i) "Request for Qualifications" (RFQ) is a solicitation document issued by the Department to develop a list of pre-qualified service providers. Entities that successfully demonstrate they meet the qualifications will enter into Agreements to Agree.

(j) "Statewide services" are those delivered around the entire state. Current examples include administering Student Leadership Centers and the Oregon Public Education Network (OPEN).

(2) By March 31 of each odd-numbered year, the Department will issue Requests for Qualifications for educational services mandated by federal statue or by state legislative direction. These RFQs will be issued to education service districts, school districts, and community college districts in specific areas of the state depending on whether the services to be provided are considered Local, Regional, Non-geographic, or Statewide.

(3) The Department will enter into Agreements to Agree with all entities that have submitted responses to Requests for Qualification that meet the criteria established for specific services.

(4) Not later than 30 days of the end of the legislative session, the Department will issue Requests for Proposals for services likely to be funded by the Oregon Legislative Assembly or the federal government in the upcoming biennium. These RFPs will be issued to entities that have entered into an Agreement to Agree with the Department.

(5) The specific criteria for each RFP will be developed by Department staff having expertise in the content area. Selection criteria will be included in the RFP.

(6) Responses to Requests for Proposals will be evaluated by a team of Department staff having expertise in the content area and expertise in the technical aspects of procurement. The team will score each proposal and retain all documentation of the process for future review.

(7) Following evaluation of proposals, the Department will award an intergovernmental agreement to the successful proposer.

(8) If the Department and the selected ESD/SD are unable to reach an agreement, the Department reserves the right to open the process for broader competition including non-governmental entities. All proposing entities will be required to comply with state and federal requirements.

(9) Any organization submitting a proposal has the right to protest the Department's decision in the manner and on the timeline indicated in each RFP. To resolve protests, the Department will follow the procedures outlined in OAR 137-030-0104(4) and (6).

(10) If unanticipated circumstances arise that are detrimental to the fulfillment of a contract's provisions, the Department reserves the right to choose a provider and negotiate an intergovernmental agreement outside of the process outlined above. Such situations may include, but are not limited to, unexpected termination of an agreement by the current provider or termination of an agreement by the Department where children's health or safety is at risk. Determination of whether such a situation exists will be determined by a Department Deputy Superintendent.

Stat. Auth.: ORS 326.051
Stats. Implemented: ORS 326.051
Hist: ODE 4-2004(Temp), f. & cert. ef. 3-5-04 thur 9-1-04

• • • • • • • • • •

Adm. Order No.: ODE 5-2004(Temp)
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04 thru 9-1-04
Notice Publication Date:
Rules Amended: 581-020-0331
Subject: The temporary amendment establishes a 90-day period of time to file a request for review. This will ensure the State Board's ability to conduct a complete and timely review of the facts and conditions leading to the local board decision.

If you have questions regarding this rule, please contact Randy Harnisch at (503) 378-3600, ext. 2350, or e-mail randy.harnisch@state.or.us. For a copy of this rule, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us.
Rules Coordinator: Debby Ryan—(503) 378-3600, ext. 2348

581-020-0331
Appeal Process

(1) An applicant whose proposal to start a public charter school is not approved may request the State Board of Education review the decision of the school district board.

(2) The request for review must be made in writing and be received by the Superintendent of Public Instruction no later than 90 days from the date the local school board took formal action to deny the charter proposal under ORS 338.055(4).

(3) The State Board of Education delegates to the Superintendent of Public Instruction or designee all administrative functions necessary or rea-

sonable in order to conduct review. This delegation to the Superintendent includes, but is not limited to:

(a) Determining the form, contents and timelines of the petition for review;

(b) Determining the records required for review and ordering the production of those records from either the applicant or school district board and establishing timelines for the production of those records.

(c) Requiring the applicant or school district board to respond to written or oral inquiries related to board review;

(d) Determining the manner, means, scope and timelines by which mediation will take place, consistent with ORS 338.075(2)(a);

(e) Determining the manner, means and content of recommendations if any, to the applicant and school district board regarding revisions to the application;

(f) Determining at any time during the review process to reject a review request if in the judgment of the Superintendent, the applicant fails to reasonably comply with the administrative review processes of the Superintendent; and

(g) Negotiate, if determined by the Superintendent to appropriate, the terms of a proposed written charter that contains terms consistent with tentative agreements reached with the applicant during the review process.

(4) At the conclusion of the administrative review process, the Superintendent shall recommend in writing to the State Board to:

(a) Reject a proposal to start a public charter school if the proposed charter school fails to meet the requirements of ORS 338; or

(b) Sponsor the public charter school upon the terms in the proposal or upon such other terms specified.

(5) The State Board will consider the recommendation of the Superintendent and any other information it deems relevant and determine based on the requirements of ORS 338 to reject the proposal to have the State Board sponsor the public charter school or agree to sponsor the public charter school.

(6) The decision of the State Board rejecting a proposal to sponsor the public charter school will be based on substantial evidence in the record and will be made within 75 days of receipt by the State Board of the Superintendent's recommendation, unless extended for good cause.

(7) This rule is retroactive to November 1, 1999.

Stat. Auth.: ORS 3263.051
Stats. Implemented: Ch. 200 OL1999 (SB 100)
Hist.: ODE 13-2000, f. & cert. ef. 5-3-00; ODE 10-2002, f. & cert. ef. 4-12-02; ODE 5-2004(Temp), f. & cert. ef. 3-15-04 thru 9-1-04

• • • • • • • • • •

Adm. Order No.: ODE 6-2004
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 3-15-04
Notice Publication Date: 2-1-04
Rules Adopted: 581-023-0104
Subject: This rule implements the requirements of SB 550.

f you have questions regarding this rule, please contact Randy Harnisch at (503) 378-3600, ext. 2350, or e-mail randy.harnisch@state.or.us. For a copy of this rule, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us.
Rules Coordinator: Debby Ryan—(503) 378-3600, ext. 2348

581-023-0104
Reimbursement to School Districts for Children with High Cost Disabilities

(1) Consistent with the provisions of this rule, a school district may apply to the Department for reimbursement from the high cost disability fund when combined district and ESD general fund expenditures for special education and related services for any student eligible and served under IDEA exceed $25,000 in a fiscal year.

(2) To be eligible for the reimbursement, the school district shall have:

(a) Determined that the student is eligible for special education and related services under one of the disability categories set forth in OAR 581-015-0051;

(b) Provided services to the student on the basis of the student's current or previous individualized education program in effect during the fiscal year; and

(c) Submitted a timely application as per Department requirements.

(3) The Department shall only distribute the reimbursement to a school district for:

(a) Expenditures exceeding $25,000 for special education and related services that are required by the individualized education program of an individual student with a disability. Qualifying expenditures include those incurred by the school district and those incurred by the ESD through the resolution process.

(b) Transportation expenditures, exclusive of local, state and federal reimbursements.

(c) Special education general fund expenditures, exclusive of federal sources, as set forth in the Maintenance of Effort requirements of the federal IDEA. District and school level administrative expenditures (e.g. salaries) may be included by first averaging the expenditures across all the special education students enrolled as identified on the most recent SECC, then applying the average to the student for whom the district is requesting reimbursement. Similarly, teacher and educational assistant salaries must be averaged across all the special education students for whom the teacher or assistant provided instruction during the school year.

(4) Expenditures not eligible for reimbursement include:

(a) Regional Program expenditures;

(b) Reimbursed Medicaid expenditures;

(c) Expenditures associated with facility operations and maintenance (e.g., heat, electricity, custodial services)

(5) In December of each year, school districts will provide the Department with an estimate of the aggregate number of students eligible for reimbursement from the High Cost Disabilities Fund and the total estimated aggregate amount of reimbursable expenditures, including ESD expenditures that will be incurred during the school year. As requested by the Department, districts will also report during the school year, updated information listing eligible students, SDID, names, estimated expenditures, and other information as requested.

(6) A school district may submit an application for each student identified who meets the criteria set forth in section (2) and (3) of this rule.

(7) The Department shall provide school districts with an application that shall require documentation that identifies all the school districts and ESD's expenditures for each student. Additional supporting documentation, subject to ODE review, may include a copy of the contract(s) between the school district and the service provider(s), invoices reflecting actual expenses, and any additional documentation of expenditures incurred as determined by the Department. These documents must be maintained at the District for at least three years after the submission of the student-level data.

(8) The Department shall develop and implement a process for reviewing applications.

(9) The Department shall prorate the distribution of funds for each school year to eligible school districts if sufficient funds are not available.

(10) Based on the outcome of section (8), the Department will exclude from reimbursement those expenditures deemed excessive, ineligible or unsubstantiated.

(11) Funds will be distributed to districts on or before May 15 for the current fiscal based on expenditure estimates. Adjustments will be made May 15 of the following year based on audited data and Department reviews of district records.

(12) The decision of the Department regarding reimbursement of costs pursuant to this rule shall be final.

Stat. Auth.: ORS 326.051, 2003 OL Ch. 715, Sec. 2
Stats. Implemented: 2003 OL Ch. 715
Hist.: ODE 6-2004, f. & cert. ef. 3-15-04

• • • • • • • • • •

Oregon Film and Video Office
Chapter 951

Adm. Order No.: FVO 1-2004(Temp)
Filed with Sec. of State: 3-12-2004
Certified to be Effective: 3-15-04 thru 9-11-04
Notice Publication Date:
Rules Adopted: 951-001-0000
Subject: Procedure for notice of intended rulemaking.
Rules Coordinator: Susan Kaye Tong—(503) 229-5832

951-001-0000
Procedure for Notice of Intended Rulemaking

(1) Definitions: For purposes of this chapter of administrative rules, unless the context demands otherwise:

(a) **OFVO** or **Office** means the Oregon Film and Video Office as organized under ORS 284.300 to 284.375.

(b) **OFVO Board** or **Board** means the Oregon Film and Video Office board as organized under ORS 284.315

(c) **Director** means the Oregon Film and Video Office executive director appointed under ORS 284.325

(2) Before permanently adopting, amending or repealing any rule, the Oregon Film and Video Office will give notice of the intended action:

(a) In the Secretary of State's Bulletin, referred to in ORS 183.360 at least 21 days before the effective date of the rule;

(b) By mailing a copy of the notice to persons on the OFVO mailing list established pursuant to ORS 183.335(8), at least 28 days before the effective date of the rule;

(c) By mailing a copy of the notice to the legislators specified in ORS 183.335(15) at least 49 days before the effective date of the rule; and

(d) By mailing or furnishing a copy of the notice to:

(A) The Associated Press;

(B) Capitol Press Room

(C) The following associations:

(i) Oregon Media Production Association

(ii) Mid-Oregon Productions Arts Network

(iii) Media Communications Association International

(iv) Central Oregon Film and Video Association

(D) The following state agencies:

(i) Oregon Economic and Community Development Department

(ii) Oregon Tourism Commission

(iii) Oregon Arts Commission

Stat. Auth.: ORS 284.300-284.315
Stats. Implemented: ORS 284.300-284.315
Hist.: FVO 1-2004(Temp), f. 3-12-04 cert. ef. 3-15-04 thru 9-11-04

• • • • • • • • • •

Adm. Order No.: FVO 2-2004
Filed with Sec. of State: 3-12-2004
Certified to be Effective: 4-15-04
Notice Publication Date: 4-1-04
Rules Adopted: 951-001-0005
Subject: The Oregon Film & Video Office under the Administrative Procedures Act adopts Division 1 and Division 4 of the Attorney General's Uniform and Model Rules.
Rules Coordinator: Susan Kaye Tong—(503) 229-5832

951-001-0005
Model Rules of Procedure

The Uniform and Model Rules of Procedure, OAR 137-001-0007 through 137-001-0080; and 137-004-0010 through 137-004-0800 as adopted by the Attorney General of the State of Oregon under the Administrative Procedures Act, effective October 1, 2001, are adopted as the rules of procedure for rulemaking and declaratory rulings for the Oregon Film & Video Office.

Stat. Auth.: ORS 284.300 - 284.315
Stats. Implemented: ORS 284.300 - 284.315
Hist.: FVO 2-2004, f. 3-12-04, cert. ef. 4-15-04

• • • • • • • • • •

Oregon Liquor Control Commission
Chapter 845

Adm. Order No.: OLCC 2-2004
Filed with Sec. of State: 2-17-2004
Certified to be Effective: 6-1-04
Notice Publication Date: 7-1-03
Rules Amended: 845-007-0015
Subject: This rule describes the sorts of advertising media which are allowed and prohibited by the Commission. Amendments to the rule clarify the use of coupons, both mail-in and instantly redeemable. The amendments include clarification on the use of customer loyalty programs, and add a prohibition against use of coupons which require the purchase of alcohol in order to obtain the coupon's benefit.
Rules Coordinator: Katie Hilton—(503) 872-5004

845-007-0015
Advertising Media, Coupons

(1) The Commission prohibits advertising through:

(a) Handbills that are posted or passed out in public areas such as parking lots and publicly owned property;

(b) Discount coupons for malt beverages, wine and cider;

(c) Point of sale items on premises where the advertised product is not sold.

(2) The Commission may prohibit advertising through additional media consistent with the objectives in OAR 845-007-0005.

(3) The Commission prohibits coupons which require the purchase of alcohol in order to obtain the coupon's benefit.

(4) The Commission allows the use of instantly redeemable and mail-in coupons. The coupons may be redeemed for food, non-alcoholic beverages and non-food items. Use of coupons must conform with the principles of OAR 845-013-0001. Coupons are prohibited for items prepared or manufactured by the retailer, such as: deli trays, in-house bakery products, "ready to eat" foods, and private label products. A licensee who violates this section commits a Category IV violation under the Commission's sanction schedule (OAR 845-006-0500).

(5) The Commission allows customer loyalty programs such as "club cards" if the promotion (club card) is offered without discrimination to all customers of the retail licensee. The retail licensee must pay for all discounts on alcoholic beverages provided to holders of the club card.

Stat. Auth.: ORS 471 & 472, including 471.030, 471.730(1) & (5), 472.030 & 472.060(1) & (2)(d)
Stats. Implemented: ORS 471.730(7)
Hist.: LCC 56, f. 10-20-76, ef. 12-1-76; LCC 7-1979, f. 4-2-79, ef. 4-5-79; Renumbered from 845-010-0091; LCC 7-1985, f. 7-30-85, ef. 9-1-85; OLCC 6-1998, f. 5-21-98, cert. ef. 6-1-98; OLCC 9-2003, f. 6-27-03, cert. ef. 7-1-03; OLCC 2-2004, f. 2-17-04, cert. ef. 6-1-04

• • • • • • • • • •

Oregon Public Employees Retirement System
Chapter 459

Adm. Order No.: PERS 4-2004
Filed with Sec. of State: 2-18-2004
Certified to be Effective: 2-18-04
Notice Publication Date: 11-1-03
Rules Adopted: 459-070-0001, 459-075-0010
Subject: New administrative rules are needed to implement and clarify Enrolled House Bill 2020, which establishes the Oregon Public Service Retirement Plan. OAR 459-070-0001 defines terms used in other proposed administrative rules related OPSRP. OAR 459-075-0010 clarifies how one becomes a member of OPSRP.
Rules Coordinator: Yvette S. Elledge—(503) 603-7713

459-070-0001
Definitions

The words and phrases used in this Division have the same meaning given them in chapter 733, Oregon Laws 2003 (Enrolled HB 2020) unless otherwise indicated in this rule. Specific and additional terms for purposes of Divisions 70, 75 and 80 are defined as follows unless context requires otherwise:

(1) "Break in service" means a period concluding on or after August 29, 2003, during which a member of PERS performs no service, as defined below, with a participating public employer in a qualifying position for a duration of:

(a) Six or more consecutive calendar months; or

(b) 12 or more consecutive calendar months under one of the following circumstances:

(A) The member of PERS ceases performance of service for purposes that have qualified the member for family leave, as described in section 2(3)(c), chapter 733, Oregon Laws 2003 (Enrolled HB 2020), as determined by the employer; or

(B) The member of PERS ceases performance of service for career development purposes, as described in section 2(3)(d), chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(2) "Calendar month" means a full month beginning on the first calendar day of a month and ending on the last calendar day of the same month.

(3) "Calendar year" means 12 calendar months beginning on January 1 and ending on December 31 following.

(4) "Employee" has the same meaning as "eligible employee" in section 1(4), chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(5) "Employee class" means a group of similarly situated employees whose positions have been designated by their employer in a policy or collective bargaining agreement as having common characteristics.

(6) "Employee contributions" means contributions made to the individual account program by an eligible employee under section 32, chapter 733, Oregon Laws 2003 (Enrolled HB 2020), or on behalf of the employee under section 34, chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(7) "Member" has the same meaning given the term in section 1(10), chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(8) "Member account" means the account of a member of the individual account program.

(9) "Member of PERS" has the same meaning as "member" in ORS 238.005(12)(a), but does not include retired members.

(10) "OPSRP" means the Oregon Public Service Retirement Plan.

(11) "Overtime" means the salary or hours, as applicable, that an employer has designated as overtime.

(12) "PERS" means the retirement system established under ORS chapter 238.

(13)(a) "Qualifying position" means a position or positions in which an employee is expected to perform 600 or more combined hours of service in a calendar year.

(b) If an employee is employed in a position or positions not designated as qualifying and performs 600 or more total hours of service in a calendar year, the position or positions will be considered qualifying and the employee shall be considered to have performed service in a qualifying position from the date of employment or January 1 of the calendar year in which the employee performed more than 600 hours of service, whichever is later.

(c) Except as provided in subsection (d) of this section, if an employee is employed in a position or positions designated as qualifying and performs less than 600 hours of service in a calendar year, the position will be considered non-qualifying from the date of employment or January 1 of the calendar year in which the employee performed less than 600 hours of service, whichever is later.

(d) For purposes of determining qualification upon initial employment in a position or positions, but not for determining a break in service or any other purpose, if an employee is employed in a position or positions for less than a full calendar year and performs less than 600 hours of service in that calendar year, but would have performed 600 hours of service or more if the employee had performed service in the same position(s) for the full calendar year, and if the employee performs 600 or more hours of service in the following calendar year, the position or positions will be considered qualifying as of the date of employment.

(14)(a) "Salary" has the same meaning given the term in section 1(16), chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(b) Salary is considered earned when paid except as provided in subsection (c) of this section and as otherwise provided in section 1(16)(b)(E), chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(c) Salary is considered earned when earned for purposes of calculating final average salary.

(15) "School employee" has the meaning given the term in section 11(6), chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(16) "Service." Except as provided in subsection (c) of this section, a person is still providing "service," for purposes of determining whether a "break in service" has occurred under Sections 2 and 2a of chapter 733, Oregon laws 2003 (Enrolled HB 2020), during any calendar month that a member:

(a) Is in an employer/employee relationship; and

(b) Receives a payment of "salary," as that term is defined in ORS 238.005(20) or similar payment from workers compensation or disability.

(c) A member who is a school employee will be considered to provide "service" during any calendar month the institution is not normally in session so long as the member is in an employer/employee relationship both before and after the period the institution is not normally in session.

Stat. Auth.: OL 2003 Ch. 733
Stats. Implemented: OL 2003 Ch. 733
Hist.: PERS 4-2004, f. & cert. ef. 2-18-04

459-075-0010
Eligibility and Membership

(1) Eligibility. An employee is eligible to become a member and receive benefits under the OPSRP pension program, and ineligible to become (or remain) a member of PERS or accrue benefits under PERS, if the employee:

(a) Begins employment in a qualifying position with a participating public employer on or after August 29, 2003;

(b) Was not a member of PERS before August 29, 2003; and

(c) Did not perform any period of service before August 29, 2003, that is credited to the six-month period required under ORS 238.015 for membership in PERS; or

(d) Was an active or inactive member of PERS on August 28, 2003, and incurs a break in service.

(2) Break in service:

(a) For purposes of this section and sections 2 and 2a of chapter 733, Oregon Laws 2003 (Enrolled HB 2020):

(A) "Active member of PERS" means an employee who is a member of PERS and not separated from service in a qualifying position with a participating public employer.

(B) "Inactive member of PERS" means an employee who is a member of PERS but was separated from service in a qualifying position with a participating public employer, including a member who was on a leave of absence without pay as described in OAR 459-010-0010.

(b) If an employee who was an active member of PERS on August 28, 2003, incurs a break in service, the employee shall be entitled to benefits under PERS for all service performed prior to the break in service, and benefits under the OPSRP pension program for all service performed after the break in service.

(c) If an employee who was an inactive member of PERS on August 28, 2003, incurs a break in service concluding prior to January 1, 2004, the employee shall be entitled to benefits under PERS for all service performed prior to the break in service and prior to January 1, 2004, and benefits under the OPSRP pension program for all service performed on or after January 1, 2004.

(d) If an employee who was an inactive member of PERS on August 28, 2003, incurs a break in service concluding on or after January 1, 2004, the employee shall be entitled to benefits under PERS for all service performed prior to the break in service and benefits under the OPSRP pension program for all service performed after the break in service.

(e) If a member of PERS ceases performance of service for one of the reasons described in OAR 459-070-0001(1)(b), the member returns to a qualifying position if the member resumes performance of hours of service and:

(A) Performs 600 hours of service in the calendar year(s) of absence; or

(B) Performs a total of 600 hours of service in the calendar year prior to leaving service, with no less than 50 hours per month performed in the last six months of that year, and performs 600 hours of service in the calendar year following the return to service, with no less than 50 hours per month performed in the first six months of that year.

(f) If a member of PERS ceases performance of service for reasons other than those described in OAR 459-070-0001(1)(b), the member returns to a qualifying position if the member resumes performance of service and performs 600 hours in the calendar year of the return to service.

(g) If a member of PERS ceases performance of service to serve as a legislator, the absence from regular employment for that purpose shall not be considered a break in service.

(h) If a member of PERS ceases performance of service to serve in the uniformed services, as defined in the 1994 federal Uniformed Services Employment and Reemployment Rights Act (USERRA), and meets the eligibility requirements for reemployment under USERRA, the absence from service for that purpose shall not be considered a break in service.

(3) Membership:

(a) Except as provided in subsection (c) of this section, an employee who meets the requirements in section (1) of this rule shall become a member of the OPSRP pension program on the first day of the calendar month after the employee completes six full calendar months of employment in a qualified position with the same participating public employer.

(b) If the six months required by subsection (a) of this section are interrupted by 30 or more consecutive working days in which the employee performs no paid service for the same participating public employer, the period of employment prior to the interruption shall not count toward the six-month requirement.

(c) An employee who was an active or inactive member of PERS on August 28, 2003, and incurred a break in service shall become a member of the OPSRP pension program on the first day of the calendar month after the return to employment.

Stat. Auth.: OL 2003 Ch. 733
Stats. Implemented: OL 2003 Ch. 733; 38 U.S.C. Sec. 4318(a)(2)(A)
Hist.: PERS 4-2004, f. & cert. ef. 2-18-04

••••••••••

Adm. Order No.: PERS 5-2004
Filed with Sec. of State: 2-18-2004
Certified to be Effective: 2-18-04
Notice Publication Date: 11-1-03
Rules Amended: 459-005-0055
Subject: This rule modification pertains to Actuarial Equivalency Factors and the methodology for implementing new factors. Modifications to this rule incorporate the provisions in HB 2004 including amendments to it made by HB 2003 §40 and HB 3020 §16. This legislation mandated regularly scheduled updates of the actuarial

equivalency factors that are used in the calculation of retirement benefits. For effective retirement dates of July 1, 2003, to January 1, 2005, PERS must use new actuarial equivalency factor tables. These tables will be based on the mortality assumptions adopted by the Board on September 10, 2002. Retirees will be subject to a "look-back" calculation to compare the benefit under the old and the new tables. In addition, beginning on January 1, 2005, the PERS Board must adopt actuarial equivalency factor tables every two calendar years, to be effective January 1 of each odd numbered year.
Rules Coordinator: Yvette S. Elledge—(503) 603-7713

459-005-0055
Actuarial Equivalency Factors

(1) **Experience Study**. The Director shall take steps to assure that the Board's consulting actuary shall present the Experience Study required by ORS 238.605 to the Board by September 1 of each even numbered year.

(2) **Actuarial Equivalency Study**. The Director shall take steps to assure, pursuant to ORS 238.630(3)(g), that the Board's consulting actuary shall present an Actuarial Equivalency Study to the Board as soon as practicable, but no later than the December 15 next following the presentation of the Experience Study described in section (1) of this rule. Such Actuarial Equivalency Study shall review the assumptions and the actuarial factors used to:

(a) Convert account balances to monthly allowances;

(b) Convert the standard form of benefit (ORS 238.300) to elective options with various survivorship features (ORS 238.305); and

(c) Reduce service retirement allowances for early retirement (ORS 238.280).

(3) **Adoption of actuarial equivalency factors**.

(a) In computing the retirement allowance of members and alternate payees with retirement dates from July 1, 2003, to January 1, 2005, the Board shall use actuarial equivalency factor tables that are based on the mortality assumptions of the actuary's 2001 experience study adopted by the Board on September 10, 2002.

(b) Beginning effective January 1, 2005, the Board shall adopt actuarial equivalency factor tables to be effective for January 1 of each odd numbered year. Actuarial equivalency factor tables adopted under this section shall comply with the standards set forth in OAR 459-005-0060.

(4) **Calculation of retirement allowance**.

(a) The provisions of this section apply to any member or alternate payee with an effective date of retirement on or after July 1, 2003, except for a person who is a judge member on June 30, 2003, and who makes an election under ORS 238.565(4).

(b) PERS shall establish years of service, an account balance and final average salary as of June 30, 2003, for each person described in subsection (a) of this section. The years of service, account balance and final average salary shall be determined as provided in section 40 of chapter 67, Oregon Laws 2003 (Enrolled HB 2003).

(c) For each person described in subsection (a) of this section, the Board shall perform the following two calculations:

(A) "Regular" calculation. The Board shall calculate the retirement allowance using:

(i) The years of service, account balance and final average salary as of the effective date of retirement;

(ii) All calculations applicable to the member under ORS 238.300(2);

(iii) The optional form of retirement allowance selected by the member at retirement under ORS 238.300, 238.305, 238.320 or 238.325; and

(iv) The actuarial equivalency factor tables in effect on the effective date of retirement.

(B) "Look-back" calculation. The Board shall calculate the retirement allowance using:

(i) The years of service, account balance and final average salary described in subsection (b) of this section;

(ii) All calculations applicable to the member under ORS 238.300(2);

(iii) The optional form of retirement allowance selected by the member under ORS 238.300, 238.305, 238.320 or 238.325; and

(iv) The actuarial equivalency factor tables in effect on June 30, 2003.

(d) The retirement allowance shall be the higher of the amounts described in paragraphs (c)(A) and (c)(B) of this section, payable as of the effective date of retirement.

(5) **Death benefit payments**. Any monthly payments to be made to a beneficiary under ORS 238.390, 238.395 or 238.405 for a member who dies on or after May 9, 2003, shall be calculated using the actuarial equivalency factor tables that are in effect on the date that the first payment is due the beneficiary.

(6) **Judge members**. The actuarial equivalency factor tables in effect on June 30, 2003, shall be used to calculate the retirement allowance and surviving spouse pension of a person who is a judge member on June 30, 2003, and who makes an election under ORS 238.565(4), whether that election is made before, on or after June 30, 2003.

Stat. Auth: ORS 238.630 & 238.650
Stats. Implemented: ORS 238.630(3)(g)
Hist.: PERS 1-1993, f. 4-14-93, cert. ef. 5-1-93; PERS 6-1996, f. 8-13-96, cert. ef. 1-1-99; PERS 5-2004, f. & cert. ef. 2-18-04

• • • • • • • • • •

Adm. Order No.: PERS 6-2004
Filed with Sec. of State: 2-18-2004
Certified to be Effective: 2-18-04
Notice Publication Date: 12-1-03
Rules Adopted: 459-075-0150
Subject: This new rule implements and clarifies the retirement credit provisions of Enrolled HB 2020, which established the Oregon Public Service Retirement Plan (OPSRP). Section (1) of the rule implements HB 2020 subsection 11(2), which grants retirement credit for the six-month period of employment required for membership in the program. This section also clarifies that the amount of credit awarded for this period will be determined in accordance with the general provisions governing accrual of retirement credit. Sections (2) and (3) of the rule implement subsection 11(5) of HB 2020, which governs prorated retirement credit to school employees.
Rules Coordinator: Yvette S. Elledge—(503) 603-7713

459-075-0150
Retirement Credit

(1) **Credit for the six-month period required by OAR 459-075-0010(3)**.

(a) Upon establishing membership in the pension program, a member shall receive credit for the hours of service required to establish membership under OAR 459-075-0010(3).

(b) The amount of credit awarded under this section shall be determined in accordance with subsections (1) and (3) through (6), section 11, chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(c) If the member's period of employment prior to establishment of membership included an interruption of service as described in OAR 459-075-0010(3)(b), no credit shall be awarded for the period of employment prior to the interruption.

(d) No credit shall be awarded for hours of service performed prior to January 1, 2004.

(2) **Retirement credit**. A member shall accrue retirement credit in accordance with section 11, chapter 733, Oregon Laws 2003 (Enrolled HB 2020).

(a) **Retirement credit for school employees**. If a member performs a combined total of 600 or more hours in a calendar year in one or more positions as a school employee, prorated retirement credit will be calculated for each position by dividing the number of the member's hours of service in each position by the number of hours of service required of a full-time school employee for that same position or comparable position.

(b) **Retirement credit for school employees employed in another qualifying position in a calendar year**. If a member performs a combined total of 600 or more hours of service in one or more positions as a school employee and another qualifying position or positions in a calendar year, prorated retirement credit will be calculated for each position in the following manner:

(A) For each position as a school employee, by using the method described in section (2)(a) of this rule; and

(B) For each non-school qualifying position, by dividing the number of the member's hours of service in each non-school qualifying position by 2000.

(3) A member only accrues retirement credit for calendar years in which the member performs 600 or more total hours of service in one or more qualifying positions. No member may receive more than one full year of retirement credit for any calendar year.

Stat. Auth.: OL 2003 Ch. 733
Stats. Implemented: OL 2003 Ch. 733
Hist.: PERS 6-2004, f. & cert. ef. 2-18-04

• • • • • • • • • •

Adm. Order No.: PERS 7-2004(Temp)
Filed with Sec. of State: 2-18-2004
Certified to be Effective: 2-18-04 thru 6-30-04

Notice Publication Date:
Rules Adopted: 459-070-0900
Subject: The temporary rule provides guidelines for administering and processing transactions in certain areas of the new Oregon Public Service Retirement (OPSRP) Pension Program and the Individual Account Program (IAP) using the processes currently in place under ORS Chapter 238, where applicable. This rule will be in place until permanent rules and associated application forms and information can be developed to administer the following areas of the OPSRP Pension Program and Individual Account Program (IAP): beneficiary designation under the IAP, withdrawals under both the Pension Program and the IAP, retirements under the IAP, and disabilities under the Pension Program.
Rules Coordinator: Yvette S. Elledge—(503) 603-7713

459-070-0900
PERS/OPSRP Transitional Rules

(1) **Purpose**. The purpose of this rule is to implement sections 8 (Withdrawal), 25a (Disability Benefit), 40 (Withdrawal), 41 (Defined Contribution Benefit), and 42 (Death Benefit), chapter 13, Oregon laws 2003 (Enrolled HB 2020).

(2) **Limitation of scope of rule**. Benefits provided under this rule shall not exceed the benefits provided in chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(3) **Definitions**. For the purposes of this rule:

(a) "Current spouse" means a married member's spouse as of the later of January 1, 2004, or (as appropriate) the date of the member's death or the date a retirement benefit or withdrawal is to be paid under the IAP.

(b) "Earliest retirement age" means the retirement age as defined in section 16, chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(c) "IAP" means the Individual Account program as set forth in sections 29 to 43, chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(d) "Married member" means a member who is married as of the later of January 1, 2004, or (as appropriate) the date of the member's death or the date a retirement benefit or withdrawal is to be paid under the IAP.

(e) "OPSRP" means the Oregon Public Service Retirement Plan.

(f) "Pension program" means the pension program as set forth in sections 5 to 26, chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(g) "Retirement Credit" means the credit for service a member receives pursuant to section 11, chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(4) **Beneficiary designation**.

(a) For the purposes of distributing the death benefit provided in section 42, chapter 733, Oregon laws 2003 (Enrolled HB 2020), the beneficiary or beneficiaries will be considered the same beneficiary or beneficiaries named on a member's Designation of Beneficiary previously filed with PERS pursuant to OAR 459-014-0030, except:

(A) Where a court order or court-approved property settlement agreement incident to any court decree of annulment or dissolution of marriage or of separation provides otherwise;

(B) Where the member has filed a new Designation of Beneficiary form specifically approved by the Public Employees Retirement Board for the purposes of section 42, chapter 733, Oregon laws 2003 (Enrolled HB 2020); or

(C) Where a married member has named a beneficiary other than his or her current spouse.

(i) In order for a member to name someone other than his or her current spouse, a spousal consent is required as set forth under section 42(2), chapter 733, Oregon laws 2003 (Enrolled HB 2020), to distribute the death benefit to anyone other than the current spouse.

(ii) A spouse may revoke the above consent by filing a revocation with PERS, with notarized signatures of both the member and the spouse. Upon the filing of such revocation, the member's current spouse shall be the beneficiary.

(b) In the case where no Designation of Beneficiary form has been filed with PERS pursuant to OAR 459-014-0030, or someone other than the current spouse is named the beneficiary and no spousal consent form has been filed with PERS, or the named beneficiary predeceases the member, the death benefit will be distributed in the following order:

(A) To the member's surviving spouse;

(B) To the member's surviving children, in equal shares; or

(C) To the member's estate.

(5) **Withdrawals**.

(a) If a member requests a withdrawal pursuant to ORS 238.265, this request will also be considered a request to withdraw from the OPSRP pension program under section 8, chapter 733, Oregon Laws 2003 (Enrolled HB 2020), and the IAP under section 40, chapter 733, Oregon Laws 2003 (Enrolled HB 2020), to the extent the member's interest under those programs is vested, unless the member affirmatively elects, on a form acceptable to and filed with PERS, not to withdraw his or her OPSRP IAP account(s).

(b) A request by a member to withdraw only his or her vested IAP accounts under section 40, chapter 733, Oregon laws 2003 (Enrolled HB 2020), will not be considered a simultaneous request to withdraw from the ORS Chapter 238 plan.

(6) **Defined Contribution Benefit**.

(a) If a member applies and is eligible for service retirement under ORS chapter 238, and has reached the earliest retirement age as defined in section 16, chapter 733, Oregon Laws 2003 (Enrolled HB 2020), the application for service retirement will also be considered an application for payment of the Defined Contribution Benefit provided under section 41, chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(b) The member may make any payment election provided for in section 41, chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(c) If a member retires under ORS Chapter 238, and has not reached the OPSRP earliest retirement age, the member's IAP account(s) will remain in the IAP until the member is eligible for retirement under OPSRP and applies for payment of his or her IAP account(s).

(d) If a member retires under ORS Chapter 238, and the member is reemployed by a participating public employer as defined in section 1(11), chapter 733, Oregon laws 2003 (Enrolled HB 2020), the IAP account(s) will be retained until the member qualifies for and requests withdrawal of the account under section 40 or retirement under section 41 of chapter 733, Oregon laws 2003 (Enrolled HB 2020).

(7) **Disability Benefit**. The disability benefits under section 25a, chapter 733, Oregon laws 2003 (Enrolled HB 2020), will be provided in the following manner:

(a) Duty disability. For the purposes of applying and qualifying for a duty-disability benefit under the OPSRP pension plan, the provisions of ORS Chapter 238 and OAR 459-007-0070 and chapter 459, division 15, will apply.

(b) Non-duty disability. For the purposes of applying and qualifying for a non-duty disability benefit under the OPSRP pension plan, in addition to the provisions of ORS Chapter 238 and OAR 459-007-0070 and chapter 459, division 15, the member must have accrued 10 years or more of retirement credit before becoming disabled.

(8) The provisions of this rule are effective on January 1, 2004.

Stat. Auth.: ORS Ch, 238 & OL 2003 Ch. 733
Stats. Implemented: ORS Ch. 238 & OL 2003 Ch. 733
Hist.: PERS 7-2004(Temp), f. & cert. ef. 2-18-04 thru 6-30-04

• • • • • • • • • •

Oregon State Lottery
Chapter 177

Adm. Order No.: LOTT 2-2004(Temp)
Filed with Sec. of State: 2-20-2004
Certified to be Effective: 2-23-04 thru 8-20-04
Notice Publication Date:
Rules Amended: 177-099-0050
Subject: Effective February 23rd, 2004, the proposed amendment revises the Keno drawing interval from five to four minutes.
Rules Coordinator: Mark W. Hohlt—(503) 540-1417

177-099-0050
Drawings

(1) General: Drawings shall take place at such times and upon such intervals as determined by the Director. Drawings shall normally take place at four minute intervals. The last drawing shall take place just prior to the deactivation of the On-Line game system for the day.

(2) Objective: Each drawing randomly selects twenty numbers from a possible eighty numbers that are the winning numbers. The winning numbers selected at each drawing are generated through the use of a computer-driven random number generator.

(3) Selection of the Keno Multiplier Number: The Lottery will conduct a separate random Keno Multiplier drawing and announce the result prior to each of the regular Keno drawings by displaying the Keno Multiplier number on the Keno monitor immediately prior to each new Keno game drawn and after the previous game pool closes. During each

random Keno Multiplier drawing, one number will be selected. The Keno Multiplier numbers available for selection are 1, 2, 3, 5, and 10. The Keno Multiplier number selected at each drawing is generated through the use of a computer-driven random number generator in accordance with the provisions of OAR 177-046-0080.

Stat. Auth.: Or. Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.200
Hist.: LC 3-1991, f. & cert. ef. 7-24-91; LC 5-1996, f. & cert. ef. 4-1-96; LC 3-1997, f. 4-25-97, cert. ef. 4-27-97; LOTT 7-1998(Temp), f. & cert. ef. 11-13-98 thru 5-7-99; LOTT 3-1999, f. 3-25-99, cert. ef. 4-4-99; LOTT 19-2002(Temp), f. 9-6-02, cert. ef. 9-9-02 thru 3-6-03; LOTT 30-2002, f. & cert. ef. 11-25-02; LOTT 3-2003(Temp), f. 3-28-03, cert. ef. 4-7-03 thru 9-30-03; LOTT 11-2003, f. & cert. ef. 6-30-03; LOTT 2-2004(Temp), f. 2-20-04, cert. ef. 2-23-04 thru 8-20-04

• • • • • • • • • •

Parks and Recreation Department
Chapter 736

Adm. Order No.: PRD 4-2004
Filed with Sec. of State: 3-15-2004
Certified to be Effective: 4-15-04
Notice Publication Date: 2-1-04
Rules Amended: 736-010-0022
Subject: Implements House Bill 2759, 2003 Legislative Session, which modifies fines for certain violations. The revised Base Fine Schedule became effective on September 1, 2003 with additional changes effective on January 1, 2004.
Rules Coordinator: Angie Springer—(503) 378-5516

736-010-0022
Fines

(1) Any person, firm or corporation violating any park rule commits a Class A, B, C, or D violation punishable, upon conviction, by a fine as established by ORS 153.138 Schedule of Base Fine Amounts.

(2) Each occurrence of a violation of a park area rule shall be considered a separate offense.

Stat. Auth.: ORS 153 & 390
Stats. Implemented: ORS 153.018, 390.050, 390.111 & 390.990
Hist.: PR 5-1983, f. & ef. 3-30-83; PRD 2-2000(Temp), f. & cert. ef. 1-14-00 thru 7-12-00; PRD 6-2000, f. & cert.. ef. 5-9-00; PRD 1-2004(Temp), f. & cert. ef. 1-15-04 thru 3-31-04; PRD 4-2004, f. 3-15-04 cert. ef. 4-15-04

• • • • • • • • • •

Racing Commission
Chapter 462

Adm. Order No.: RC 1-2004
Filed with Sec. of State: 3-3-2004
Certified to be Effective: 3-3-04
Notice Publication Date: 1-1-04
Rules Amended: 462-120-0020
Subject: Amends the rule to include the periodic use of a metal detector to inspect jockeys for contraband prior to leaving for the saddling paddock.
Rules Coordinator: Carol N. Morgan—(503) 731-4052

462-120-0020
Search; Warrant/Warrantless

(1) Any person who applies for or is issued a license by the commission and any person who enters a restricted area is deemed to have given consent to a warrantless search by commission investigators or stewards/judges of the person's personal property (including clothing worn and items carried by the person), the person's vehicle and any premises which the person occupies while the person or the property is in any place under the jurisdiction of the commission, subject to the following:

(a) The investigators or stewards/judges may search during times that the race meet is licensed to conduct racing and for 15 days prior to the beginning and 15 days after the end of the race meet.

(b) The investigators or stewards/judges may search when they have a reasonable suspicion that the person possesses stolen property, a prohibited or injectable drug or medication, controlled substance, unauthorized hypodermic instrument, needle or syringe, unauthorized mechanical or electrical devices, unauthorized equipment, contraband (including illegal gambling paraphernalia), weapon or other evidence of a violation of racing statute or administrative rules.

(c) Notwithstanding the provisions of subsection (b), the investigators may perform a periodic inspection of the jockey room, including the assigned space of any jockey. The investigators may also periodically use a metal detector to inspect each jockey for contraband prior to leaving the jockey area for the saddling paddock. These inspections may be conducted without prior notice.

(d) If the subject of the search is not an applicant for a license or licensed by the commission, the search may be conducted only if the person was given oral or written notice of this rule upon entering the restricted area, or if the person is a trespasser onto the restricted area.

(e) If the search concerns the person or the property of a licensee who is represented by an association pertaining to racing and recognized by the Oregon Racing Commission, the person will be informed that they have the right to have an association representative to witness the search, if one is available at that time or within 15 minutes of the time that the search is requested by the investigator or steward/judge. If the licensee is not informed of the right, it will not invalidate the search. If the representative is not immediately available, the subject of the search must be under the observation of the investigator or steward/judge until the representative arrives or fails to arrive in the prescribed time.

(f) Failure of any person to consent to a search in accordance with this rule will subject the person to appropriate discipline, including, if the person is a licensee, suspension and ruling-off by the judges/stewards, and possible revocation by the commission, or will subject the person to ejection and/or exclusion from places under the jurisdiction of the commission if an applicant or other unlicensed person. All persons to be searched shall be advised that failure to permit a search may result in revocation of their license (if a licensee) or exclusion from restricted premises (if not licensed).

(g) Nothing in this rule prohibits the application for and the execution of an administrative or criminal search warrant if appropriate under the circumstances.

(2) No licensee may race any greyhound in Oregon unless it has been housed in a kennel licensed by the ORC or unless the kennel owner agrees in writing to submit to warrantless searches of the kennel premises and grounds.

(3) Any person in custody or control of any materials described in subsection (1)(b) of this rule shall immediately surrender those materials to an investigator upon request. Every race meet licensee and all officials and employees thereof shall give every possible aid and assistance to any department, bureau, division, officer, agent, inspector, or other person connected with the United States government or with the State of Oregon or other political subdivision who may be investigating or prosecuting any person suspected of possessing any drug, narcotic, stimulant, depressant, or local anesthetic, hypodermic syringes, hypodermic needles, or any electrical, mechanical, or other device which, in the opinion of the steward/judges, is of such character as could affect the racing condition of a horse/greyhound in a race. Upon the specific request of the individual being searched, a split sample of any suspected prohibited drug or medication, or controlled substance, or other material suspected of containing any of them shall be obtained unless there is insufficient specimen for a split sample. Any materials surrendered to an investigator pursuant to this rule will be returned, subject to amounts needed for analysis, if it is later found that the material was lawfully possessed.

Stat. Auth.: ORS 462.250
Stats. Implemented: ORS 462.450
Hist.: RC 3-2000, f. 3-27-00, cert. ef. 5-1-00; RC 5-2002, f. 12-8-02, cert. ef. 1-1-03; RC 1-2004, f. & cert. ef. 3-3-04

• • • • • • • • • •

Secretary of State, Archives Division
Chapter 166

Adm. Order No.: OSA 1-2004
Filed with Sec. of State: 3-3-2004
Certified to be Effective: 3-3-04
Notice Publication Date: 2-1-04
Rules Adopted: 166-020-0011
Subject: New rule to implement statute that directs state agencies and local governments to not enter into records storage agreements with storage entities that would restrict the State Archivist's access to public records.
Rules Coordinator: Julie Yamaka—(503) 373-0701, ext. 240

166-020-0011
Access to Public Records by the State Archivist

Pursuant to ORS 357.875, no state agency or local government shall enter into or renew an agreement with any records storage entity that restricts the access or inspection of Oregon public records by the State Archivist.

Stat. Auth.: ORS 357.875
Stats. Implemented: ORS 357.875
Hist.: OSA 1-2004, f. & cert. ef. 3-3-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
101-001-0020	12-4-03	Adopt	1-1-04
101-005-0010	12-4-03	Adopt	1-1-04
101-005-0020	12-4-03	Adopt	1-1-04
101-005-0030	12-4-03	Adopt	1-1-04
101-005-0040	12-4-03	Adopt	1-1-04
101-005-0050	12-4-03	Adopt	1-1-04
101-005-0060	12-4-03	Adopt	1-1-04
101-005-0070	12-4-03	Adopt	1-1-04
101-005-0080	12-4-03	Adopt	1-1-04
101-005-0090	12-4-03	Adopt	1-1-04
101-005-0100	12-4-03	Adopt	1-1-04
101-005-0110	12-4-03	Adopt	1-1-04
101-005-0120	12-4-03	Adopt	1-1-04
101-005-0130	12-4-03	Adopt	1-1-04
101-005-0140	12-4-03	Adopt	1-1-04
101-006-0010	12-4-03	Adopt	1-1-04
101-006-0020	12-4-03	Adopt	1-1-04
101-010-0005	12-4-03	Amend	1-1-04
101-020-0010	12-4-03	Amend	1-1-04
101-020-0015	12-4-03	Amend	1-1-04
101-020-0018	12-4-03	Amend	1-1-04
101-020-0020	12-4-03	Amend	1-1-04
101-020-0030	12-4-03	Amend	1-1-04
101-020-0035	12-4-03	Amend	1-1-04
101-020-0040	12-4-03	Amend	1-1-04
101-030-0005	12-4-03	Amend	1-1-04
101-030-0022	12-4-03	Adopt	1-1-04
101-030-0040	12-4-03	Amend	1-1-04
101-040-0005	12-4-03	Amend	1-1-04
101-040-0010	12-4-03	Amend	1-1-04
101-040-0025	12-4-03	Amend	1-1-04
101-040-0030	12-4-03	Amend	1-1-04
101-040-0035	12-4-03	Amend	1-1-04
101-040-0040	12-4-03	Amend	1-1-04
101-040-0045	12-4-03	Amend	1-1-04
101-040-0050	12-4-03	Amend	1-1-04
101-040-0060	12-4-03	Repeal	1-1-04
101-040-0070	12-4-03	Repeal	1-1-04
101-040-0080	12-4-03	Adopt	1-1-04
101-050-0010	12-4-03	Amend	1-1-04
101-050-0015	12-4-03	Amend	1-1-04
101-050-0025	12-4-03	Amend	1-1-04
105-040-0030	12-20-03	Amend(T)	2-1-04
105-040-0030	3-5-04	Amend	4-1-04
105-040-0030(T)	3-5-04	Repeal	4-1-04
105-040-0050	11-25-03	Amend(T)	1-1-04
105-040-0050	3-15-04	Amend	4-1-04
121-040-0010	12-24-03	Amend	2-1-04
122-040-0040	12-30-03	Adopt	2-1-04
122-040-0050	12-30-03	Adopt	2-1-04
122-040-0060	12-30-03	Adopt	2-1-04
122-070-0000	12-4-03	Amend	1-1-04
122-070-0010	12-4-03	Amend	1-1-04
122-070-0030	12-4-03	Amend	1-1-04
122-070-0060	12-4-03	Amend	1-1-04
122-070-0065	12-4-03	Adopt	1-1-04
122-070-0070	12-4-03	Amend	1-1-04
122-070-0080	12-4-03	Amend	1-1-04
123-006-0005	12-23-03	Amend(T)	2-1-04
123-006-0015	12-23-03	Amend(T)	2-1-04
123-006-0041	12-23-03	Adopt(T)	2-1-04
123-006-0051	12-23-03	Adopt(T)	2-1-04
123-020-0000	2-21-04	Adopt(T)	3-1-04
123-020-0005	2-21-04	Amend(T)	3-1-04
123-020-0010	2-21-04	Amend(T)	3-1-04
123-020-0015	2-21-04	Amend(T)	3-1-04
123-020-0020	2-21-04	Amend(T)	3-1-04
123-020-0025	2-21-04	Amend(T)	3-1-04
123-020-0030	2-21-04	Amend(T)	3-1-04
123-020-0035	2-21-04	Amend(T)	3-1-04
123-020-0040	2-21-04	Amend(T)	3-1-04
123-020-0050	2-21-04	Suspend	3-1-04
123-025-0005	2-3-04	Amend(T)	3-1-04
123-025-0010	2-3-04	Amend(T)	3-1-04
123-025-0012	2-3-04	Adopt(T)	3-1-04
123-025-0015	2-3-04	Amend(T)	3-1-04
123-025-0017	2-3-04	Amend(T)	3-1-04
123-025-0021	2-3-04	Amend(T)	3-1-04
123-025-0023	2-3-04	Amend(T)	3-1-04
123-025-0025	2-3-04	Amend(T)	3-1-04
123-025-0030	2-3-04	Amend(T)	3-1-04
123-027-0035	2-3-04	Amend(T)	3-1-04
123-027-0040	2-3-04	Amend(T)	3-1-04
123-027-0050	2-3-04	Amend(T)	3-1-04
123-027-0055	2-3-04	Adopt(T)	3-1-04
123-027-0060	2-3-04	Amend(T)	3-1-04
123-027-0070	2-3-04	Amend(T)	3-1-04
123-027-0080	2-3-04	Suspend	3-1-04
123-027-0105	2-3-04	Adopt(T)	3-1-04
123-027-0155	2-3-04	Adopt(T)	3-1-04
123-027-0160	2-3-04	Adopt(T)	3-1-04
123-027-0165	2-3-04	Adopt(T)	3-1-04
123-027-0170	2-3-04	Adopt(T)	3-1-04
123-027-0200	2-3-04	Adopt(T)	3-1-04
123-027-0210	2-3-04	Adopt(T)	3-1-04
123-030-0004	2-3-04	Amend(T)	3-1-04
123-030-0010	2-3-04	Amend(T)	3-1-04
123-030-0020	2-3-04	Amend(T)	3-1-04
123-030-0030	2-3-04	Amend(T)	3-1-04
123-030-0040	2-3-04	Amend(T)	3-1-04
123-030-0050	2-3-04	Amend(T)	3-1-04
123-035-0000	2-3-04	Adopt(T)	3-1-04
123-035-0005	2-3-04	Adopt(T)	3-1-04
123-035-0010	2-3-04	Adopt(T)	3-1-04
123-042-0010	2-3-04	Amend(T)	3-1-04
123-042-0020	2-3-04	Amend(T)	3-1-04
123-042-0030	2-3-04	Amend(T)	3-1-04
123-042-0040	2-3-04	Amend(T)	3-1-04
123-042-0050	2-3-04	Suspend	3-1-04
123-042-0060	2-3-04	Suspend	3-1-04
123-042-0070	2-3-04	Amend(T)	3-1-04
123-042-0075	2-3-04	Suspend	3-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
123-042-0080	2-3-04	Amend(T)	3-1-04
123-042-0140	2-3-04	Suspend	3-1-04
123-042-0150	2-3-04	Amend(T)	3-1-04
123-042-0160	2-3-04	Amend(T)	3-1-04
123-042-0170	2-3-04	Suspend	3-1-04
123-042-0180	2-3-04	Amend(T)	3-1-04
123-042-0190	2-3-04	Amend(T)	3-1-04
123-049-0005	2-3-04	Amend	3-1-04
123-049-0010	2-3-04	Amend	3-1-04
123-049-0020	2-3-04	Amend	3-1-04
123-049-0030	2-3-04	Amend	3-1-04
123-049-0040	2-3-04	Amend	3-1-04
123-049-0050	2-3-04	Amend	3-1-04
123-049-0060	2-3-04	Adopt	3-1-04
123-055-0100	2-3-04	Amend(T)	3-1-04
123-055-0120	2-3-04	Amend(T)	3-1-04
123-055-0200	2-3-04	Amend(T)	3-1-04
123-055-0240	2-3-04	Amend(T)	3-1-04
123-055-0300	2-3-04	Amend(T)	3-1-04
123-055-0340	2-3-04	Amend(T)	3-1-04
123-055-0400	2-3-04	Amend(T)	3-1-04
123-055-0420	2-3-04	Amend(T)	3-1-04
123-055-0440	2-3-04	Amend(T)	3-1-04
123-055-0460	2-3-04	Amend(T)	3-1-04
123-055-0525	2-3-04	Amend(T)	3-1-04
123-055-0600	2-3-04	Amend(T)	3-1-04
123-055-0620	2-3-04	Amend(T)	3-1-04
123-055-0900	2-3-04	Amend(T)	3-1-04
123-057-0110	2-3-04	Amend(T)	3-1-04
123-057-0130	2-3-04	Amend(T)	3-1-04
123-057-0170	2-3-04	Amend(T)	3-1-04
123-057-0190	2-3-04	Amend(T)	3-1-04
123-057-0210	2-3-04	Amend(T)	3-1-04
123-057-0230	2-3-04	Amend(T)	3-1-04
123-057-0310	2-3-04	Amend(T)	3-1-04
123-057-0330	2-3-04	Amend(T)	3-1-04
123-057-0350	2-3-04	Amend(T)	3-1-04
123-057-0410	2-3-04	Amend(T)	3-1-04
123-057-0430	2-3-04	Amend(T)	3-1-04
123-057-0450	2-3-04	Amend(T)	3-1-04
123-057-0470	2-3-04	Amend(T)	3-1-04
123-057-0510	2-3-04	Amend(T)	3-1-04
123-057-0530	2-3-04	Amend(T)	3-1-04
123-057-0710	2-3-04	Amend(T)	3-1-04
123-068-0015	12-15-03	Adopt(T)	1-1-04
123-068-0105	12-15-03	Adopt(T)	1-1-04
123-068-0205	12-15-03	Adopt(T)	1-1-04
123-068-0305	12-15-03	Adopt(T)	1-1-04
125-125-0050	3-5-04	Adopt(T)	4-1-04
125-125-0100	3-5-04	Adopt(T)	4-1-04
125-125-0150	3-5-04	Adopt(T)	4-1-04
125-125-0200	3-5-04	Adopt(T)	4-1-04
125-125-0250	3-5-04	Adopt(T)	4-1-04
125-125-0300	3-5-04	Adopt(T)	4-1-04
125-125-0350	3-5-04	Adopt(T)	4-1-04
125-125-0400	3-5-04	Adopt(T)	4-1-04
125-125-0450	3-5-04	Adopt(T)	4-1-04
137-001-0070	12-9-03	Amend	1-1-04
137-001-0085	12-9-03	Repeal	1-1-04
137-003-0000	1-1-04	Amend	1-1-04
137-003-0501	1-1-04	Amend	1-1-04
137-003-0510	1-1-04	Amend	1-1-04
137-003-0515	1-1-04	Amend	1-1-04
137-003-0520	1-1-04	Amend	1-1-04
137-003-0525	1-1-04	Amend	1-1-04
137-003-0528	1-1-04	Amend	1-1-04
137-003-0530	1-1-04	Amend	1-1-04
137-003-0535	1-1-04	Amend	1-1-04
137-003-0540	1-1-04	Amend	1-1-04
137-003-0545	1-1-04	Amend	1-1-04
137-003-0555	1-1-04	Amend	1-1-04
137-003-0560	1-1-04	Amend	1-1-04
137-003-0565	1-1-04	Amend	1-1-04
137-003-0570	1-1-04	Amend	1-1-04
137-003-0572	1-1-04	Amend	1-1-04
137-003-0573	1-1-04	Amend	1-1-04
137-003-0575	1-1-04	Amend	1-1-04
137-003-0580	1-1-04	Amend	1-1-04
137-003-0585	1-1-04	Amend	1-1-04
137-003-0590	1-1-04	Amend	1-1-04
137-003-0595	1-1-04	Amend	1-1-04
137-003-0600	1-1-04	Amend	1-1-04
137-003-0605	1-1-04	Amend	1-1-04
137-003-0610	1-1-04	Amend	1-1-04
137-003-0615	1-1-04	Amend	1-1-04
137-003-0625	1-1-04	Amend	1-1-04
137-003-0630	1-1-04	Amend	1-1-04
137-003-0635	1-1-04	Amend	1-1-04
137-003-0640	1-1-04	Amend	1-1-04
137-003-0645	1-1-04	Amend	1-1-04
137-003-0650	1-1-04	Amend	1-1-04
137-003-0655	1-1-04	Amend	1-1-04
137-003-0660	1-1-04	Amend	1-1-04
137-003-0665	1-1-04	Amend	1-1-04
137-003-0670	1-1-04	Amend	1-1-04
137-003-0675	1-1-04	Amend	1-1-04
137-003-0690	1-1-04	Amend	1-1-04
137-003-0695	1-1-04	Amend	1-1-04
137-004-0800	12-9-03	Amend	1-1-04
137-008-0000	12-9-03	Amend	1-1-04
137-008-0010	12-9-03	Amend	1-1-04
137-008-0010	12-10-03	Amend(T)	1-1-04
137-025-0020	4-1-04	Amend	4-1-04
137-025-0160	4-1-04	Amend	4-1-04
137-025-0180	4-1-04	Amend	4-1-04
137-040-0017	1-2-04	Amend	2-1-04
137-040-0500	1-2-04	Amend	2-1-04
137-040-0510	1-2-04	Amend	2-1-04
137-040-0520	1-2-04	Amend	2-1-04
137-040-0550	1-2-04	Amend	2-1-04
137-040-0560	1-2-04	Amend	2-1-04
137-040-0565	1-2-04	Adopt	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
137-045-0010	12-9-03	Amend	1-1-04
137-045-0015	12-9-03	Amend	1-1-04
137-045-0030	12-9-03	Amend	1-1-04
137-045-0035	12-9-03	Amend	1-1-04
137-045-0050	12-9-03	Amend	1-1-04
137-045-0055	12-9-03	Adopt	1-1-04
137-045-0060	12-9-03	Amend	1-1-04
137-045-0070	12-9-03	Amend	1-1-04
137-045-0080	12-9-03	Amend	1-1-04
137-045-0090	12-9-03	Amend	1-1-04
137-055-1020	1-5-04	Amend	2-1-04
137-055-1160	1-5-04	Amend	2-1-04
137-055-3200	1-5-04	Adopt	2-1-04
137-055-3220	1-5-04	Amend	2-1-04
137-055-3360	1-5-04	Amend	2-1-04
137-055-3400	1-5-04	Amend	2-1-04
137-055-3420	1-5-04	Amend	2-1-04
137-055-3440	1-5-04	Amend	2-1-04
137-055-3490	1-5-04	Amend	2-1-04
137-055-3660	1-5-04	Adopt	2-1-04
137-055-4060	1-5-04	Amend	2-1-04
137-055-4080	1-5-04	Amend	2-1-04
137-055-4100	1-5-04	Amend	2-1-04
137-055-4110	1-5-04	Adopt	2-1-04
137-055-4120	1-5-04	Amend	2-1-04
137-055-4130	1-5-04	Amend	2-1-04
137-055-4140	1-5-04	Repeal	2-1-04
137-055-4160	1-5-04	Amend	2-1-04
137-055-4180	1-5-04	Amend	2-1-04
137-055-4200	1-5-04	Repeal	2-1-04
137-055-4220	1-5-04	Repeal	2-1-04
137-055-4240	1-5-04	Repeal	2-1-04
137-055-4260	1-5-04	Repeal	2-1-04
137-055-4280	1-5-04	Repeal	2-1-04
137-055-4440	1-5-04	Amend	2-1-04
137-055-4450	1-5-04	Adopt	2-1-04
137-055-4520	1-5-04	Amend	2-1-04
137-055-5020	1-5-04	Amend	2-1-04
137-055-5025	1-5-04	Adopt	2-1-04
137-055-5040	1-5-04	Amend	2-1-04
137-055-5110	1-5-04	Amend	2-1-04
137-055-5220	1-5-04	Amend	2-1-04
137-055-5510	1-5-04	Adopt	2-1-04
137-055-6020	1-5-04	Amend	2-1-04
137-055-6025	1-5-04	Amend	2-1-04
137-055-6110	1-5-04	Amend	2-1-04
137-060-0010	2-11-04	Repeal	3-1-04
137-060-0011	2-11-04	Repeal	3-1-04
137-060-0012	2-11-04	Repeal	3-1-04
137-060-0013	2-11-04	Repeal	3-1-04
137-060-0014	2-11-04	Repeal	3-1-04
137-060-0015	2-11-04	Repeal	3-1-04
137-060-0016	2-11-04	Repeal	3-1-04
137-060-0020	2-11-04	Repeal	3-1-04
137-060-0021	2-11-04	Repeal	3-1-04
137-060-0022	2-11-04	Repeal	3-1-04
137-060-0023	2-11-04	Repeal	3-1-04
137-060-0024	2-11-04	Repeal	3-1-04
137-060-0025	2-11-04	Repeal	3-1-04
137-060-0026	2-11-04	Repeal	3-1-04
137-060-0030	2-11-04	Repeal	3-1-04
137-060-0031	2-11-04	Repeal	3-1-04
137-060-0032	2-11-04	Repeal	3-1-04
137-060-0033	2-11-04	Repeal	3-1-04
137-060-0034	2-11-04	Repeal	3-1-04
137-060-0035	2-11-04	Repeal	3-1-04
137-060-0036	2-11-04	Repeal	3-1-04
137-060-0040	2-11-04	Repeal	3-1-04
137-060-0041	2-11-04	Repeal	3-1-04
137-060-0042	2-11-04	Repeal	3-1-04
137-060-0043	2-11-04	Repeal	3-1-04
137-060-0044	2-11-04	Repeal	3-1-04
137-060-0045	2-11-04	Repeal	3-1-04
137-060-0100	2-11-04	Adopt	3-1-04
137-060-0110	2-11-04	Adopt	3-1-04
137-060-0120	2-11-04	Adopt	3-1-04
137-060-0130	2-11-04	Adopt	3-1-04
137-060-0140	2-11-04	Adopt	3-1-04
137-060-0150	2-11-04	Adopt	3-1-04
137-060-0160	2-11-04	Adopt	3-1-04
137-060-0200	2-11-04	Adopt	3-1-04
137-060-0210	2-11-04	Adopt	3-1-04
137-060-0220	2-11-04	Adopt	3-1-04
137-060-0230	2-11-04	Adopt	3-1-04
137-060-0240	2-11-04	Adopt	3-1-04
137-060-0250	2-11-04	Adopt	3-1-04
137-060-0260	2-11-04	Adopt	3-1-04
137-060-0300	2-11-04	Adopt	3-1-04
137-060-0310	2-11-04	Adopt	3-1-04
137-060-0320	2-11-04	Adopt	3-1-04
137-060-0330	2-11-04	Adopt	3-1-04
137-060-0340	2-11-04	Adopt	3-1-04
137-060-0350	2-11-04	Adopt	3-1-04
137-060-0360	2-11-04	Adopt	3-1-04
137-060-0400	2-11-04	Adopt	3-1-04
137-060-0410	2-11-04	Adopt	3-1-04
137-060-0420	2-11-04	Adopt	3-1-04
137-060-0430	2-11-04	Adopt	3-1-04
137-060-0440	2-11-04	Adopt	3-1-04
137-060-0450	2-11-04	Adopt	3-1-04
137-084-0001	1-29-04	Adopt	3-1-04
137-084-0005	1-29-04	Adopt	3-1-04
137-084-0010	1-29-04	Adopt	3-1-04
137-084-0020	1-29-04	Adopt	3-1-04
137-084-0030	1-29-04	Adopt	3-1-04
137-085-0001	2-1-04	Adopt(T)	3-1-04
137-085-0010	2-1-04	Adopt(T)	3-1-04
137-085-0020	2-1-04	Adopt(T)	3-1-04
137-085-0030	2-1-04	Adopt(T)	3-1-04
137-085-0040	2-1-04	Adopt(T)	3-1-04
137-085-0050	2-1-04	Adopt(T)	3-1-04
141-030-0010	1-1-04	Amend	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
141-030-0015	1-1-04	Amend	1-1-04
141-030-0025	1-1-04	Amend	1-1-04
141-030-0034	1-1-04	Amend	1-1-04
141-030-0035	1-1-04	Amend	1-1-04
141-030-0036	1-1-04	Amend	1-1-04
141-030-0037	1-1-04	Amend	1-1-04
141-030-0038	1-1-04	Repeal	1-1-04
141-030-0039	1-1-04	Am. & Ren.	1-1-04
141-030-0039	1-1-04	Amend	1-1-04
141-030-0040	1-1-04	Renumber	1-1-04
141-030-0045	1-1-04	Adopt	1-1-04
141-035-0005	1-1-04	Amend	1-1-04
141-035-0010	1-1-04	Repeal	1-1-04
141-035-0011	1-1-04	Adopt	1-1-04
141-035-0012	1-1-04	Adopt	1-1-04
141-035-0013	1-1-04	Amend	1-1-04
141-035-0015	1-1-04	Amend	1-1-04
141-035-0016	1-1-04	Adopt	1-1-04
141-035-0018	1-1-04	Adopt	1-1-04
141-035-0020	1-1-04	Amend	1-1-04
141-035-0025	1-1-04	Amend	1-1-04
141-035-0030	1-1-04	Amend	1-1-04
141-035-0035	1-1-04	Amend	1-1-04
141-035-0040	1-1-04	Amend	1-1-04
141-035-0045	1-1-04	Amend	1-1-04
141-035-0047	1-1-04	Amend	1-1-04
141-035-0048	1-1-04	Amend	1-1-04
141-035-0050	1-1-04	Amend	1-1-04
141-035-0055	1-1-04	Amend	1-1-04
141-035-0060	1-1-04	Amend	1-1-04
141-035-0065	1-1-04	Amend	1-1-04
141-035-0068	1-1-04	Adopt	1-1-04
141-035-0070	1-1-04	Amend	1-1-04
141-035-0075	1-1-04	Adopt	1-1-04
141-040-0005	1-1-04	Amend	1-1-04
141-040-0010	1-1-04	Amend	1-1-04
141-040-0020	1-1-04	Amend	1-1-04
141-040-0030	1-1-04	Amend	1-1-04
141-040-0035	1-1-04	Amend	1-1-04
141-040-0040	1-1-04	Amend	1-1-04
141-040-0200	1-1-04	Amend	1-1-04
141-040-0211	1-1-04	Amend	1-1-04
141-040-0212	1-1-04	Amend	1-1-04
141-040-0214	1-1-04	Amend	1-1-04
141-040-0220	1-1-04	Amend	1-1-04
141-045-0005	1-1-04	Amend	1-1-04
141-045-0010	1-1-04	Amend	1-1-04
141-045-0015	1-1-04	Amend	1-1-04
141-045-0021	1-1-04	Amend	1-1-04
141-045-0031	1-1-04	Amend	1-1-04
141-045-0041	1-1-04	Amend	1-1-04
141-045-0061	1-1-04	Amend	1-1-04
141-045-0100	1-1-04	Amend	1-1-04
141-045-0105	1-1-04	Amend	1-1-04
141-045-0115	1-1-04	Amend	1-1-04
141-045-0120	1-1-04	Amend	1-1-04
141-045-0121	1-1-04	Amend	1-1-04
141-045-0122	1-1-04	Amend	1-1-04
141-045-0123	1-1-04	Amend	1-1-04
141-045-0124	1-1-04	Amend	1-1-04
141-045-0125	1-1-04	Amend	1-1-04
141-045-0126	1-1-04	Amend	1-1-04
141-045-0130	1-1-04	Amend	1-1-04
141-045-0150	1-1-04	Amend	1-1-04
141-045-0155	1-1-04	Amend	1-1-04
141-045-0160	1-1-04	Amend	1-1-04
141-045-0170	1-1-04	Amend	1-1-04
141-045-0180	1-1-04	Amend	1-1-04
141-045-0185	1-1-04	Amend	1-1-04
141-085-0010	11-26-03	Amend	1-1-04
141-085-0027	11-26-03	Amend	1-1-04
141-085-0028	11-26-03	Amend	1-1-04
141-085-0029	11-26-03	Amend	1-1-04
141-085-0075	11-26-03	Amend	1-1-04
141-085-0096	11-26-03	Amend	1-1-04
141-085-0115	11-26-03	Amend	1-1-04
141-085-0121	11-26-03	Amend	1-1-04
141-085-0126	11-26-03	Amend	1-1-04
141-085-0131	11-26-03	Amend	1-1-04
141-085-0141	11-26-03	Amend	1-1-04
141-085-0146	11-26-03	Amend	1-1-04
141-085-0151	11-26-03	Amend	1-1-04
141-085-0156	11-26-03	Amend	1-1-04
141-085-0161	11-26-03	Amend	1-1-04
141-085-0176	11-26-03	Amend	1-1-04
141-085-0263	11-26-03	Amend	1-1-04
141-085-0410	11-26-03	Amend	1-1-04
141-085-0421	11-26-03	Amend	1-1-04
141-085-0430	11-26-03	Amend	1-1-04
141-085-0450	11-26-03	Adopt	1-1-04
141-089-0180	11-26-03	Amend	1-1-04
141-090-0020	11-26-03	Amend	1-1-04
141-090-0030	11-26-03	Amend	1-1-04
150-294.175(2)-(A)	12-31-03	Adopt	2-1-04
150-294.175(2)-(B)	12-31-03	Adopt	2-1-04
150-294.187	12-31-03	Amend	2-1-04
150-294.211(26)	12-31-03	Renumber	2-1-04
150-294.435(1)-(C)	12-31-03	Adopt	2-1-04
150-305.220(1)	12-31-03	Amend	2-1-04
150-305.220(2)	12-31-03	Amend	2-1-04
150-306.115	12-31-03	Amend	2-1-04
150-308.156(5)-(B)	12-31-03	Amend	2-1-04
150-308.159	12-31-03	Adopt	2-1-04
150-308.219	12-31-03	Amend	2-1-04
150-308.250	12-31-03	Amend	2-1-04
150-309.100(3)-(B)	12-31-03	Amend	2-1-04
150-309.100(3)-(C)	12-31-03	Amend	2-1-04
150-309.110(1)-(A)	12-31-03	Amend	2-1-04
150-309.110(1)-(B)	12-31-03	Amend	2-1-04
150-309.110(1)-(D)	12-31-03	Adopt	2-1-04
150-309.110(1)-(E)	12-31-03	Adopt	2-1-04
150-309.115(1)-(C)	12-31-03	Adopt	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
150-309.115(2)-(f)	12-31-03	Renumber	2-1-04
150-311.205(1)(b)	12-31-03	Renumber	2-1-04
150-311.205(1)(c)-(A)	12-31-03	Renumber	2-1-04
150-311.205(1)(c)-(C)	12-31-03	Am. & Ren.	2-1-04
150-311.672(1)(a)	12-31-03	Amend	2-1-04
150-311.708	12-31-03	Amend	2-1-04
150-311.806-(A)	12-31-03	Amend	2-1-04
150-312.040(1)(b)	12-31-03	Amend	2-1-04
150-314.295	12-31-03	Adopt	2-1-04
150-314.385(c)-(B)	12-31-03	Amend	2-1-04
150-314.415(1)(b)	12-31-03	Am. & Ren.	2-1-04
150-314.415(1)(c)	12-31-03	Am. & Ren.	2-1-04
150-314.505-(A)	12-31-03	Amend	2-1-04
150-314.610(1)-(A)	12-31-03	Amend	2-1-04
150-314.610(1)-(B)	12-31-03	Amend	2-1-04
150-314.610(1)-(C)	12-31-03	Amend	2-1-04
150-314.615-(F)	12-31-03	Amend	2-1-04
150-314.655(2)-(B)	12-31-03	Amend	2-1-04
150-314.665(6)(c)	12-31-03	Adopt	2-1-04
150-314.840	12-31-03	Amend	2-1-04
150-315.113	12-31-03	Adopt	2-1-04
150-315.262	12-31-03	Amend	2-1-04
150-316.054	12-31-03	Amend	2-1-04
150-316.127-(D)	12-31-03	Amend	2-1-04
150-321.005	12-31-03	Amend	2-1-04
150-321.045	12-31-03	Amend	2-1-04
150-321.282(1)-(C)	12-31-03	Repeal	2-1-04
150-321.282(1)-(D)	12-31-03	Repeal	2-1-04
150-321.282(1)-(E)	12-31-03	Repeal	2-1-04
150-321.282(1)-(I)	12-31-03	Repeal	2-1-04
150-321.282(2)(a)	12-31-03	Repeal	2-1-04
150-321.282(2)(c)	12-31-03	Repeal	2-1-04
150-321.282(5)	12-31-03	Repeal	2-1-04
150-321.282(6)(a)-(A)	12-31-03	Am. & Ren.	2-1-04
150-321.282(6)(a)-(D)	12-31-03	Am. & Ren.	2-1-04
150-321.358(2)(b)	12-31-03	Am. & Ren.	2-1-04
150-321.358(3)(b)	12-31-03	Am. & Ren.	2-1-04
150-321.358(4)	12-31-03	Am. & Ren.	2-1-04
150-321.379(1)-(A)	12-31-03	Repeal	2-1-04
150-321.379(1)-(B)	12-31-03	Repeal	2-1-04
150-321.379(2)-(A)	12-31-03	Repeal	2-1-04
150-321.379(2)-(C)	12-31-03	Repeal	2-1-04
150-321.430(1)	12-31-03	Repeal	2-1-04
150-321.430(3)-(A)	12-31-03	Repeal	2-1-04
150-321.430(3)-(B)	12-31-03	Repeal	2-1-04
150-321.430(3)-(C)	12-31-03	Repeal	2-1-04
150-321.430(3)-(D)	12-31-03	Repeal	2-1-04
150-321.432-(A)	12-31-03	Amend	2-1-04
150-321.434	12-31-03	Repeal	2-1-04
150-321.434(1)	12-31-03	Repeal	2-1-04
150-321.434(2)	12-31-03	Repeal	2-1-04
150-321.515	12-31-03	Repeal	2-1-04
150-321.815(2)(b)	12-31-03	Am. & Ren.	2-1-04
150-321.815(4)	12-31-03	Am. & Ren.	2-1-04
150-321.950	12-31-03	Repeal	2-1-04
150-570.560	12-31-03	Renumber	2-1-04
150-Ch. 1078 Sec. 2 & 35 1999 Session	12-31-03	Renumber	2-1-04
150-Ch. 1078 Sec. 2 & 35 1999 Session	12-31-03	Renumber	2-1-04
150-OL 2003 Ch. 454 Sec. 1(1)	12-31-03	Adopt	2-1-04
150-OL 2003 Ch. 454 Sec. 1(12)	12-31-03	Adopt	2-1-04
150-OL 2003 Ch. 454 Sec. 1(13)	12-31-03	Adopt	2-1-04
150-OL 2003 Ch. 454 Sec. 4(1)(c)	12-31-03	Adopt	2-1-04
150-OL 2003 Ch. 454 Sec. 4(3)	12-31-03	Adopt	2-1-04
150-OL 2003 Ch. 541 Sec. 3	12-31-03	Adopt	2-1-04
150-OL 2003 Ch. 621 Sec. 109(1)	12-31-03	Adopt	2-1-04
150-OR Laws 2003, Ch. 818	1-1-04	Adopt(T)	1-1-04
161-002-0000	2-3-04	Amend	3-1-04
161-006-0160	11-24-03	Amend	1-1-04
161-015-0030	11-24-03	Amend	1-1-04
161-020-0045	11-24-03	Amend	1-1-04
161-020-0055	11-24-03	Amend	1-1-04
161-020-0140	11-24-03	Amend	1-1-04
161-025-0050	11-24-03	Amend	1-1-04
161-025-0060	2-3-04	Amend	3-1-04
161-050-0040	11-24-03	Amend	1-1-04
161-050-0050	11-24-03	Amend	1-1-04
165-001-0090	12-31-03	Adopt	2-1-04
165-002-0005	12-5-03	Amend	1-1-04
165-002-0010	12-5-03	Amend	1-1-04
165-002-0025	12-5-03	Amend	1-1-04
165-007-0030	12-31-03	Amend	2-1-04
165-010-0005	12-5-03	Amend	1-1-04
165-010-0060	12-5-03	Amend	1-1-04
165-010-0080	12-5-03	Amend	1-1-04
165-010-0090	12-5-03	Amend	1-1-04
165-012-0005	12-12-03	Amend	1-1-04
165-012-0050	12-5-03	Amend	1-1-04
165-012-0060	12-5-03	Amend	1-1-04
165-012-0230	12-5-03	Amend	1-1-04
165-012-0230	12-15-03	Amend(T)	1-1-04
165-013-0010	12-5-03	Amend	1-1-04
165-013-0010	2-13-04	Amend	3-1-04
165-013-0020	12-5-03	Amend	1-1-04
165-014-0005	12-5-03	Amend	1-1-04
165-014-0006	12-5-03	Repeal	1-1-04
165-014-0080	12-5-03	Repeal	1-1-04
165-014-0085	12-5-03	Repeal	1-1-04
165-020-0005	12-5-03	Amend	1-1-04
166-001-0000	11-24-03	Amend	1-1-04
166-020-0011	3-3-04	Adopt	4-1-04
166-101-0010	11-24-03	Amend	1-1-04
166-200-0130	11-24-03	Amend	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
166-500-0000	11-20-03	Amend	1-1-04
166-500-0015	11-20-03	Amend	1-1-04
166-500-0040	11-20-03	Amend	1-1-04
166-500-0045	11-20-03	Amend	1-1-04
166-500-0050	11-20-03	Amend	1-1-04
166-500-0055	11-20-03	Amend	1-1-04
170-060-1000	1-15-04	Adopt(T)	2-1-04
177-045-0000	1-5-04	Amend(T)	2-1-04
177-045-0010	1-5-04	Amend(T)	2-1-04
177-045-0020	1-5-04	Suspend	2-1-04
177-045-0030	1-5-04	Amend(T)	2-1-04
177-045-0040	1-5-04	Amend(T)	2-1-04
177-045-0050	1-5-04	Adopt(T)	2-1-04
177-045-0060	1-5-04	Adopt(T)	2-1-04
177-045-0070	1-5-04	Adopt(T)	2-1-04
177-045-0080	1-5-04	Adopt(T)	2-1-04
177-082-0100	12-19-03	Repeal	2-1-04
177-091-0000	12-19-03	Adopt	2-1-04
177-091-0010	12-19-03	Adopt	2-1-04
177-091-0020	12-19-03	Adopt	2-1-04
177-091-0030	12-19-03	Adopt	2-1-04
177-091-0040	12-19-03	Adopt	2-1-04
177-091-0050	12-19-03	Adopt	2-1-04
177-091-0060	12-19-03	Adopt	2-1-04
177-091-0070	12-19-03	Adopt	2-1-04
177-091-0080	12-19-03	Adopt	2-1-04
177-091-0090	12-19-03	Adopt	2-1-04
177-091-0100	12-19-03	Adopt	2-1-04
177-091-0110	12-19-03	Adopt	2-1-04
177-099-0050	2-23-04	Amend(T)	4-1-04
213-001-0000	1-1-04	Amend	2-1-04
213-001-0005	1-1-04	Amend	2-1-04
213-003-0001	1-1-04	Amend	2-1-04
213-005-0001	1-1-04	Amend	2-1-04
213-005-0004	1-1-04	Amend	2-1-04
213-005-0007	1-1-04	Amend	2-1-04
213-011-0003	1-1-04	Amend	2-1-04
213-017-0001	1-1-04	Amend	2-1-04
213-017-0002	1-1-04	Amend	2-1-04
213-017-0003	1-1-04	Amend	2-1-04
213-017-0004	1-1-04	Amend	2-1-04
213-017-0005	1-1-04	Amend	2-1-04
213-017-0006	1-1-04	Amend	2-1-04
213-017-0007	1-1-04	Amend	2-1-04
213-017-0008	1-1-04	Amend	2-1-04
213-017-0009	1-1-04	Amend	2-1-04
213-017-0010	1-1-04	Amend	2-1-04
213-017-0011	1-1-04	Amend	2-1-04
213-018-0038	1-1-04	Amend	2-1-04
213-018-0047	1-1-04	Adopt	2-1-04
213-018-0048	1-1-04	Adopt	2-1-04
213-018-0050	1-1-04	Amend	2-1-04
213-018-0090	1-1-04	Amend	2-1-04
213-019-0007	1-1-04	Amend	2-1-04
213-019-0008	1-1-04	Amend	2-1-04
213-019-0010	1-1-04	Amend	2-1-04
213-019-0011	1-1-04	Amend	2-1-04
255-060-0011	1-14-04	Amend(T)	2-1-04
255-070-0001	1-14-04	Amend	2-1-04
259-008-0010	12-22-03	Amend	2-1-04
259-008-0011	1-20-04	Amend	3-1-04
259-008-0025	12-22-03	Amend	2-1-04
259-008-0060	1-20-04	Amend	3-1-04
259-008-0068	1-16-04	Adopt	3-1-04
274-020-0341	1-22-04	Amend(T)	3-1-04
274-020-0341(T)	1-22-04	Suspend	3-1-04
274-020-0388	1-15-04	Amend(T)	2-1-04
274-020-0388	2-24-04	Amend	4-1-04
274-020-0388(T)	2-24-04	Repeal	4-1-04
274-040-0015	12-31-03	Amend	2-1-04
274-040-0015(T)	12-31-03	Repeal	2-1-04
274-040-0030	12-31-03	Amend	2-1-04
274-040-0030(T)	12-31-03	Repeal	2-1-04
291-001-0020	12-12-03	Amend	1-1-04
291-001-0025	12-12-03	Amend	1-1-04
291-001-0070	12-12-03	Repeal	1-1-04
291-013-0010	1-27-04	Amend(T)	3-1-04
291-013-0100	1-27-04	Amend(T)	3-1-04
291-013-0215	1-27-04	Amend(T)	3-1-04
291-062-0010	1-14-04	Suspend	2-1-04
291-062-0020	1-14-04	Suspend	2-1-04
291-062-0030	1-14-04	Suspend	2-1-04
291-062-0040	1-14-04	Suspend	2-1-04
291-062-0050	1-14-04	Suspend	2-1-04
291-062-0060	1-14-04	Suspend	2-1-04
291-062-0070	1-14-04	Suspend	2-1-04
291-062-0080	1-14-04	Suspend	2-1-04
291-062-0100	1-14-04	Adopt(T)	2-1-04
291-062-0110	1-14-04	Adopt(T)	2-1-04
291-062-0120	1-14-04	Adopt(T)	2-1-04
291-062-0130	1-14-04	Adopt(T)	2-1-04
291-062-0140	1-14-04	Adopt(T)	2-1-04
291-062-0150	1-14-04	Adopt(T)	2-1-04
291-062-0160	1-14-04	Adopt(T)	2-1-04
291-064-0060	12-2-03	Amend	1-1-04
291-117-0020	1-20-04	Amend(T)	3-1-04
309-018-0100	3-1-04	Repeal	4-1-04
309-018-0110	3-1-04	Repeal	4-1-04
309-018-0120	3-1-04	Repeal	4-1-04
309-018-0130	3-1-04	Repeal	4-1-04
309-018-0140	3-1-04	Repeal	4-1-04
309-018-0150	3-1-04	Repeal	4-1-04
309-018-0160	3-1-04	Repeal	4-1-04
309-018-0170	3-1-04	Repeal	4-1-04
309-018-0180	3-1-04	Repeal	4-1-04
309-018-0190	3-1-04	Repeal	4-1-04
309-041-0300	1-1-04	Repeal	2-1-04
309-041-0305	1-1-04	Repeal	2-1-04
309-041-0310	1-1-04	Repeal	2-1-04
309-041-0315	1-1-04	Repeal	2-1-04
309-041-0320	1-1-04	Repeal	2-1-04
309-041-0375	1-1-04	Repeal	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
309-041-0400	1-1-04	Repeal	2-1-04
309-041-0405	1-1-04	Repeal	2-1-04
309-041-0410	1-1-04	Repeal	2-1-04
309-041-0415	1-1-04	Repeal	2-1-04
309-041-0435	1-1-04	Repeal	2-1-04
309-041-0445	1-1-04	Repeal	2-1-04
309-041-0450	1-1-04	Repeal	2-1-04
309-041-0455	1-1-04	Repeal	2-1-04
309-041-0460	1-1-04	Repeal	2-1-04
309-041-0465	1-1-04	Repeal	2-1-04
309-041-0470	1-1-04	Repeal	2-1-04
309-041-0475	1-1-04	Repeal	2-1-04
309-041-0480	1-1-04	Repeal	2-1-04
309-041-1750	12-28-03	Am. & Ren.	2-1-04
309-041-1760	12-28-03	Am. & Ren.	2-1-04
309-041-1770	12-28-03	Am. & Ren.	2-1-04
309-041-1780	12-28-03	Am. & Ren.	2-1-04
309-041-1790	12-28-03	Am. & Ren.	2-1-04
309-041-1800	12-28-03	Am. & Ren.	2-1-04
309-041-1810	12-28-03	Am. & Ren.	2-1-04
309-041-1820	12-28-03	Am. & Ren.	2-1-04
309-041-1830	12-28-03	Am. & Ren.	2-1-04
309-041-1840	12-28-03	Am. & Ren.	2-1-04
309-041-1850	12-28-03	Am. & Ren.	2-1-04
309-041-1860	12-28-03	Am. & Ren.	2-1-04
309-041-1870	12-28-03	Am. & Ren.	2-1-04
309-041-1880	12-28-03	Am. & Ren.	2-1-04
309-041-1890	12-28-03	Am. & Ren.	2-1-04
309-041-1900	12-28-03	Am. & Ren.	2-1-04
309-041-1910	12-28-03	Am. & Ren.	2-1-04
309-041-1920	12-28-03	Am. & Ren.	2-1-04
309-041-2000	12-28-03	Am. & Ren.	2-1-04
309-041-2010	12-28-03	Am. & Ren.	2-1-04
309-041-2020	12-28-03	Am. & Ren.	2-1-04
309-041-2030	12-28-03	Am. & Ren.	2-1-04
309-041-2040	12-28-03	Am. & Ren.	2-1-04
309-041-2050	12-28-03	Am. & Ren.	2-1-04
309-041-2060	12-28-03	Am. & Ren.	2-1-04
309-041-2070	12-28-03	Am. & Ren.	2-1-04
309-041-2080	12-28-03	Am. & Ren.	2-1-04
309-041-2090	12-28-03	Am. & Ren.	2-1-04
309-041-2110	12-28-03	Am. & Ren.	2-1-04
309-041-2120	12-28-03	Am. & Ren.	2-1-04
309-041-2130	12-28-03	Am. & Ren.	2-1-04
309-041-2140	12-28-03	Am. & Ren.	2-1-04
309-041-2150	12-28-03	Am. & Ren.	2-1-04
309-041-2160	12-28-03	Am. & Ren.	2-1-04
309-041-2170	12-28-03	Am. & Ren.	2-1-04
309-041-2180	12-28-03	Am. & Ren.	2-1-04
309-044-0100	12-11-03	Amend(T)	1-1-04
309-044-0110	12-11-03	Amend(T)	1-1-04
309-044-0120	12-11-03	Amend(T)	1-1-04
309-044-0130	12-11-03	Amend(T)	1-1-04
309-044-0140	12-11-03	Amend(T)	1-1-04
309-044-0150	12-11-03	Amend(T)	1-1-04
309-044-0160	12-11-03	Amend(T)	1-1-04
309-044-0170	12-11-03	Amend(T)	1-1-04
309-044-0180	12-11-03	Amend(T)	1-1-04
309-044-0190	12-11-03	Amend(T)	1-1-04
309-044-0200	12-11-03	Amend(T)	1-1-04
309-044-0210	12-11-03	Amend(T)	1-1-04
309-047-0000	12-28-03	Am. & Ren.	2-1-04
309-047-0005	12-28-03	Am. & Ren.	2-1-04
309-047-0010	12-28-03	Am. & Ren.	2-1-04
309-047-0015	12-28-03	Am. & Ren.	2-1-04
309-047-0018	12-28-03	Am. & Ren.	2-1-04
309-047-0025	12-28-03	Am. & Ren.	2-1-04
309-047-0030	12-28-03	Am. & Ren.	2-1-04
309-047-0035	12-28-03	Am. & Ren.	2-1-04
309-047-0040	12-28-03	Am. & Ren.	2-1-04
309-047-0045	12-28-03	Am. & Ren.	2-1-04
309-047-0050	12-28-03	Am. & Ren.	2-1-04
309-047-0055	12-28-03	Am. & Ren.	2-1-04
309-047-0060	12-28-03	Am. & Ren.	2-1-04
309-047-0065	12-28-03	Am. & Ren.	2-1-04
309-047-0070	12-28-03	Am. & Ren.	2-1-04
309-047-0075	12-28-03	Am. & Ren.	2-1-04
309-047-0080	12-28-03	Am. & Ren.	2-1-04
309-047-0085	12-28-03	Am. & Ren.	2-1-04
309-047-0090	12-28-03	Am. & Ren.	2-1-04
309-047-0095	12-28-03	Am. & Ren.	2-1-04
309-047-0100	12-28-03	Am. & Ren.	2-1-04
309-047-0105	12-28-03	Am. & Ren.	2-1-04
309-047-0110	12-28-03	Am. & Ren.	2-1-04
309-047-0115	12-28-03	Am. & Ren.	2-1-04
309-047-0120	12-28-03	Am. & Ren.	2-1-04
309-047-0125	12-28-03	Am. & Ren.	2-1-04
309-047-0130	12-28-03	Am. & Ren.	2-1-04
309-047-0133	12-28-03	Am. & Ren.	2-1-04
309-047-0135	12-28-03	Am. & Ren.	2-1-04
309-047-0140	12-28-03	Am. & Ren.	2-1-04
309-048-0000	1-1-04	Repeal	2-1-04
309-048-0005	1-1-04	Repeal	2-1-04
309-048-0010	1-1-04	Repeal	2-1-04
309-048-0015	1-1-04	Repeal	2-1-04
309-048-0020	1-1-04	Repeal	2-1-04
309-048-0025	1-1-04	Repeal	2-1-04
309-048-0030	1-1-04	Repeal	2-1-04
309-048-0035	1-1-04	Repeal	2-1-04
309-049-0030	1-1-04	Repeal	2-1-04
309-049-0035	1-1-04	Repeal	2-1-04
309-049-0040	1-1-04	Repeal	2-1-04
309-049-0045	1-1-04	Repeal	2-1-04
309-049-0050	1-1-04	Repeal	2-1-04
309-049-0055	1-1-04	Repeal	2-1-04
309-049-0060	1-1-04	Repeal	2-1-04
309-049-0065	1-1-04	Repeal	2-1-04
309-049-0070	1-1-04	Repeal	2-1-04
309-049-0075	1-1-04	Repeal	2-1-04
309-049-0080	1-1-04	Repeal	2-1-04
309-049-0085	1-1-04	Repeal	2-1-04
309-049-0090	1-1-04	Repeal	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
309-049-0095	1-1-04	Repeal	2-1-04
309-049-0100	1-1-04	Repeal	2-1-04
309-049-0105	1-1-04	Repeal	2-1-04
309-049-0110	1-1-04	Repeal	2-1-04
309-049-0115	1-1-04	Repeal	2-1-04
309-049-0120	1-1-04	Repeal	2-1-04
309-049-0130	1-1-04	Repeal	2-1-04
309-049-0135	1-1-04	Repeal	2-1-04
309-049-0140	1-1-04	Repeal	2-1-04
309-049-0145	1-1-04	Repeal	2-1-04
309-049-0150	1-1-04	Repeal	2-1-04
309-049-0155	1-1-04	Repeal	2-1-04
309-049-0160	1-1-04	Repeal	2-1-04
309-049-0165	1-1-04	Repeal	2-1-04
309-049-0170	1-1-04	Repeal	2-1-04
309-049-0175	1-1-04	Repeal	2-1-04
309-049-0180	1-1-04	Repeal	2-1-04
309-049-0185	1-1-04	Repeal	2-1-04
309-049-0190	1-1-04	Repeal	2-1-04
309-049-0193	1-1-04	Repeal	2-1-04
309-049-0195	1-1-04	Repeal	2-1-04
309-049-0200	1-1-04	Repeal	2-1-04
309-049-0205	1-1-04	Repeal	2-1-04
309-049-0207	1-1-04	Repeal	2-1-04
309-049-0210	1-1-04	Repeal	2-1-04
309-049-0215	1-1-04	Repeal	2-1-04
309-049-0220	1-1-04	Repeal	2-1-04
309-049-0225	1-1-04	Repeal	2-1-04
330-070-0010	1-21-04	Amend	3-1-04
330-070-0013	1-21-04	Amend	3-1-04
330-070-0014	1-21-04	Amend	3-1-04
330-070-0020	1-21-04	Amend	3-1-04
330-070-0021	1-21-04	Amend	3-1-04
330-070-0022	1-21-04	Amend	3-1-04
330-070-0024	1-21-04	Amend	3-1-04
330-070-0025	1-21-04	Amend	3-1-04
330-070-0026	1-21-04	Amend	3-1-04
330-070-0027	1-21-04	Amend	3-1-04
330-070-0040	1-21-04	Amend	3-1-04
330-070-0045	1-21-04	Amend	3-1-04
330-070-0048	1-21-04	Amend	3-1-04
330-070-0055	1-21-04	Amend	3-1-04
330-070-0059	1-21-04	Adopt	3-1-04
330-070-0060	1-21-04	Amend	3-1-04
330-070-0062	1-21-04	Amend	3-1-04
330-070-0063	1-21-04	Amend	3-1-04
330-070-0064	1-21-04	Adopt	3-1-04
330-070-0070	1-21-04	Amend	3-1-04
330-070-0073	1-21-04	Amend	3-1-04
330-070-0085	1-21-04	Amend	3-1-04
330-070-0089	1-21-04	Amend	3-1-04
330-070-0091	1-21-04	Amend	3-1-04
330-070-0097	1-21-04	Amend	3-1-04
330-090-0105	1-21-04	Amend	3-1-04
330-090-0110	1-21-04	Amend	3-1-04
330-090-0120	1-21-04	Amend	3-1-04
330-090-0130	1-21-04	Amend	3-1-04
330-090-0135	1-21-04	Amend	3-1-04
330-090-0140	1-21-04	Amend	3-1-04
330-090-0150	1-21-04	Amend	3-1-04
331-001-0000	2-13-04	Adopt	3-1-04
331-001-0010	2-13-04	Adopt	3-1-04
331-001-0020	2-13-04	Adopt	3-1-04
331-010-0000	2-13-04	Adopt	3-1-04
331-010-0010	2-13-04	Adopt	3-1-04
331-010-0020	2-13-04	Adopt	3-1-04
331-010-0030	2-13-04	Adopt	3-1-04
331-010-0040	2-13-04	Adopt	3-1-04
331-020-0000	2-13-04	Adopt	3-1-04
331-020-0010	2-13-04	Adopt	3-1-04
331-020-0020	2-13-04	Adopt	3-1-04
331-020-0030	2-13-04	Adopt	3-1-04
331-020-0040	2-13-04	Adopt	3-1-04
331-020-0050	2-13-04	Adopt	3-1-04
331-020-0060	2-13-04	Adopt	3-1-04
331-020-0070	2-13-04	Adopt	3-1-04
331-030-0000	2-13-04	Adopt	3-1-04
331-030-0010	2-13-04	Adopt	3-1-04
331-030-0020	2-13-04	Adopt	3-1-04
331-030-0030	2-13-04	Adopt	3-1-04
333-013-0006	1-2-04	Repeal	2-1-04
333-013-0026	1-2-04	Repeal	2-1-04
333-020-0125	12-16-03	Amend	2-1-04
333-020-0127	12-16-03	Adopt	2-1-04
333-020-0130	12-16-03	Amend	2-1-04
333-020-0135	12-16-03	Amend	2-1-04
333-020-0140	12-16-03	Amend	2-1-04
333-020-0145	12-16-03	Amend	2-1-04
333-020-0147	12-16-03	Adopt	2-1-04
333-020-0149	12-16-03	Adopt	2-1-04
333-020-0150	12-16-03	Amend	2-1-04
333-020-0151	12-16-03	Adopt	2-1-04
333-020-0153	12-16-03	Adopt	2-1-04
333-020-0155	12-16-03	Amend	2-1-04
333-020-0160	12-16-03	Amend	2-1-04
333-020-0165	12-16-03	Amend	2-1-04
333-029-0105	2-13-04	Amend(T)	3-1-04
333-029-0110	2-13-04	Amend(T)	3-1-04
333-030-0095	2-13-04	Amend(T)	3-1-04
333-054-0000	1-5-04	Amend	2-1-04
333-054-0000(T)	1-5-04	Repeal	2-1-04
333-054-0010	1-5-04	Amend	2-1-04
333-054-0010(T)	1-5-04	Repeal	2-1-04
333-054-0020	1-5-04	Amend	2-1-04
333-054-0020(T)	1-5-04	Repeal	2-1-04
333-054-0030	1-5-04	Amend	2-1-04
333-054-0030(T)	1-5-04	Repeal	2-1-04
333-054-0040	1-5-04	Amend	2-1-04
333-054-0040(T)	1-5-04	Repeal	2-1-04
333-054-0050	1-5-04	Amend	2-1-04
333-054-0050(T)	1-5-04	Repeal	2-1-04
333-054-0060	1-5-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
333-054-0060(T)	1-5-04	Repeal	2-1-04
333-054-0070	1-5-04	Amend	2-1-04
333-054-0070(T)	1-5-04	Repeal	2-1-04
333-054-0090	1-5-04	Repeal	2-1-04
333-054-0100	1-5-04	Adopt	2-1-04
333-054-0100(T)	1-5-04	Repeal	2-1-04
333-064-0005	12-8-03	Amend	1-1-04
333-064-0005(T)	12-8-03	Repeal	1-1-04
333-064-0010	12-8-03	Amend	1-1-04
333-064-0010(T)	12-8-03	Repeal	1-1-04
333-064-0015	12-8-03	Amend	1-1-04
333-064-0015(T)	12-8-03	Repeal	1-1-04
333-064-0025	12-8-03	Amend	1-1-04
333-064-0025(T)	12-8-03	Repeal	1-1-04
333-064-0030	12-8-03	Amend	1-1-04
333-064-0030(T)	12-8-03	Repeal	1-1-04
333-064-0035	12-8-03	Amend	1-1-04
333-064-0035(T)	12-8-03	Repeal	1-1-04
333-064-0040	12-8-03	Amend	1-1-04
333-064-0040(T)	12-8-03	Repeal	1-1-04
333-064-0060	12-8-03	Amend	1-1-04
333-064-0060(T)	12-8-03	Repeal	1-1-04
333-064-0065	12-8-03	Amend	1-1-04
333-064-0065(T)	12-8-03	Repeal	1-1-04
333-064-0070	12-8-03	Adopt	1-1-04
333-064-0070(T)	12-8-03	Repeal	1-1-04
333-150-0000	2-13-04	Amend(T)	3-1-04
333-157-0045	2-13-04	Amend(T)	3-1-04
333-157-0050	2-13-04	Suspend	3-1-04
333-157-0060	2-13-04	Suspend	3-1-04
333-157-0090	2-13-04	Suspend	3-1-04
333-162-0300	2-13-04	Amend(T)	3-1-04
333-162-0930	2-13-04	Amend(T)	3-1-04
333-162-1005	2-13-04	Adopt(T)	3-1-04
333-170-0010	2-13-04	Amend(T)	3-1-04
333-170-0020	2-13-04	Amend(T)	3-1-04
333-170-0030	2-13-04	Amend(T)	3-1-04
333-170-0040	2-13-04	Amend(T)	3-1-04
333-170-0050	2-13-04	Amend(T)	3-1-04
333-170-0060	2-13-04	Amend(T)	3-1-04
333-170-0070	2-13-04	Amend(T)	3-1-04
333-170-0080	2-13-04	Amend(T)	3-1-04
333-170-0090	2-13-04	Amend(T)	3-1-04
333-170-0100	2-13-04	Amend(T)	3-1-04
333-170-0120	2-13-04	Amend(T)	3-1-04
333-170-0130	2-13-04	Amend(T)	3-1-04
333-505-0007	2-6-04	Amend	3-1-04
333-536-0000	2-6-04	Adopt(T)	3-1-04
333-536-0005	2-6-04	Adopt(T)	3-1-04
333-536-0010	2-6-04	Adopt(T)	3-1-04
333-536-0015	2-6-04	Adopt(T)	3-1-04
333-536-0020	2-6-04	Adopt(T)	3-1-04
333-536-0025	2-6-04	Adopt(T)	3-1-04
333-536-0030	2-6-04	Adopt(T)	3-1-04
333-536-0035	2-6-04	Adopt(T)	3-1-04
333-536-0040	2-6-04	Adopt(T)	3-1-04
333-536-0045	2-6-04	Adopt(T)	3-1-04
333-536-0050	2-6-04	Adopt(T)	3-1-04
333-536-0055	2-6-04	Adopt(T)	3-1-04
333-536-0060	2-6-04	Adopt(T)	3-1-04
333-536-0065	2-6-04	Adopt(T)	3-1-04
333-536-0070	2-6-04	Adopt(T)	3-1-04
333-536-0075	2-6-04	Adopt(T)	3-1-04
333-536-0080	2-6-04	Adopt(T)	3-1-04
333-536-0085	2-6-04	Adopt(T)	3-1-04
333-536-0090	2-6-04	Adopt(T)	3-1-04
333-536-0095	2-6-04	Adopt(T)	3-1-04
333-536-0100	2-6-04	Adopt(T)	3-1-04
333-560-0010	1-16-04	Amend	3-1-04
333-635-0000	1-16-04	Repeal	3-1-04
333-635-0010	1-16-04	Repeal	3-1-04
333-635-0020	1-16-04	Repeal	3-1-04
333-635-0030	1-16-04	Repeal	3-1-04
333-675-0000	3-11-04	Amend	4-1-04
333-675-0010	3-11-04	Am. & Ren.	4-1-04
333-675-0020	3-11-04	Amend	4-1-04
333-675-0030	3-11-04	Amend	4-1-04
333-675-0040	3-11-04	Amend	4-1-04
334-010-0005	2-23-04	Amend	4-1-04
334-010-0010	2-23-04	Amend	4-1-04
334-010-0015	2-23-04	Amend	4-1-04
334-010-0017	2-23-04	Amend	4-1-04
334-010-0025	2-23-04	Amend	4-1-04
334-010-0050	2-23-04	Amend	4-1-04
335-005-0025	2-6-04	Amend	3-1-04
335-070-0030	2-6-04	Amend	3-1-04
335-070-0060	2-6-04	Amend	3-1-04
335-095-0020	2-6-04	Amend	3-1-04
335-095-0030	2-6-04	Amend	3-1-04
338-010-0015	3-1-04	Amend(T)	4-1-04
338-010-0025	3-1-04	Amend(T)	4-1-04
338-010-0030	3-1-04	Amend(T)	4-1-04
338-010-0035	3-1-04	Amend(T)	4-1-04
338-010-0050	3-1-04	Amend(T)	4-1-04
340-011-0005	12-12-03	Amend	1-1-04
340-011-0035	12-12-03	Am. & Ren.	1-1-04
340-011-0097	12-12-03	Am. & Ren.	1-1-04
340-011-0098	12-12-03	Am. & Ren.	1-1-04
340-011-0103	12-12-03	Am. & Ren.	1-1-04
340-011-0106	12-12-03	Renumber	1-1-04
340-011-0107	12-12-03	Am. & Ren.	1-1-04
340-011-0122	12-12-03	Renumber	1-1-04
340-011-0124	12-12-03	Am. & Ren.	1-1-04
340-011-0131	12-12-03	Am. & Ren.	1-1-04
340-011-0132	12-12-03	Am. & Ren.	1-1-04
340-011-0136	12-12-03	Am. & Ren.	1-1-04
340-011-0520	12-12-03	Adopt	1-1-04
340-011-0535	12-12-03	Adopt	1-1-04
340-011-0545	12-12-03	Adopt	1-1-04
340-011-0550	12-12-03	Adopt	1-1-04
340-011-0555	12-12-03	Adopt	1-1-04
340-011-0580	12-12-03	Adopt	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
340-011-0585	12-12-03	Adopt	1-1-04
340-041-0001	12-9-03	Amend	1-1-04
340-041-0002	12-9-03	Adopt	1-1-04
340-041-0004	12-9-03	Adopt	1-1-04
340-041-0006	12-9-03	Repeal	1-1-04
340-041-0007	12-9-03	Adopt	1-1-04
340-041-0009	12-9-03	Adopt	1-1-04
340-041-0016	12-9-03	Adopt	1-1-04
340-041-0021	12-9-03	Adopt	1-1-04
340-041-0026	12-9-03	Repeal	1-1-04
340-041-0027	12-9-03	Am. & Ren.	1-1-04
340-041-0028	12-9-03	Adopt	1-1-04
340-041-0031	12-9-03	Adopt	1-1-04
340-041-0032	12-9-03	Adopt	1-1-04
340-041-0033	12-9-03	Adopt	1-1-04
340-041-0034	12-9-03	Repeal	1-1-04
340-041-0036	12-9-03	Adopt	1-1-04
340-041-0046	12-9-03	Adopt	1-1-04
340-041-0053	12-9-03	Adopt	1-1-04
340-041-0057	12-9-03	Adopt	1-1-04
340-041-0061	12-9-03	Adopt	1-1-04
340-041-0101	12-9-03	Adopt	1-1-04
340-041-0103	12-9-03	Adopt	1-1-04
340-041-0104	12-9-03	Adopt	1-1-04
340-041-0120	12-9-03	Repeal	1-1-04
340-041-0121	12-9-03	Adopt	1-1-04
340-041-0122	12-9-03	Adopt	1-1-04
340-041-0124	12-9-03	Adopt	1-1-04
340-041-0130	12-9-03	Adopt	1-1-04
340-041-0133	12-9-03	Adopt	1-1-04
340-041-0135	12-9-03	Adopt	1-1-04
340-041-0140	12-9-03	Adopt	1-1-04
340-041-0143	12-9-03	Adopt	1-1-04
340-041-0145	12-9-03	Adopt	1-1-04
340-041-0150	12-9-03	Am. & Ren.	1-1-04
340-041-0151	12-9-03	Adopt	1-1-04
340-041-0154	12-9-03	Adopt	1-1-04
340-041-0156	12-9-03	Adopt	1-1-04
340-041-0160	12-9-03	Adopt	1-1-04
340-041-0164	12-9-03	Adopt	1-1-04
340-041-0165	12-9-03	Adopt	1-1-04
340-041-0170	12-9-03	Adopt	1-1-04
340-041-0174	12-9-03	Adopt	1-1-04
340-041-0175	12-9-03	Adopt	1-1-04
340-041-0180	12-9-03	Adopt	1-1-04
340-041-0184	12-9-03	Adopt	1-1-04
340-041-0185	12-9-03	Adopt	1-1-04
340-041-0190	12-9-03	Adopt	1-1-04
340-041-0194	12-9-03	Adopt	1-1-04
340-041-0195	12-9-03	Adopt	1-1-04
340-041-0201	12-9-03	Adopt	1-1-04
340-041-0202	12-9-03	Repeal	1-1-04
340-041-0204	12-9-03	Adopt	1-1-04
340-041-0205	12-9-03	Repeal	1-1-04
340-041-0207	12-9-03	Adopt	1-1-04
340-041-0215	12-9-03	Repeal	1-1-04
340-041-0220	12-9-03	Adopt	1-1-04
340-041-0224	12-9-03	Adopt	1-1-04
340-041-0225	12-9-03	Adopt	1-1-04
340-041-0230	12-9-03	Adopt	1-1-04
340-041-0234	12-9-03	Adopt	1-1-04
340-041-0235	12-9-03	Adopt	1-1-04
340-041-0242	12-9-03	Repeal	1-1-04
340-041-0245	12-9-03	Repeal	1-1-04
340-041-0250	12-9-03	Adopt	1-1-04
340-041-0254	12-9-03	Adopt	1-1-04
340-041-0255	12-9-03	Repeal	1-1-04
340-041-0256	12-9-03	Adopt	1-1-04
340-041-0260	12-9-03	Adopt	1-1-04
340-041-0264	12-9-03	Adopt	1-1-04
340-041-0265	12-9-03	Adopt	1-1-04
340-041-0270	12-9-03	Repeal	1-1-04
340-041-0271	12-9-03	Adopt	1-1-04
340-041-0274	12-9-03	Adopt	1-1-04
340-041-0275	12-9-03	Adopt	1-1-04
340-041-0282	12-9-03	Repeal	1-1-04
340-041-0285	12-9-03	Repeal	1-1-04
340-041-0286	12-9-03	Adopt	1-1-04
340-041-0289	12-9-03	Adopt	1-1-04
340-041-0290	12-9-03	Adopt	1-1-04
340-041-0295	12-9-03	Repeal	1-1-04
340-041-0300	12-9-03	Adopt	1-1-04
340-041-0304	12-9-03	Adopt	1-1-04
340-041-0305	12-9-03	Adopt	1-1-04
340-041-0310	12-9-03	Adopt	1-1-04
340-041-0314	12-9-03	Adopt	1-1-04
340-041-0315	12-9-03	Adopt	1-1-04
340-041-0320	12-9-03	Adopt	1-1-04
340-041-0322	12-9-03	Repeal	1-1-04
340-041-0324	12-9-03	Adopt	1-1-04
340-041-0325	12-9-03	Repeal	1-1-04
340-041-0326	12-9-03	Adopt	1-1-04
340-041-0330	12-9-03	Adopt	1-1-04
340-041-0334	12-9-03	Adopt	1-1-04
340-041-0335	12-9-03	Repeal	1-1-04
340-041-0336	12-9-03	Adopt	1-1-04
340-041-0340	12-9-03	Adopt	1-1-04
340-041-0344	12-9-03	Adopt	1-1-04
340-041-0345	12-9-03	Adopt	1-1-04
340-041-0350	12-9-03	Adopt	1-1-04
340-041-0362	12-9-03	Repeal	1-1-04
340-041-0365	12-9-03	Repeal	1-1-04
340-041-0375	12-9-03	Repeal	1-1-04
340-041-0385	12-9-03	Repeal	1-1-04
340-041-0442	12-9-03	Repeal	1-1-04
340-041-0445	12-9-03	Repeal	1-1-04
340-041-0455	12-9-03	Repeal	1-1-04
340-041-0470	12-9-03	Repeal	1-1-04
340-041-0482	12-9-03	Repeal	1-1-04
340-041-0485	12-9-03	Repeal	1-1-04
340-041-0495	12-9-03	Repeal	1-1-04
340-041-0522	12-9-03	Repeal	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
340-041-0525	12-9-03	Repeal	1-1-04
340-041-0535	12-9-03	Repeal	1-1-04
340-041-0562	12-9-03	Repeal	1-1-04
340-041-0565	12-9-03	Repeal	1-1-04
340-041-0575	12-9-03	Repeal	1-1-04
340-041-0580	12-9-03	Repeal	1-1-04
340-041-0602	12-9-03	Repeal	1-1-04
340-041-0605	12-9-03	Repeal	1-1-04
340-041-0615	12-9-03	Repeal	1-1-04
340-041-0642	12-9-03	Repeal	1-1-04
340-041-0645	12-9-03	Repeal	1-1-04
340-041-0655	12-9-03	Repeal	1-1-04
340-041-0682	12-9-03	Repeal	1-1-04
340-041-0765	12-9-03	Repeal	1-1-04
340-041-0775	12-9-03	Repeal	1-1-04
340-041-0802	12-9-03	Repeal	1-1-04
340-041-0805	12-9-03	Repeal	1-1-04
340-041-0815	12-9-03	Repeal	1-1-04
340-041-0842	12-9-03	Repeal	1-1-04
340-041-0845	12-9-03	Repeal	1-1-04
340-041-0855	12-9-03	Repeal	1-1-04
340-041-0882	12-9-03	Repeal	1-1-04
340-041-0885	12-9-03	Repeal	1-1-04
340-041-0895	12-9-03	Repeal	1-1-04
340-041-0922	12-9-03	Repeal	1-1-04
340-041-0925	12-9-03	Repeal	1-1-04
340-041-0935	12-9-03	Repeal	1-1-04
340-041-0962	12-9-03	Repeal	1-1-04
340-041-0965	12-9-03	Repeal	1-1-04
340-041-0975	12-9-03	Repeal	1-1-04
340-200-0040	12-12-03	Amend	1-1-04
340-214-0400	12-12-03	Adopt	1-1-04
340-214-0410	12-12-03	Adopt	1-1-04
340-214-0420	12-12-03	Adopt	1-1-04
340-214-0430	12-12-03	Adopt	1-1-04
340-228-0400	12-12-03	Adopt	1-1-04
340-228-0410	12-12-03	Adopt	1-1-04
340-228-0420	12-12-03	Adopt	1-1-04
340-228-0430	12-12-03	Adopt	1-1-04
340-228-0440	12-12-03	Adopt	1-1-04
340-228-0450	12-12-03	Adopt	1-1-04
340-228-0460	12-12-03	Adopt	1-1-04
340-228-0470	12-12-03	Adopt	1-1-04
340-228-0480	12-12-03	Adopt	1-1-04
340-228-0490	12-12-03	Adopt	1-1-04
340-228-0500	12-12-03	Adopt	1-1-04
340-228-0510	12-12-03	Adopt	1-1-04
340-228-0520	12-12-03	Adopt	1-1-04
340-228-0530	12-12-03	Adopt	1-1-04
350-120-0010	4-1-04	Amend	4-1-04
350-120-0015	4-1-04	Adopt	4-1-04
350-120-0020	4-1-04	Amend	4-1-04
350-120-0025	4-1-04	Adopt	4-1-04
350-120-0030	4-1-04	Amend	4-1-04
350-120-0040	4-1-04	Amend	4-1-04
350-120-0050	4-1-04	Adopt	4-1-04
410-007-0000	3-1-04	Repeal	4-1-04
410-007-0010	3-1-04	Repeal	4-1-04
410-007-0020	3-1-04	Repeal	4-1-04
410-007-0030	3-1-04	Repeal	4-1-04
410-007-0040	3-1-04	Repeal	4-1-04
410-007-0050	3-1-04	Repeal	4-1-04
410-007-0060	3-1-04	Repeal	4-1-04
410-007-0070	3-1-04	Repeal	4-1-04
410-007-0080	3-1-04	Repeal	4-1-04
410-007-0200	3-1-04	Adopt	4-1-04
410-007-0210	3-1-04	Adopt	4-1-04
410-007-0220	3-1-04	Adopt	4-1-04
410-007-0230	3-1-04	Adopt	4-1-04
410-007-0240	3-1-04	Adopt	4-1-04
410-007-0250	3-1-04	Adopt	4-1-04
410-007-0260	3-1-04	Adopt	4-1-04
410-007-0270	3-1-04	Adopt	4-1-04
410-007-0280	3-1-04	Adopt	4-1-04
410-007-0290	3-1-04	Adopt	4-1-04
410-007-0300	3-1-04	Adopt	4-1-04
410-007-0310	3-1-04	Adopt	4-1-04
410-007-0320	3-1-04	Adopt	4-1-04
410-007-0330	3-1-04	Adopt	4-1-04
410-007-0340	3-1-04	Adopt	4-1-04
410-007-0350	3-1-04	Adopt	4-1-04
410-007-0360	3-1-04	Adopt	4-1-04
410-007-0370	3-1-04	Adopt	4-1-04
410-007-0380	3-1-04	Adopt	4-1-04
410-120-1160	4-1-04	Amend	4-1-04
410-120-1195	1-1-04	Amend	2-1-04
410-120-1200	4-1-04	Amend	4-1-04
410-120-1280	4-1-04	Amend	4-1-04
410-120-1340	4-1-04	Amend	4-1-04
410-120-1360	4-1-04	Amend	4-1-04
410-120-1520	4-1-04	Amend	4-1-04
410-120-1540	4-1-04	Amend	4-1-04
410-120-1570	4-1-04	Amend	4-1-04
410-121-0000	4-1-04	Amend	4-1-04
410-121-0021	12-1-03	Adopt	1-1-04
410-121-0030	3-1-04	Amend	4-1-04
410-121-0033	2-1-04	Adopt	3-1-04
410-121-0040	12-1-03	Amend	1-1-04
410-121-0040	12-15-03	Amend(T)	1-1-04
410-121-0040	3-1-04	Amend	4-1-04
410-121-0040(T)	3-1-04	Repeal	4-1-04
410-121-0060	4-1-04	Amend	4-1-04
410-121-0061	4-1-04	Amend	4-1-04
410-121-0100	4-1-04	Amend	4-1-04
410-121-0135	4-1-04	Amend	4-1-04
410-121-0140	12-1-03	Amend	1-1-04
410-121-0140	4-1-04	Amend	4-1-04
410-121-0143	4-1-04	Amend	4-1-04
410-121-0144	4-1-04	Amend	4-1-04
410-121-0145	4-1-04	Amend	4-1-04
410-121-0146	3-15-04	Amend	3-1-04
410-121-0146	3-15-04	Amend(T)	4-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
410-121-0147	4-1-04	Amend	4-1-04
410-121-0148	4-1-04	Amend	4-1-04
410-121-0150	4-1-04	Amend	4-1-04
410-121-0154	4-1-04	Repeal	4-1-04
410-121-0155	4-1-04	Amend	4-1-04
410-121-0157	4-4-04	Amend(T)	3-1-04
410-121-0160	3-15-04	Amend	3-1-04
410-121-0160	3-15-04	Amend(T)	4-1-04
410-121-0160	4-15-04	Amend	4-1-04
410-121-0180	4-1-04	Repeal	4-1-04
410-121-0185	4-1-04	Amend	4-1-04
410-121-0190	4-1-04	Amend	4-1-04
410-121-0200	4-1-04	Amend	4-1-04
410-121-0300	12-1-03	Amend(T)	1-1-04
410-121-0300	2-1-04	Amend	3-1-04
410-121-0320	2-1-04	Amend	3-1-04
410-121-0420	4-1-04	Amend	4-1-04
410-121-0580	4-1-04	Amend	4-1-04
410-121-0625	4-1-04	Amend	4-1-04
410-122-0040	3-15-04	Amend	3-1-04
410-122-0040	3-15-04	Amend(T)	4-1-04
410-125-0080	4-1-04	Amend	4-1-04
410-125-0115	3-15-04	Amend(T)	4-1-04
410-125-0121	3-15-04	Amend(T)	4-1-04
410-125-0141	1-1-04	Amend	2-1-04
410-125-0181	1-1-04	Amend	2-1-04
410-125-0181	3-15-04	Amend(T)	4-1-04
410-125-0195	1-1-04	Amend	2-1-04
410-125-0225	4-1-04	Repeal	4-1-04
410-125-0410	4-1-04	Amend	4-1-04
410-125-2000	4-1-04	Amend	4-1-04
410-127-0080	1-1-04	Amend	2-1-04
410-129-0080	12-1-03	Amend	1-1-04
410-129-0100	4-1-04	Amend	4-1-04
410-129-0200	4-1-04	Amend	4-1-04
410-129-0260	4-1-04	Amend	4-1-04
410-130-0000	4-1-04	Amend	4-1-04
410-130-0180	4-1-04	Amend	4-1-04
410-130-0200	4-1-04	Amend	4-1-04
410-130-0220	4-1-04	Amend	4-1-04
410-130-0240	4-1-04	Amend	4-1-04
410-130-0255	4-1-04	Amend	4-1-04
410-130-0585	4-1-04	Amend	4-1-04
410-130-0587	4-1-04	Amend	4-1-04
410-130-0680	4-1-04	Amend	4-1-04
410-130-0700	4-1-04	Amend	4-1-04
410-131-0160	1-1-04	Amend	2-1-04
410-131-0280	4-1-04	Amend	4-1-04
410-132-0100	1-1-04	Amend	2-1-04
410-133-0090	12-15-03	Amend(T)	1-1-04
410-133-0090	2-1-04	Amend	3-1-04
410-141-0480	1-1-04	Amend	2-1-04
410-141-0500	1-1-04	Amend	2-1-04
410-141-0520	1-1-04	Amend	2-1-04
410-141-0520	4-1-04	Amend(T)	4-1-04
410-142-0300	12-1-03	Amend	1-1-04
410-148-0000	4-1-04	Amend	4-1-04
410-148-0020	4-1-04	Amend	4-1-04
410-148-0080	4-1-04	Amend	4-1-04
410-148-0120	4-1-04	Amend	4-1-04
410-148-0260	4-1-04	Amend	4-1-04
410-148-0280	4-1-04	Amend	4-1-04
410-148-0300	4-1-04	Amend	4-1-04
411-009-0000	3-1-04	Repeal	4-1-04
411-009-0005	3-1-04	Repeal	4-1-04
411-009-0015	3-1-04	Repeal	4-1-04
411-009-0021	3-1-04	Repeal	4-1-04
411-009-0040	3-1-04	Repeal	4-1-04
411-009-0050	3-1-04	Repeal	4-1-04
411-009-0060	3-1-04	Repeal	4-1-04
411-009-0070	3-1-04	Repeal	4-1-04
411-009-0080	3-1-04	Repeal	4-1-04
411-009-0090	3-1-04	Repeal	4-1-04
411-009-0100	3-1-04	Repeal	4-1-04
411-009-0110	3-1-04	Repeal	4-1-04
411-030-0020	12-11-03	Amend(T)	1-1-04
411-030-0033	12-11-03	Amend(T)	1-1-04
411-030-0040	12-11-03	Amend(T)	1-1-04
411-030-0060	12-11-03	Amend(T)	1-1-04
411-030-0065	12-11-03	Amend(T)	1-1-04
411-055-0000	2-4-04	Amend	3-1-04
411-055-0003	2-4-04	Amend	3-1-04
411-056-0005	2-4-04	Amend	3-1-04
411-056-0007	2-4-04	Amend	3-1-04
411-300-0110	12-11-03	Amend(T)	1-1-04
411-320-0010	1-1-04	Adopt	2-1-04
411-320-0020	1-1-04	Adopt	2-1-04
411-320-0030	1-1-04	Adopt	2-1-04
411-320-0040	1-1-04	Adopt	2-1-04
411-320-0050	1-1-04	Adopt	2-1-04
411-320-0060	1-1-04	Adopt	2-1-04
411-320-0070	1-1-04	Adopt	2-1-04
411-320-0080	1-1-04	Adopt	2-1-04
411-320-0090	1-1-04	Adopt	2-1-04
411-320-0100	1-1-04	Adopt	2-1-04
411-320-0110	1-1-04	Adopt	2-1-04
411-320-0120	1-1-04	Adopt	2-1-04
411-320-0130	1-1-04	Adopt	2-1-04
411-320-0140	1-1-04	Adopt	2-1-04
411-320-0150	1-1-04	Adopt	2-1-04
411-320-0160	1-1-04	Adopt	2-1-04
411-320-0170	1-1-04	Adopt	2-1-04
411-320-0180	1-1-04	Adopt	2-1-04
411-320-0190	1-1-04	Adopt	2-1-04
411-320-0200	1-1-04	Adopt	2-1-04
411-325-0010	1-1-04	Adopt	2-1-04
411-325-0020	1-1-04	Adopt	2-1-04
411-325-0030	1-1-04	Adopt	2-1-04
411-325-0040	1-1-04	Adopt	2-1-04
411-325-0050	1-1-04	Adopt	2-1-04
411-325-0060	1-1-04	Adopt	2-1-04
411-325-0070	1-1-04	Adopt	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
411-325-0080	1-1-04	Adopt	2-1-04
411-325-0090	1-1-04	Adopt	2-1-04
411-325-0100	1-1-04	Adopt	2-1-04
411-325-0110	1-1-04	Adopt	2-1-04
411-325-0120	1-1-04	Adopt	2-1-04
411-325-0130	1-1-04	Adopt	2-1-04
411-325-0140	1-1-04	Adopt	2-1-04
411-325-0150	1-1-04	Adopt	2-1-04
411-325-0160	1-1-04	Adopt	2-1-04
411-325-0170	1-1-04	Adopt	2-1-04
411-325-0180	1-1-04	Adopt	2-1-04
411-325-0190	1-1-04	Adopt	2-1-04
411-325-0200	1-1-04	Adopt	2-1-04
411-325-0210	1-1-04	Adopt	2-1-04
411-325-0220	1-1-04	Adopt	2-1-04
411-325-0230	1-1-04	Adopt	2-1-04
411-325-0240	1-1-04	Adopt	2-1-04
411-325-0250	1-1-04	Adopt	2-1-04
411-325-0260	1-1-04	Adopt	2-1-04
411-325-0270	1-1-04	Adopt	2-1-04
411-325-0280	1-1-04	Adopt	2-1-04
411-325-0290	1-1-04	Adopt	2-1-04
411-325-0300	1-1-04	Adopt	2-1-04
411-325-0310	1-1-04	Adopt	2-1-04
411-325-0320	1-1-04	Adopt	2-1-04
411-325-0330	1-1-04	Adopt	2-1-04
411-325-0340	1-1-04	Adopt	2-1-04
411-325-0350	1-1-04	Adopt	2-1-04
411-325-0360	1-1-04	Adopt	2-1-04
411-325-0370	1-1-04	Adopt	2-1-04
411-325-0380	1-1-04	Adopt	2-1-04
411-325-0390	1-1-04	Adopt	2-1-04
411-325-0400	1-1-04	Adopt	2-1-04
411-325-0410	1-1-04	Adopt	2-1-04
411-325-0420	1-1-04	Adopt	2-1-04
411-325-0430	1-1-04	Adopt	2-1-04
411-325-0440	1-1-04	Adopt	2-1-04
411-325-0450	1-1-04	Adopt	2-1-04
411-325-0460	1-1-04	Adopt	2-1-04
411-325-0470	1-1-04	Adopt	2-1-04
411-325-0480	1-1-04	Adopt	2-1-04
411-330-0010	12-28-03	Adopt	2-1-04
411-330-0020	12-28-03	Adopt	2-1-04
411-330-0030	12-28-03	Adopt	2-1-04
411-330-0040	12-28-03	Adopt	2-1-04
411-330-0050	12-28-03	Adopt	2-1-04
411-330-0060	12-28-03	Adopt	2-1-04
411-330-0070	12-28-03	Adopt	2-1-04
411-330-0080	12-28-03	Adopt	2-1-04
411-330-0090	12-28-03	Adopt	2-1-04
411-330-0100	12-28-03	Adopt	2-1-04
411-330-0110	12-28-03	Adopt	2-1-04
411-330-0120	12-28-03	Adopt	2-1-04
411-330-0130	12-28-03	Adopt	2-1-04
411-330-0140	12-28-03	Adopt	2-1-04
411-330-0150	12-28-03	Adopt	2-1-04
411-330-0160	12-28-03	Adopt	2-1-04
411-330-0170	12-28-03	Adopt	2-1-04
413-010-0700	1-1-04	Amend	2-1-04
413-010-0705	1-1-04	Amend	2-1-04
413-010-0712	1-1-04	Amend	2-1-04
413-010-0714	1-1-04	Amend	2-1-04
413-010-0715	1-1-04	Amend	2-1-04
413-010-0716	1-1-04	Amend	2-1-04
413-010-0717	1-1-04	Amend	2-1-04
413-010-0718	1-1-04	Amend	2-1-04
413-010-0719	1-1-04	Repeal	2-1-04
413-010-0720	1-1-04	Amend	2-1-04
413-010-0721	1-1-04	Amend	2-1-04
413-010-0722	1-1-04	Amend	2-1-04
413-010-0723	1-1-04	Amend	2-1-04
413-010-0732	1-1-04	Amend	2-1-04
413-010-0735	1-1-04	Amend	2-1-04
413-010-0738	1-1-04	Amend	2-1-04
413-010-0740	1-1-04	Amend	2-1-04
413-010-0743	1-1-04	Amend	2-1-04
413-010-0745	1-1-04	Amend	2-1-04
413-010-0746	1-1-04	Amend	2-1-04
413-010-0748	1-1-04	Adopt	2-1-04
413-010-0750	1-1-04	Amend	2-1-04
413-040-0200	1-1-04	Amend	2-1-04
413-040-0205	1-1-04	Adopt	2-1-04
413-040-0210	1-1-04	Amend	2-1-04
413-040-0215	1-1-04	Adopt	2-1-04
413-040-0220	1-1-04	Repeal	2-1-04
413-040-0230	1-1-04	Amend	2-1-04
413-040-0240	1-1-04	Amend	2-1-04
413-040-0250	1-1-04	Am. & Ren.	2-1-04
413-040-0260	1-1-04	Amend	2-1-04
413-040-0265	1-1-04	Adopt	2-1-04
413-040-0270	1-1-04	Amend	2-1-04
413-040-0280	1-1-04	Amend	2-1-04
413-040-0290	1-1-04	Amend	2-1-04
413-040-0300	1-1-04	Amend	2-1-04
413-040-0310	1-1-04	Amend	2-1-04
413-040-0320	1-1-04	Amend	2-1-04
413-040-0330	1-1-04	Amend	2-1-04
413-050-0200	12-12-03	Amend	1-1-04
413-050-0210	12-12-03	Amend	1-1-04
413-050-0220	12-12-03	Amend	1-1-04
413-050-0230	12-12-03	Amend	1-1-04
413-050-0240	12-12-03	Amend	1-1-04
413-050-0250	12-12-03	Amend	1-1-04
413-050-0260	12-12-03	Amend	1-1-04
413-050-0270	12-12-03	Amend	1-1-04
413-050-0280	12-12-03	Amend	1-1-04
413-050-0290	12-12-03	Amend	1-1-04
413-050-0300	12-12-03	Amend	1-1-04
413-070-0500	1-1-04	Amend	2-1-04
413-070-0505	1-1-04	Amend	2-1-04
413-070-0510	1-1-04	Amend	2-1-04
413-070-0515	1-1-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
413-070-0517	1-1-04	Amend	2-1-04
413-070-0915	1-1-04	Amend(T)	2-1-04
413-070-0935	1-1-04	Amend(T)	2-1-04
413-070-0937	1-1-04	Amend(T)	2-1-04
413-070-0980	1-1-04	Amend(T)	2-1-04
413-070-0981	1-1-04	Amend(T)	2-1-04
413-070-0981(T)	1-1-04	Suspend	2-1-04
413-070-0982	1-1-04	Adopt(T)	2-1-04
413-080-0040	3-1-04	Adopt(T)	4-1-04
413-080-0045	3-1-04	Adopt(T)	4-1-04
413-080-0050	3-1-04	Adopt(T)	4-1-04
413-080-0055	3-1-04	Adopt(T)	4-1-04
413-080-0060	3-1-04	Adopt(T)	4-1-04
413-100-0020	2-10-04	Amend	3-1-04
413-100-0030	2-10-04	Amend	3-1-04
413-100-0030(T)	2-10-04	Repeal	3-1-04
413-100-0040	2-10-04	Amend	3-1-04
413-100-0040(T)	2-10-04	Repeal	3-1-04
413-100-0050	2-10-04	Amend	3-1-04
413-100-0050(T)	2-10-04	Repeal	3-1-04
413-100-0070	2-10-04	Amend	3-1-04
413-100-0070(T)	2-10-04	Repeal	3-1-04
413-100-0080	2-10-04	Amend	3-1-04
413-100-0080(T)	2-10-04	Repeal	3-1-04
413-100-0110	2-10-04	Amend	3-1-04
413-100-0110(T)	2-10-04	Repeal	3-1-04
413-100-0130	2-10-04	Amend	3-1-04
413-100-0130(T)	2-10-04	Repeal	3-1-04
413-100-0135	2-10-04	Amend	3-1-04
413-100-0135(T)	2-10-04	Repeal	3-1-04
413-100-0150	2-10-04	Amend	3-1-04
413-100-0150(T)	2-10-04	Repeal	3-1-04
413-100-0160	2-10-04	Amend	3-1-04
413-100-0160(T)	2-10-04	Repeal	3-1-04
413-100-0240	2-10-04	Amend	3-1-04
413-100-0240(T)	2-10-04	Repeal	3-1-04
413-100-0276	2-10-04	Amend	3-1-04
413-100-0276(T)	2-10-04	Repeal	3-1-04
413-100-0290	2-10-04	Amend	3-1-04
413-100-0290(T)	2-10-04	Repeal	3-1-04
413-110-0000	1-1-04	Amend	2-1-04
413-110-0010	1-1-04	Amend	2-1-04
413-110-0020	1-1-04	Amend	2-1-04
413-110-0030	1-1-04	Amend	2-1-04
413-110-0040	1-1-04	Amend	2-1-04
413-110-0100	1-1-04	Amend	2-1-04
413-110-0110	1-1-04	Amend	2-1-04
413-110-0120	1-1-04	Amend	2-1-04
413-110-0130	1-1-04	Amend	2-1-04
413-110-0140	1-1-04	Amend	2-1-04
413-110-0300	1-1-04	Amend	2-1-04
413-110-0310	1-1-04	Amend	2-1-04
413-110-0320	1-1-04	Amend	2-1-04
413-110-0330	1-1-04	Amend	2-1-04
413-110-0340	1-1-04	Amend	2-1-04
413-110-0350	1-1-04	Amend	2-1-04
413-110-0360	1-1-04	Amend	2-1-04
413-120-0115	11-25-03	Amend(T)	1-1-04
413-120-0175	11-25-03	Amend(T)	1-1-04
413-120-0500	1-1-04	Amend	2-1-04
413-120-0510	1-1-04	Amend	2-1-04
413-120-0520	1-1-04	Amend	2-1-04
413-120-0530	1-1-04	Amend	2-1-04
413-120-0540	1-1-04	Amend	2-1-04
413-120-0550	1-1-04	Adopt	2-1-04
413-130-0125	11-19-03	Amend(T)	1-1-04
413-210-0800	1-9-04	Amend	2-1-04
413-210-0806	1-9-04	Amend	2-1-04
413-210-0821	1-9-04	Amend	2-1-04
413-330-0085	12-17-03	Amend(T)	2-1-04
413-330-0087	12-17-03	Amend(T)	2-1-04
413-330-0090	12-17-03	Amend(T)	2-1-04
413-330-0095	12-17-03	Amend(T)	2-1-04
413-330-0097	12-17-03	Adopt(T)	2-1-04
413-330-0098	12-17-03	Adopt(T)	2-1-04
413-330-0900	1-1-04	Amend(T)	2-1-04
413-330-0910	1-1-04	Amend(T)	2-1-04
413-330-0920	1-1-04	Amend(T)	2-1-04
413-330-0930	1-1-04	Amend(T)	2-1-04
413-330-0940	1-1-04	Amend(T)	2-1-04
413-330-0950	1-1-04	Amend(T)	2-1-04
413-330-0960	1-1-04	Suspend	2-1-04
413-330-0970	1-1-04	Amend(T)	2-1-04
413-330-0980	1-1-04	Amend(T)	2-1-04
413-330-0990	1-1-04	Amend(T)	2-1-04
413-330-1000	1-1-04	Amend(T)	2-1-04
413-330-1010	1-1-04	Amend(T)	2-1-04
414-050-0010	12-28-03	Adopt(T)	2-1-04
414-061-0000	12-7-03	Amend	1-1-04
414-061-0010	12-7-03	Amend	1-1-04
414-061-0020	12-7-03	Amend	1-1-04
414-061-0030	12-7-03	Amend	1-1-04
414-061-0040	12-7-03	Amend	1-1-04
414-061-0050	12-7-03	Amend	1-1-04
414-061-0060	12-7-03	Amend	1-1-04
414-061-0070	12-7-03	Amend	1-1-04
414-061-0080	12-7-03	Amend	1-1-04
414-061-0090	12-7-03	Amend	1-1-04
414-061-0100	12-7-03	Amend	1-1-04
414-061-0110	12-7-03	Amend	1-1-04
414-061-0120	12-7-03	Amend	1-1-04
414-150-0055	12-28-03	Amend	2-1-04
414-150-0080	12-28-03	Amend	2-1-04
414-150-0120	12-28-03	Amend	2-1-04
414-205-0000	12-28-03	Amend	2-1-04
414-300-0000	12-28-03	Amend	2-1-04
414-300-0005	12-28-03	Amend	2-1-04
414-300-0010	12-28-03	Amend	2-1-04
414-300-0180	12-28-03	Amend	2-1-04
414-300-0190	12-28-03	Amend	2-1-04
414-300-0200	12-28-03	Amend	2-1-04
414-300-0210	12-28-03	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
414-300-0280	12-28-03	Amend	2-1-04
414-300-0360	12-28-03	Amend	2-1-04
414-350-0010	12-28-03	Amend	2-1-04
414-350-0010	12-28-03	Amend	2-1-04
414-350-0020	12-28-03	Amend	2-1-04
414-350-0210	12-28-03	Amend	2-1-04
414-350-0235	12-28-03	Amend	2-1-04
414-500-0030	12-28-03	Amend	2-1-04
414-600-0000	12-7-03	Suspend	1-1-04
414-600-0010	12-7-03	Suspend	1-1-04
414-600-0020	12-7-03	Suspend	1-1-04
414-600-0030	12-7-03	Suspend	1-1-04
414-600-0040	12-7-03	Suspend	1-1-04
414-600-0050	12-7-03	Suspend	1-1-04
414-600-0060	12-7-03	Suspend	1-1-04
414-600-0070	12-7-03	Suspend	1-1-04
414-600-0080	12-7-03	Suspend	1-1-04
414-600-0090	12-7-03	Suspend	1-1-04
414-600-0100	12-7-03	Suspend	1-1-04
414-700-0000	12-7-03	Adopt	1-1-04
414-700-0010	12-7-03	Adopt	1-1-04
414-700-0020	12-7-03	Adopt	1-1-04
414-700-0030	12-7-03	Adopt	1-1-04
414-700-0040	12-7-03	Adopt	1-1-04
414-700-0050	12-7-03	Adopt	1-1-04
414-700-0060	12-7-03	Adopt	1-1-04
414-700-0070	12-7-03	Adopt	1-1-04
414-700-0080	12-7-03	Adopt	1-1-04
414-700-0090	12-7-03	Adopt	1-1-04
436-001-0000	4-1-04	Amend	4-1-04
436-001-0001	4-1-04	Amend	4-1-04
436-001-0003	4-1-04	Amend	4-1-04
436-001-0004	4-1-04	Amend	4-1-04
436-001-0005	4-1-04	Amend	4-1-04
436-001-0007	4-1-04	Amend	4-1-04
436-001-0008	4-1-04	Amend	4-1-04
436-001-0025	4-1-04	Repeal	4-1-04
436-001-0030	4-1-04	Amend	4-1-04
436-001-0045	4-1-04	Repeal	4-1-04
436-001-0055	4-1-04	Repeal	4-1-04
436-001-0065	4-1-04	Repeal	4-1-04
436-001-0090	4-1-04	Repeal	4-1-04
436-001-0105	4-1-04	Repeal	4-1-04
436-001-0110	4-1-04	Amend	4-1-04
436-001-0120	4-1-04	Repeal	4-1-04
436-001-0135	4-1-04	Repeal	4-1-04
436-001-0140	4-1-04	Repeal	4-1-04
436-001-0150	4-1-04	Amend	4-1-04
436-001-0155	4-1-04	Amend	4-1-04
436-001-0160	4-1-04	Amend	4-1-04
436-001-0170	4-1-04	Amend	4-1-04
436-001-0171	4-1-04	Repeal	4-1-04
436-001-0175	4-1-04	Repeal	4-1-04
436-001-0185	4-1-04	Amend	4-1-04
436-001-0191	4-1-04	Repeal	4-1-04
436-001-0195	4-1-04	Repeal	4-1-04
436-001-0201	4-1-04	Amend	4-1-04
436-001-0205	4-1-04	Repeal	4-1-04
436-001-0210	4-1-04	Amend	4-1-04
436-001-0225	4-1-04	Amend	4-1-04
436-001-0226	4-1-04	Amend	4-1-04
436-001-0231	4-1-04	Repeal	4-1-04
436-001-0240	4-1-04	Amend	4-1-04
436-001-0255	4-1-04	Repeal	4-1-04
436-001-0260	4-1-04	Amend	4-1-04
436-001-0265	1-1-04	Amend(T)	1-1-04
436-001-0265	4-1-04	Amend	4-1-04
436-001-0275	4-1-04	Amend	4-1-04
436-001-0285	4-1-04	Repeal	4-1-04
436-001-0295	4-1-04	Repeal	4-1-04
436-001-0300	4-1-04	Adopt	4-1-04
436-009-0003	4-1-04	Amend	4-1-04
436-009-0004	4-1-04	Amend	4-1-04
436-009-0005	4-1-04	Amend	4-1-04
436-009-0008	1-1-04	Amend(T)	1-1-04
436-009-0008	4-1-04	Amend	4-1-04
436-009-0010	4-1-04	Amend	4-1-04
436-009-0015	1-1-04	Amend(T)	1-1-04
436-009-0015	4-1-04	Amend	4-1-04
436-009-0020	4-1-04	Amend	4-1-04
436-009-0022	4-1-04	Amend	4-1-04
436-009-0025	4-1-04	Amend	4-1-04
436-009-0030	4-1-04	Amend	4-1-04
436-009-0040	4-1-04	Amend	4-1-04
436-009-0050	4-1-04	Amend	4-1-04
436-009-0060	1-1-04	Amend(T)	1-1-04
436-009-0060	4-1-04	Amend	4-1-04
436-009-0070	1-1-04	Amend(T)	1-1-04
436-009-0070	4-1-04	Amend	4-1-04
436-009-0080	1-1-04	Amend(T)	1-1-04
436-009-0080	4-1-04	Amend	4-1-04
436-009-0090	4-1-04	Amend	4-1-04
436-010-0003	4-1-04	Amend	4-1-04
436-010-0005	1-1-04	Amend(T)	1-1-04
436-010-0005	4-1-04	Amend	4-1-04
436-010-0008	1-1-04	Amend(T)	1-1-04
436-010-0008	4-1-04	Amend	4-1-04
436-010-0210	1-1-04	Amend(T)	1-1-04
436-010-0210	4-1-04	Amend	4-1-04
436-010-0220	1-1-04	Amend(T)	1-1-04
436-010-0220	4-1-04	Amend	4-1-04
436-010-0230	1-1-04	Amend(T)	1-1-04
436-010-0230	4-1-04	Amend	4-1-04
436-010-0240	1-1-04	Amend(T)	1-1-04
436-010-0240	4-1-04	Amend	4-1-04
436-010-0250	1-1-04	Amend(T)	1-1-04
436-010-0250	4-1-04	Amend	4-1-04
436-010-0265	1-1-04	Amend(T)	1-1-04
436-010-0265	4-1-04	Amend	4-1-04
436-010-0270	1-1-04	Amend(T)	1-1-04
436-010-0270	4-1-04	Amend	4-1-04
436-010-0275	1-1-04	Amend(T)	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
436-010-0275	4-1-04	Amend	4-1-04
436-010-0280	1-1-04	Amend(T)	1-1-04
436-010-0280	4-1-04	Amend	4-1-04
436-010-0340	1-1-04	Amend(T)	1-1-04
436-010-0340	4-1-04	Amend	4-1-04
436-010-0350	4-1-04	Repeal	4-1-04
436-015-0008	1-1-04	Amend(T)	1-1-04
436-015-0030	1-1-04	Amend(T)	1-1-04
436-015-0050	1-1-04	Amend(T)	1-1-04
436-015-0060	1-1-04	Amend(T)	1-1-04
436-015-0070	1-1-04	Amend(T)	1-1-04
436-015-0090	1-1-04	Amend(T)	1-1-04
436-030-0002	2-29-04	Amend	4-1-04
436-030-0003	1-1-04	Amend(T)	1-1-04
436-030-0003	2-29-04	Amend	4-1-04
436-030-0003(T)	2-29-04	Repeal	4-1-04
436-030-0005	1-1-04	Amend(T)	1-1-04
436-030-0005	2-29-04	Amend	4-1-04
436-030-0005(T)	2-29-04	Repeal	4-1-04
436-030-0007	1-1-04	Amend(T)	1-1-04
436-030-0007	2-29-04	Amend	4-1-04
436-030-0007(T)	2-29-04	Repeal	4-1-04
436-030-0009	1-1-04	Amend(T)	1-1-04
436-030-0009	2-29-04	Amend	4-1-04
436-030-0009(T)	2-29-04	Repeal	4-1-04
436-030-0010	1-1-04	Amend(T)	1-1-04
436-030-0010	2-29-04	Amend	4-1-04
436-030-0010(T)	2-29-04	Repeal	4-1-04
436-030-0015	2-29-04	Amend	4-1-04
436-030-0017	2-29-04	Amend	4-1-04
436-030-0020	2-29-04	Amend	4-1-04
436-030-0023	2-29-04	Adopt	4-1-04
436-030-0023	2-29-04	Amend	4-1-04
436-030-0034	1-1-04	Amend(T)	1-1-04
436-030-0034	2-29-04	Amend	4-1-04
436-030-0034(T)	2-29-04	Repeal	4-1-04
436-030-0035	1-1-04	Amend(T)	1-1-04
436-030-0035	2-29-04	Amend	4-1-04
436-030-0035(T)	2-29-04	Repeal	4-1-04
436-030-0036	2-29-04	Amend	4-1-04
436-030-0038	2-29-04	Amend	4-1-04
436-030-0045	2-29-04	Am. & Ren.	4-1-04
436-030-0045	2-29-04	Amend	4-1-04
436-030-0055	2-29-04	Amend	4-1-04
436-030-0065	2-29-04	Amend	4-1-04
436-030-0066	2-29-04	Amend	4-1-04
436-030-0115	1-1-04	Amend(T)	1-1-04
436-030-0115	2-29-04	Amend	4-1-04
436-030-0115(T)	2-29-04	Repeal	4-1-04
436-030-0125	1-1-04	Amend(T)	1-1-04
436-030-0125	2-29-04	Amend	4-1-04
436-030-0125(T)	2-29-04	Repeal	4-1-04
436-030-0135	1-1-04	Amend(T)	1-1-04
436-030-0135	2-29-04	Amend	4-1-04
436-030-0135(T)	2-29-04	Repeal	4-1-04
436-030-0145	1-1-04	Amend(T)	1-1-04
436-030-0145	2-29-04	Amend	4-1-04
436-030-0145(T)	2-29-04	Repeal	4-1-04
436-030-0155	2-29-04	Amend	4-1-04
436-030-0165	1-1-04	Amend(T)	1-1-04
436-030-0165	2-29-04	Amend	4-1-04
436-030-0165(T)	2-29-04	Repeal	4-1-04
436-030-0175	2-29-04	Amend	4-1-04
436-030-0185	1-1-04	Amend(T)	1-1-04
436-030-0185	2-29-04	Amend	4-1-04
436-030-0185(T)	2-29-04	Repeal	4-1-04
436-030-0575	2-29-04	Amend	4-1-04
436-030-0580	2-29-04	Amend	4-1-04
436-030-0581	2-29-04	Repeal	4-1-04
436-035-0500	1-21-04	Amend(T)	3-1-04
436-045-0008	1-1-04	Amend	1-1-04
436-050-0003	1-1-04	Amend	1-1-04
436-050-0005	1-1-04	Amend	1-1-04
436-050-0006	1-1-04	Amend	1-1-04
436-050-0008	1-1-04	Amend	1-1-04
436-050-0020	1-1-04	Repeal	1-1-04
436-050-0040	1-1-04	Amend	1-1-04
436-050-0050	1-1-04	Amend	1-1-04
436-050-0055	1-1-04	Amend	1-1-04
436-050-0060	1-1-04	Amend	1-1-04
436-050-0080	1-1-04	Amend	1-1-04
436-050-0090	1-1-04	Amend	1-1-04
436-050-0100	1-1-04	Amend	1-1-04
436-050-0110	1-1-04	Amend	1-1-04
436-050-0120	1-1-04	Amend	1-1-04
436-050-0150	1-1-04	Amend	1-1-04
436-050-0150(T)	1-1-04	Repeal	1-1-04
436-050-0160	1-1-04	Amend	1-1-04
436-050-0160(T)	1-1-04	Repeal	1-1-04
436-050-0165	1-1-04	Adopt	1-1-04
436-050-0165(T)	1-1-04	Repeal	1-1-04
436-050-0170	1-1-04	Amend	1-1-04
436-050-0175	1-1-04	Amend	1-1-04
436-050-0180	1-1-04	Amend	1-1-04
436-050-0185	1-1-04	Amend	1-1-04
436-050-0190	1-1-04	Amend	1-1-04
436-050-0195	1-1-04	Amend	1-1-04
436-050-0200	1-1-04	Amend	1-1-04
436-050-0210	1-1-04	Amend	1-1-04
436-050-0220	1-1-04	Amend	1-1-04
436-050-0260	1-1-04	Amend	1-1-04
436-050-0270	1-1-04	Amend	1-1-04
436-050-0280	1-1-04	Amend	1-1-04
436-050-0290	1-1-04	Amend	1-1-04
436-050-0400	1-1-04	Amend	1-1-04
436-050-0440	1-1-04	Amend	1-1-04
436-050-0480	1-1-04	Adopt	1-1-04
436-055-0008	1-1-04	Amend	1-1-04
436-060-0005	1-1-04	Amend(T)	1-1-04
436-060-0005	2-29-04	Amend	4-1-04
436-060-0008	1-1-04	Amend	1-1-04
436-060-0008	2-29-04	Amend	4-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
436-060-0009	2-29-04	Amend	4-1-04
436-060-0010	1-1-04	Amend(T)	1-1-04
436-060-0010	2-29-04	Amend	4-1-04
436-060-0010(T)	1-1-04	Suspend	1-1-04
436-060-0015	2-29-04	Amend	4-1-04
436-060-0017	2-29-04	Amend	4-1-04
436-060-0019	1-1-04	Amend(T)	1-1-04
436-060-0019	2-29-04	Amend	4-1-04
436-060-0019(T)	1-1-04	Suspend	1-1-04
436-060-0020	1-1-04	Amend(T)	1-1-04
436-060-0020	2-29-04	Amend	4-1-04
436-060-0025	2-29-04	Amend	4-1-04
436-060-0030	1-1-04	Amend(T)	1-1-04
436-060-0030	2-29-04	Amend	4-1-04
436-060-0035	1-1-04	Amend(T)	1-1-04
436-060-0035	2-29-04	Amend	4-1-04
436-060-0035(T)	1-1-04	Suspend	1-1-04
436-060-0040	2-29-04	Amend	4-1-04
436-060-0060	2-29-04	Amend	4-1-04
436-060-0095	1-1-04	Amend(T)	1-1-04
436-060-0095	2-29-04	Amend	4-1-04
436-060-0105	1-1-04	Amend(T)	1-1-04
436-060-0105	2-29-04	Amend	4-1-04
436-060-0135	2-29-04	Amend	4-1-04
436-060-0140	1-1-04	Amend(T)	1-1-04
436-060-0140	2-29-04	Amend	4-1-04
436-060-0147	2-29-04	Amend	4-1-04
436-060-0150	1-1-04	Amend(T)	1-1-04
436-060-0150	2-29-04	Amend	4-1-04
436-060-0180	2-29-04	Amend	4-1-04
436-060-0190	2-29-04	Amend	4-1-04
436-060-0195	2-29-04	Amend	4-1-04
436-060-0200	2-29-04	Amend	4-1-04
436-060-0210	2-29-04	Repeal	4-1-04
436-060-0500	2-29-04	Amend	4-1-04
436-070-0008	1-1-04	Amend	1-1-04
436-075-0008	1-1-04	Amend	1-1-04
436-080-0001	1-1-04	Amend	1-1-04
436-080-0002	1-1-04	Amend	1-1-04
436-080-0003	1-1-04	Amend	1-1-04
436-080-0005	1-1-04	Amend	1-1-04
436-080-0006	1-1-04	Amend	1-1-04
436-080-0010	1-1-04	Amend	1-1-04
436-080-0020	1-1-04	Amend	1-1-04
436-080-0030	1-1-04	Amend	1-1-04
436-080-0040	1-1-04	Amend	1-1-04
436-080-0050	1-1-04	Repeal	1-1-04
436-080-0060	1-1-04	Amend	1-1-04
436-080-0065	1-1-04	Amend	1-1-04
436-080-0070	1-1-04	Amend	1-1-04
436-080-0080	1-1-04	Amend	1-1-04
436-085-0008	1-1-04	Amend	1-1-04
436-120-0003	4-1-04	Amend	4-1-04
436-120-0004	4-1-04	Amend	4-1-04
436-120-0008	1-1-04	Amend(T)	1-1-04
436-120-0008	4-1-04	Amend	4-1-04
436-120-0320	4-1-04	Amend	4-1-04
436-120-0340	4-1-04	Amend	4-1-04
436-120-0350	4-1-04	Amend	4-1-04
436-120-0360	4-1-04	Amend	4-1-04
436-120-0410	4-1-04	Amend	4-1-04
436-120-0500	4-1-04	Amend	4-1-04
436-120-0710	4-1-04	Amend	4-1-04
436-120-0720	4-1-04	Amend	4-1-04
436-120-0830	4-1-04	Amend	4-1-04
436-120-0840	4-1-04	Amend	4-1-04
436-120-0920	4-1-04	Repeal	4-1-04
436-150-0008	1-1-04	Amend	1-1-04
436-160-0003	1-1-04	Amend	1-1-04
436-160-0310	1-1-04	Amend	1-1-04
436-160-0320	1-1-04	Amend	1-1-04
436-160-0340	1-1-04	Amend	1-1-04
436-160-0350	1-1-04	Amend	1-1-04
436-160-0360	1-1-04	Amend	1-1-04
437-001-0015	11-26-03	Amend	1-1-04
437-001-0096	11-26-03	Amend	1-1-04
437-001-0171	11-26-03	Amend	1-1-04
437-001-0203	11-26-03	Amend	1-1-04
437-001-0265	11-26-03	Amend	1-1-04
437-001-0270	11-26-03	Amend	1-1-04
437-001-0430	11-26-03	Amend	1-1-04
437-001-0700	11-26-03	Amend	1-1-04
437-001-0765	11-26-03	Amend	1-1-04
437-002-0220	12-5-03	Amend	1-1-04
437-003-0001	12-5-03	Amend	1-1-04
437-003-0001	1-1-04	Amend	2-1-04
437-003-0754	1-1-04	Repeal	2-1-04
437-003-1754	1-1-04	Adopt	2-1-04
437-003-1760	1-1-04	Repeal	2-1-04
438-006-0064	1-1-04	Adopt	1-1-04
438-015-0110	1-1-04	Adopt	1-1-04
440-020-0010	1-1-04	Adopt	2-1-04
440-020-0015	1-1-04	Adopt	2-1-04
440-055-0000	1-1-04	Repeal	2-1-04
440-055-0005	1-1-04	Repeal	2-1-04
440-055-0008	1-1-04	Adopt	2-1-04
440-100-0010	1-1-04	Adopt	2-1-04
441-001-0005	1-1-04	Adopt	2-1-04
441-001-0010	1-1-04	Adopt	2-1-04
441-001-0020	1-1-04	Adopt	2-1-04
441-001-0030	1-1-04	Adopt	2-1-04
441-001-0040	1-1-04	Adopt	2-1-04
441-001-0050	1-1-04	Adopt	2-1-04
441-002-0005	1-1-04	Adopt	2-1-04
441-002-0010	1-1-04	Adopt	2-1-04
441-002-0020	1-1-04	Adopt	2-1-04
441-002-0030	1-1-04	Adopt	2-1-04
441-002-0040	1-1-04	Adopt	2-1-04
441-035-0045	11-26-03	Amend(T)	1-1-04
441-049-1001	11-26-03	Adopt(T)	1-1-04
441-049-1021	11-26-03	Amend(T)	1-1-04
441-049-1031	11-26-03	Amend(T)	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
441-049-1041	11-26-03	Amend(T)	1-1-04
441-049-1051	11-26-03	Amend(T)	1-1-04
441-065-0001	11-26-03	Adopt(T)	1-1-04
441-065-0015	11-26-03	Amend(T)	1-1-04
441-065-0020	11-26-03	Amend(T)	1-1-04
441-065-0035	11-26-03	Amend(T)	1-1-04
441-065-0170	11-26-03	Amend(T)	1-1-04
441-065-0180	11-26-03	Amend(T)	1-1-04
441-065-0270	11-26-03	Amend(T)	1-1-04
441-075-0020	11-26-03	Amend(T)	1-1-04
441-095-0030	11-26-03	Amend(T)	1-1-04
441-175-0002	11-26-03	Adopt(T)	1-1-04
441-175-0010	1-1-04	Amend	2-1-04
441-175-0015	11-26-03	Amend(T)	1-1-04
441-175-0035	1-1-04	Repeal	2-1-04
441-175-0055	1-1-04	Amend	2-1-04
441-175-0060	11-26-03	Amend(T)	1-1-04
441-175-0080	11-26-03	Amend(T)	1-1-04
441-175-0085	11-26-03	Amend(T)	1-1-04
441-175-0100	11-26-03	Amend(T)	1-1-04
441-175-0120	11-26-03	Amend(T)	1-1-04
441-175-0130	11-26-03	Amend(T)	1-1-04
441-175-0130	1-1-04	Amend	2-1-04
441-175-0160	11-26-03	Amend(T)	1-1-04
441-175-0165	11-26-03	Amend(T)	1-1-04
441-175-0171	11-26-03	Amend(T)	1-1-04
441-195-0035	1-1-04	Repeal	2-1-04
441-730-0030	1-1-04	Amend	2-1-04
441-740-0030	1-1-04	Adopt	2-1-04
441-810-0200	1-1-04	Adopt	2-1-04
441-810-0210	1-1-04	Adopt	2-1-04
441-810-0220	1-1-04	Adopt	2-1-04
441-810-0230	1-1-04	Adopt	2-1-04
441-810-0240	1-1-04	Adopt	2-1-04
441-810-0250	1-1-04	Adopt	2-1-04
441-810-0260	1-1-04	Adopt	2-1-04
441-860-0020	1-1-04	Amend	2-1-04
441-860-0050	1-1-04	Amend	2-1-04
441-880-0050	1-1-04	Adopt	2-1-04
445-050-0005	2-15-04	Amend	2-1-04
445-050-0020	2-15-04	Amend	2-1-04
445-050-0030	2-15-04	Amend	2-1-04
445-050-0040	2-15-04	Amend	2-1-04
445-050-0050	2-15-04	Amend	2-1-04
445-050-0060	2-15-04	Amend	2-1-04
445-050-0080	2-15-04	Amend	2-1-04
445-050-0090	2-15-04	Amend	2-1-04
445-050-0155	2-15-04	Amend	2-1-04
459-005-0001	11-20-03	Amend	1-1-04
459-005-0001	12-15-03	Amend	1-1-04
459-005-0001(T)	11-20-03	Repeal	1-1-04
459-005-0055	2-18-04	Amend	4-1-04
459-005-0250	1-1-04	Adopt	1-1-04
459-005-0320	1-22-04	Repeal	3-1-04
459-007-0001	12-15-03	Amend	1-1-04
459-007-0001(T)	12-15-03	Repeal	1-1-04
459-007-0003	12-15-03	Adopt	1-1-04
459-007-0040	12-15-03	Amend	1-1-04
459-007-0040(T)	12-15-03	Repeal	1-1-04
459-007-0050	12-15-03	Amend	1-1-04
459-007-0050(T)	12-15-03	Repeal	1-1-04
459-007-0060	12-15-03	Amend	1-1-04
459-007-0060(T)	12-15-03	Repeal	1-1-04
459-007-0070	4-1-04	Amend	1-1-04
459-007-0080	4-1-04	Amend	1-1-04
459-007-0090	4-1-04	Amend	1-1-04
459-007-0095	12-15-03	Adopt	1-1-04
459-007-0100	12-15-03	Repeal	1-1-04
459-009-0100	1-1-04	Amend	2-1-04
459-009-0110	1-1-04	Repeal	2-1-04
459-011-0100	1-22-04	Amend	3-1-04
459-011-0110	1-22-04	Amend	3-1-04
459-013-0300	12-15-03	Adopt	1-1-04
459-017-0060	12-15-03	Amend(T)	1-1-04
459-035-0050	1-1-04	Amend	1-1-04
459-045-0001	11-20-03	Amend	1-1-04
459-045-0001(T)	11-20-03	Repeal	1-1-04
459-060-0001	12-15-03	Amend	1-1-04
459-060-0010	12-15-03	Amend	1-1-04
459-060-0020	12-15-03	Amend	1-1-04
459-070-0001	2-18-04	Adopt	4-1-04
459-070-0100	1-1-04	Adopt	2-1-04
459-070-0110	1-1-04	Adopt	2-1-04
459-070-0900	2-18-04	Adopt(T)	4-1-04
459-075-0010	2-18-04	Adopt	4-1-04
459-075-0030	1-1-04	Adopt	2-1-04
459-075-0100	1-22-04	Adopt	3-1-04
459-075-0150	2-18-04	Adopt	4-1-04
459-080-0010	1-1-04	Adopt	1-1-04
459-080-0100	1-22-04	Adopt	3-1-04
459-080-0200	1-1-04	Adopt(T)	1-1-04
459-080-0500	1-1-04	Adopt	1-1-04
461-025-0311	1-1-04	Amend	2-1-04
461-110-0330	1-1-04	Amend	2-1-04
461-110-0350	12-17-03	Amend(T)	2-1-04
461-115-0015	1-1-04	Amend	2-1-04
461-115-0705	1-1-04	Amend	2-1-04
461-120-0120	1-1-04	Amend	2-1-04
461-120-0125	1-1-04	Amend(T)	2-1-04
461-120-0125(T)	1-1-04	Suspend	2-1-04
461-120-0340	1-1-04	Amend	2-1-04
461-120-0345	1-1-04	Amend	2-1-04
461-120-0345	1-1-04	Amend	2-1-04
461-135-0010	1-1-04	Amend	2-1-04
461-135-0180	1-1-04	Repeal	2-1-04
461-135-0301	12-1-03	Amend(T)	1-1-04
461-135-0400	1-1-04	Amend	2-1-04
461-135-0401	1-1-04	Amend	2-1-04
461-135-0700	1-1-04	Amend(T)	2-1-04
461-135-0700(T)	1-1-04	Suspend	2-1-04
461-135-0730	1-1-04	Amend	2-1-04
461-135-0780	1-1-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
461-135-0830	1-1-04	Amend	2-1-04
461-135-0832	1-1-04	Amend	2-1-04
461-135-0845	2-5-04	Amend(T)	3-1-04
461-135-0847	1-1-04	Adopt	2-1-04
461-135-1120	1-1-04	Amend	2-1-04
461-135-1120	2-19-04	Amend(T)	4-1-04
461-135-1130	12-1-03	Amend(T)	1-1-04
461-135-1130	1-1-04	Amend	2-1-04
461-135-1130	1-1-04	Amend	2-1-04
461-135-1130	2-19-04	Amend(T)	4-1-04
461-135-1130(T)	12-1-03	Suspend	1-1-04
461-155-0020	1-1-04	Amend	2-1-04
461-155-0030	1-1-04	Amend	2-1-04
461-155-0035	1-1-04	Amend	2-1-04
461-155-0150	1-1-04	Amend	2-1-04
461-155-0150	1-1-04	Amend	2-1-04
461-155-0225	2-13-04	Amend(T)	3-1-04
461-155-0235	3-1-04	Amend(T)	4-1-04
461-155-0250	1-1-04	Amend	2-1-04
461-155-0270	1-1-04	Amend	2-1-04
461-155-0300	1-1-04	Amend	2-1-04
461-155-0526	1-1-04	Amend	2-1-04
461-155-0526	1-1-04	Amend	2-1-04
461-155-0680	1-1-04	Amend	2-1-04
461-160-0580	1-1-04	Amend	2-1-04
461-160-0620	1-1-04	Amend	2-1-04
461-165-0030	1-1-04	Amend	2-1-04
461-165-0400	3-1-04	Repeal	4-1-04
461-170-0010	1-1-04	Amend	2-1-04
461-175-0200	1-1-04	Amend	2-1-04
461-180-0070	1-1-04	Amend	2-1-04
461-180-0105	12-1-03	Amend(T)	1-1-04
461-180-0105	1-1-04	Amend	2-1-04
461-190-0110	1-1-04	Amend	2-1-04
461-190-0161	1-1-04	Amend	2-1-04
461-190-0191	1-1-04	Repeal	2-1-04
461-190-0211	1-1-04	Amend	2-1-04
461-190-0360	1-1-04	Amend	2-1-04
461-193-0560	1-1-04	Amend	2-1-04
461-195-0501	1-1-04	Amend	2-1-04
461-195-0561	1-1-04	Amend	2-1-04
462-120-0020	3-3-04	Amend	4-1-04
471-010-0050	1-4-04	Amend	2-1-04
471-010-0051	1-4-04	Amend	2-1-04
471-010-0054	1-4-04	Amend	2-1-04
471-010-0057	1-4-04	Adopt	2-1-04
471-012-0010	12-14-03	Amend	1-1-04
471-012-0015	12-14-03	Amend	1-1-04
471-012-0020	12-14-03	Amend	1-1-04
471-015-0005	12-14-03	Amend	1-1-04
471-015-0010	12-14-03	Amend	1-1-04
471-015-0015	12-14-03	Amend	1-1-04
471-015-0020	12-14-03	Amend	1-1-04
471-030-0040	12-14-03	Amend	1-1-04
471-030-0045	12-14-03	Amend	1-1-04
471-030-0125	1-4-04	Adopt	2-1-04
471-030-0130	1-4-04	Repeal	2-1-04
471-030-0135	1-4-04	Repeal	2-1-04
471-030-0140	1-4-04	Repeal	2-1-04
471-030-0145	1-4-04	Repeal	2-1-04
471-031-0076	12-14-03	Amend	1-1-04
471-031-0077	12-14-03	Adopt	1-1-04
471-031-0140	12-14-03	Amend	1-1-04
471-031-0141	12-14-03	Amend	1-1-04
471-031-0142	12-14-03	Adopt	1-1-04
471-060-0005	1-4-04	Amend	2-1-04
543-050-0000	1-1-04	Repeal	1-1-04
543-050-0020	1-1-04	Repeal	1-1-04
543-050-0030	1-1-04	Repeal	1-1-04
543-050-0040	1-1-04	Repeal	1-1-04
543-050-0050	1-1-04	Repeal	1-1-04
543-060-0000	1-1-04	Adopt	1-1-04
543-060-0010	1-1-04	Adopt	1-1-04
543-060-0020	1-1-04	Adopt	1-1-04
543-060-0030	1-1-04	Adopt	1-1-04
543-060-0040	1-1-04	Adopt	1-1-04
543-060-0060	1-1-04	Adopt	1-1-04
575-030-0005	2-12-04	Amend	3-1-04
575-031-0015	2-12-04	Amend	3-1-04
577-060-0020	11-18-03	Amend(T)	1-1-04
580-010-0029	12-3-03	Amend	1-1-04
580-010-0030	12-3-03	Amend	1-1-04
580-010-0031	12-3-03	Amend	1-1-04
580-010-0033	12-3-03	Amend	1-1-04
580-010-0035	12-3-03	Amend	1-1-04
580-010-0037	12-3-03	Amend	1-1-04
580-010-0040	12-3-03	Amend	1-1-04
580-010-0041	12-3-03	Amend	1-1-04
580-010-0045	12-3-03	Amend	1-1-04
580-020-0006	12-1-03	Adopt(T)	1-1-04
580-021-0044	12-1-03	Adopt(T)	1-1-04
580-040-0035	12-24-03	Amend	2-1-04
581-001-0120	3-5-04	Adopt(T)	4-1-04
581-015-0075	1-15-04	Amend	2-1-04
581-015-0126	1-15-04	Amend	2-1-04
581-015-0900	1-15-04	Amend	2-1-04
581-015-0935	1-15-04	Amend	2-1-04
581-015-0938	1-15-04	Amend	2-1-04
581-015-0940	1-15-04	Amend	2-1-04
581-015-0960	1-15-04	Amend	2-1-04
581-015-0964	1-15-04	Amend	2-1-04
581-015-0968	1-15-04	Amend	2-1-04
581-015-0970	1-15-04	Amend	2-1-04
581-015-0972	1-15-04	Amend	2-1-04
581-015-0980	1-15-04	Amend	2-1-04
581-015-0990	1-15-04	Amend	2-1-04
581-020-0331	3-15-04	Amend(T)	4-1-04
581-021-0023	1-15-04	Adopt	2-1-04
581-022-1730	1-15-04	Amend	2-1-04
581-023-0104	3-15-04	Adopt	4-1-04
581-045-0001	1-1-04	Amend	2-1-04
581-045-0012	1-1-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
581-045-0018	1-1-04	Amend	2-1-04
581-045-0019	1-1-04	Amend	2-1-04
581-045-0023	1-1-04	Amend	2-1-04
581-045-0026	1-1-04	Amend	2-1-04
581-045-0032	1-1-04	Amend	2-1-04
581-045-0065	1-1-04	Amend	2-1-04
581-045-0068	1-1-04	Amend	2-1-04
581-045-0200	1-1-04	Amend	2-1-04
582-010-0005	12-31-03	Amend	2-1-04
582-010-0010	12-31-03	Amend	2-1-04
582-010-0015	12-31-03	Amend	2-1-04
582-010-0020	12-31-03	Amend	2-1-04
582-010-0025	12-31-03	Amend	2-1-04
582-010-0030	12-31-03	Adopt	2-1-04
582-020-0005	1-30-04	Adopt	3-1-04
582-020-0010	1-30-04	Amend	3-1-04
582-020-0015	1-30-04	Adopt	3-1-04
582-020-0020	1-30-04	Amend	3-1-04
582-020-0030	1-30-04	Amend	3-1-04
582-020-0040	1-30-04	Amend	3-1-04
582-020-0050	1-30-04	Amend	3-1-04
582-020-0060	1-30-04	Amend	3-1-04
582-020-0070	1-30-04	Amend	3-1-04
582-020-0080	1-30-04	Amend	3-1-04
582-020-0090	1-30-04	Amend	3-1-04
582-020-0100	1-30-04	Amend	3-1-04
582-020-0110	1-30-04	Amend	3-1-04
582-020-0120	1-30-04	Amend	3-1-04
582-020-0125	1-30-04	Adopt	3-1-04
582-030-0000	3-12-04	Amend	4-1-04
582-030-0005	3-12-04	Amend	4-1-04
582-030-0008	3-12-04	Amend	4-1-04
582-030-0010	3-12-04	Amend	4-1-04
582-030-0020	3-12-04	Amend	4-1-04
582-030-0025	3-12-04	Adopt	4-1-04
582-030-0030	3-12-04	Amend	4-1-04
582-030-0040	3-12-04	Amend	4-1-04
582-070-0010	3-9-04	Amend	4-1-04
582-070-0020	12-31-03	Amend	2-1-04
582-070-0030	3-9-04	Amend	4-1-04
582-080-0020	12-31-03	Amend	2-1-04
582-085-0020	12-31-03	Amend	2-1-04
583-030-0010	2-11-04	Amend(T)	3-1-04
583-030-0020	2-11-04	Amend(T)	3-1-04
583-030-0021	1-14-04	Amend	2-1-04
583-030-0030	1-14-04	Amend	2-1-04
583-030-0035	2-11-04	Amend(T)	3-1-04
583-030-0041	2-11-04	Amend(T)	3-1-04
583-030-0042	2-11-04	Amend(T)	3-1-04
583-030-0045	1-14-04	Amend	2-1-04
583-030-0046	2-11-04	Amend(T)	3-1-04
583-040-0025	2-13-04	Amend	3-1-04
589-020-0220	11-20-03	Adopt(T)	1-1-04
603-001-0001	2-10-04	Amend	3-1-04
603-013-0600	2-13-04	Amend	3-1-04
603-013-0602	2-13-04	Amend	3-1-04
603-013-0604	2-13-04	Amend	3-1-04
603-013-0616	2-13-04	Amend	3-1-04
603-014-0016	1-23-04	Amend	3-1-04
603-016-0471	2-13-04	Repeal	3-1-04
603-016-0476	2-13-04	Repeal	3-1-04
603-016-0481	2-13-04	Repeal	3-1-04
603-016-0486	2-13-04	Repeal	3-1-04
603-016-0491	2-13-04	Repeal	3-1-04
603-016-0496	2-13-04	Repeal	3-1-04
603-016-0500	2-13-04	Repeal	3-1-04
603-016-0505	2-13-04	Repeal	3-1-04
603-016-0510	2-13-04	Repeal	3-1-04
603-051-0801	2-13-04	Repeal	3-1-04
603-051-0802	2-13-04	Repeal	3-1-04
603-051-0810	2-13-04	Repeal	3-1-04
603-051-0812	2-13-04	Repeal	3-1-04
603-051-0814	2-13-04	Repeal	3-1-04
603-051-0816	2-13-04	Repeal	3-1-04
603-051-0818	2-13-04	Repeal	3-1-04
603-051-0819	2-13-04	Repeal	3-1-04
603-051-0821	2-13-04	Repeal	3-1-04
603-051-0823	2-13-04	Repeal	3-1-04
603-051-0825	2-13-04	Repeal	3-1-04
603-051-0827	2-13-04	Repeal	3-1-04
603-051-0829	2-13-04	Repeal	3-1-04
603-051-0950	2-13-04	Repeal	3-1-04
603-052-0325	2-13-04	Repeal	3-1-04
603-052-0326	2-13-04	Repeal	3-1-04
603-052-0327	2-13-04	Repeal	3-1-04
603-052-0331	2-13-04	Repeal	3-1-04
603-052-0332	2-13-04	Repeal	3-1-04
603-052-0333	2-13-04	Repeal	3-1-04
603-052-0335	2-13-04	Repeal	3-1-04
603-052-0340	2-13-04	Repeal	3-1-04
603-052-0345	2-13-04	Repeal	3-1-04
603-052-0400	2-13-04	Repeal	3-1-04
603-052-0425	2-13-04	Repeal	3-1-04
603-052-0810	2-13-04	Repeal	3-1-04
603-052-1000	2-13-04	Repeal	3-1-04
603-052-1010	2-13-04	Repeal	3-1-04
603-054-0010	2-13-04	Repeal	3-1-04
603-054-0027	3-12-04	Adopt	4-1-04
603-057-0006	12-23-03	Amend	2-1-04
603-057-0006(T)	12-23-03	Repeal	2-1-04
603-095-0140	1-23-03	Amend	3-1-04
603-095-3600	1-12-04	Adopt	2-1-04
603-095-3620	1-12-04	Adopt	2-1-04
603-095-3640	1-12-04	Adopt	2-1-04
603-095-3660	1-12-04	Adopt	2-1-04
603-095-3700	1-23-04	Adopt	3-1-04
603-095-3720	1-23-04	Adopt	3-1-04
603-095-3740	1-23-04	Adopt	3-1-04
603-095-3760	1-23-04	Adopt	3-1-04
604-030-0010	1-1-04	Adopt	1-1-04
604-030-0020	1-1-04	Adopt	1-1-04
604-030-0030	1-1-04	Adopt	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
604-030-0040	1-1-04	Adopt	1-1-04
605-030-0010	1-15-04	Adopt	2-1-04
605-030-0020	1-15-04	Adopt	2-1-04
605-030-0030	1-15-04	Adopt	2-1-04
605-030-0040	1-15-04	Adopt	2-1-04
606-010-0025	1-15-04	Amend	2-1-04
606-030-0010	1-15-04	Adopt	2-1-04
606-030-0020	1-15-04	Adopt	2-1-04
606-030-0040	1-15-04	Adopt	2-1-04
607-030-0010	1-1-04	Adopt	1-1-04
607-030-0020	1-1-04	Adopt	1-1-04
607-030-0030	1-1-04	Adopt	1-1-04
607-030-0040	1-1-04	Adopt	1-1-04
608-010-0015	1-2-04	Amend	2-1-04
608-010-0020	1-2-04	Amend	2-1-04
608-030-0010	1-2-04	Adopt	2-1-04
608-030-0020	1-2-04	Adopt	2-1-04
608-030-0030	1-2-04	Adopt	2-1-04
608-030-0040	1-2-04	Adopt	2-1-04
611-030-0010	1-15-04	Adopt	2-1-04
611-030-0020	1-15-04	Adopt	2-1-04
611-030-0030	1-15-04	Adopt	2-1-04
611-030-0040	1-15-04	Adopt	2-1-04
617-010-0090	1-16-04	Adopt	2-1-04
617-030-0010	1-16-04	Adopt	2-1-04
617-030-0020	1-16-04	Adopt	2-1-04
617-030-0030	1-16-04	Adopt	2-1-04
617-030-0040	1-16-04	Adopt	2-1-04
620-010-0050	1-14-04	Adopt	2-1-04
620-030-0010	1-14-04	Adopt	2-1-04
620-030-0020	1-14-04	Adopt	2-1-04
620-030-0030	1-14-04	Adopt	2-1-04
620-030-0040	1-14-04	Adopt	2-1-04
623-030-0010	12-8-03	Adopt	1-1-04
623-030-0020	12-8-03	Adopt	1-1-04
623-030-0030	12-8-03	Adopt	1-1-04
624-010-0000	1-16-04	Amend	2-1-04
624-010-0020	1-16-04	Amend	2-1-04
624-010-0030	1-16-04	Amend	2-1-04
624-010-0050	1-16-04	Adopt	2-1-04
624-010-0060	1-16-04	Adopt	2-1-04
624-030-0010	1-16-04	Adopt	2-1-04
624-030-0020	1-16-04	Adopt	2-1-04
624-030-0030	1-16-04	Adopt	2-1-04
624-030-0040	1-16-04	Adopt	2-1-04
629-001-0015	2-10-04	Amend	3-1-04
629-001-0025	2-10-04	Amend	3-1-04
629-001-0040	2-10-04	Amend	3-1-04
629-001-0045	2-10-04	Amend	3-1-04
629-001-0055	2-10-04	Adopt	3-1-04
629-001-0055(T)	2-10-04	Repeal	3-1-04
629-043-0041	1-30-04	Amend	3-1-04
629-670-0300	2-10-04	Amend	3-1-04
629-670-0310	2-10-04	Amend	3-1-04
629-670-0315	2-10-04	Amend	3-1-04
629-672-0210	2-10-04	Amend	3-1-04
629-672-0220	2-10-04	Amend	3-1-04
629-672-0310	2-10-04	Amend	3-1-04
635-001-0105	1-1-04	Amend	1-1-04
635-004-0005	1-1-04	Amend	1-1-04
635-004-0018	1-1-04	Amend	1-1-04
635-004-0027	1-1-04	Amend(T)	1-1-04
635-004-0036	1-1-04	Amend	1-1-04
635-005-0045	12-1-03	Amend(T)	1-1-04
635-005-0048	12-1-03	Adopt(T)	1-1-04
635-005-0048	2-13-04	Adopt	3-1-04
635-005-0048(T)	2-13-04	Repeal	3-1-04
635-005-0205	11-21-03	Amend(T)	1-1-04
635-006-0140	1-1-04	Amend	1-1-04
635-006-0150	1-1-04	Amend	1-1-04
635-006-0210	12-1-03	Amend(T)	1-1-04
635-006-0210	2-13-04	Amend	3-1-04
635-006-0210(T)	2-13-04	Repeal	3-1-04
635-006-0232	2-1-04	Amend	2-1-04
635-006-0850	1-1-04	Amend	1-1-04
635-006-0910	1-31-04	Amend(T)	3-1-04
635-011-0100	1-1-04	Amend	1-1-04
635-011-0101	1-1-04	Amend	1-1-04
635-013-0003	1-1-04	Amend	1-1-04
635-013-0004	1-1-04	Amend	1-1-04
635-014-0080	1-1-04	Amend	1-1-04
635-014-0090	12-11-03	Amend(T)	1-1-04
635-014-0090	1-1-04	Amend	1-1-04
635-014-0090	1-1-04	Amend(T)	1-1-04
635-014-0090(T)	12-11-03	Suspend	1-1-04
635-014-0090(T)	1-1-04	Repeal	1-1-04
635-016-0080	1-1-04	Amend	1-1-04
635-016-0090	1-1-04	Amend	1-1-04
635-017-0080	1-1-04	Amend	1-1-04
635-017-0090	1-1-04	Amend	1-1-04
635-018-0080	1-1-04	Amend	1-1-04
635-018-0090	1-1-04	Amend	1-1-04
635-019-0080	1-1-04	Amend	1-1-04
635-019-0090	1-1-04	Amend	1-1-04
635-021-0080	1-1-04	Amend	1-1-04
635-021-0090	1-1-04	Amend	1-1-04
635-023-0080	1-1-04	Amend	1-1-04
635-023-0090	1-1-04	Amend	1-1-04
635-023-0090	2-1-04	Amend(T)	3-1-04
635-023-0100	2-13-04	Repeal	3-1-04
635-023-0125	2-13-04	Adopt	3-1-04
635-023-0125	3-10-04	Amend(T)	4-1-04
635-039-0080	1-1-04	Amend	1-1-04
635-039-0090	11-21-03	Amend(T)	1-1-04
635-039-0090	1-1-04	Amend	1-1-04
635-039-0090	1-1-04	Amend	1-1-04
635-04-0033	1-1-04	Amend	1-1-04
635-041-0060	12-1-03	Amend(T)	1-1-04
635-041-0065	1-1-04	Amend(T)	2-1-04
635-041-0065	2-2-04	Amend(T)	3-1-04
635-041-0065	3-10-04	Amend(T)	4-1-04
635-042-0022	2-13-04	Adopt	3-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
635-042-0022	3-1-04	Amend(T)	4-1-04
635-042-0022	3-3-04	Amend(T)	4-1-04
635-042-0022	3-8-04	Amend(T)	4-1-04
635-042-0022	3-10-04	Amend(T)	4-1-04
635-042-0022	3-15-04	Amend(T)	4-1-04
635-042-0110	2-13-04	Amend	3-1-04
635-042-0130	1-1-04	Amend(T)	2-1-04
635-042-0135	1-1-04	Amend(T)	2-1-04
635-042-0135	2-2-04	Amend(T)	3-1-04
635-042-0145	2-13-04	Amend	3-1-04
635-042-0145	3-12-04	Amend(T)	4-1-04
635-042-0160	2-13-04	Amend	3-1-04
635-042-0160	3-12-04	Amend(T)	4-1-04
635-042-0180	2-13-04	Amend	3-1-04
635-045-0000	1-1-04	Amend	1-1-04
635-045-0002	1-1-04	Amend	1-1-04
635-050-0045	2-11-04	Amend	3-1-04
635-053-0000	1-16-04	Amend(T)	2-1-04
635-053-0015	1-16-04	Amend(T)	2-1-04
635-053-0025	1-16-04	Amend(T)	2-1-04
635-060-0000	1-1-04	Amend	1-1-04
635-060-0005	1-1-04	Amend	1-1-04
635-060-0008	1-1-04	Amend	1-1-04
635-060-0030	1-1-04	Amend	1-1-04
635-060-0046	1-1-04	Amend	1-1-04
635-060-0055	4-1-04	Amend	1-1-04
635-065-0001	1-1-04	Amend	1-1-04
635-065-0015	1-1-04	Amend	1-1-04
635-065-0401	1-1-04	Amend	1-1-04
635-065-0501	1-1-04	Amend	1-1-04
635-065-0625	1-1-04	Amend	1-1-04
635-065-0705	1-1-04	Amend	1-1-04
635-065-0720	1-1-04	Amend	1-1-04
635-065-0740	1-1-04	Amend	1-1-04
635-065-0760	11-25-03	Amend(T)	1-1-04
635-065-0760	6-16-04	Amend	1-1-04
635-065-0765	1-1-04	Amend	1-1-04
635-066-0000	1-1-04	Amend	1-1-04
635-066-0010	1-1-04	Amend	1-1-04
635-067-0000	1-1-04	Amend	1-1-04
635-067-0015	1-1-04	Amend	1-1-04
635-067-0024	1-1-04	Amend	1-1-04
635-067-0028	1-1-04	Adopt	1-1-04
635-067-0029	1-1-04	Adopt	1-1-04
635-067-0032	1-1-04	Amend	1-1-04
635-067-0034	1-1-04	Amend	1-1-04
635-067-0041	1-1-04	Adopt	1-1-04
635-068-0000	1-19-04	Amend	1-1-04
635-069-0000	2-2-04	Amend	1-1-04
635-070-0000	12-24-03	Amend(T)	2-1-04
635-070-0000	2-2-04	Amend(T)	3-1-04
635-070-0000	4-1-04	Amend	1-1-04
635-070-0005	2-2-04	Amend(T)	3-1-04
635-070-0010	12-24-03	Amend(T)	2-1-04
635-071-0000	1-1-04	Amend	1-1-04
635-071-0000	1-13-04	Amend(T)	2-1-04
635-071-0005	1-13-04	Amend(T)	2-1-04
635-072-0000	1-1-04	Amend	1-1-04
635-073-0000	12-24-03	Amend(T)	2-1-04
635-073-0000	2-2-04	Amend	1-1-04
635-073-0060	12-24-03	Amend(T)	2-1-04
635-073-0070	1-1-04	Amend	1-1-04
635-073-0090	1-1-04	Amend	1-1-04
635-075-0005	1-1-04	Amend	1-1-04
635-075-0015	1-1-04	Amend	1-1-04
635-075-0020	1-1-04	Amend	1-1-04
635-075-0029	1-1-04	Amend	1-1-04
635-078-0001	1-1-04	Amend	1-1-04
635-078-0005	1-1-04	Amend	1-1-04
635-078-0008	1-1-04	Amend	1-1-04
635-080-0030	1-1-04	Amend	1-1-04
635-080-0031	1-1-04	Amend	1-1-04
635-120-0001	3-5-04	Amend	4-1-04
635-120-0005	3-5-04	Amend	4-1-04
635-120-0010	3-5-04	Amend	4-1-04
635-120-0015	3-5-04	Amend	4-1-04
635-120-0020	3-5-04	Amend	4-1-04
635-500-1820	12-15-03	Amend	1-1-04
635-500-1830	12-15-03	Amend	1-1-04
635-500-1850	12-15-03	Amend	1-1-04
635-500-1920	12-15-03	Amend	1-1-04
635-500-1930	12-15-03	Amend	1-1-04
635-500-3120	12-15-03	Amend	1-1-04
635-500-6000	12-15-03	Adopt	1-1-04
635-500-6010	12-15-03	Adopt	1-1-04
635-500-6020	12-15-03	Adopt	1-1-04
635-500-6030	12-15-03	Adopt	1-1-04
635-500-6040	12-15-03	Adopt	1-1-04
635-500-6050	12-15-03	Adopt	1-1-04
635-500-6060	12-15-03	Adopt	1-1-04
641-030-0010	1-15-04	Adopt	1-1-04
641-030-0020	1-15-04	Adopt	1-1-04
641-030-0030	1-15-04	Adopt	1-1-04
642-010-0020	1-15-04	Amend	1-1-04
642-030-0010	1-15-04	Adopt	1-1-04
642-030-0020	1-15-04	Adopt	1-1-04
642-030-0030	1-15-04	Adopt	1-1-04
643-010-0030	1-16-04	Adopt	3-1-04
643-030-0010	1-16-04	Adopt	3-1-04
643-030-0020	1-16-04	Adopt	3-1-04
643-030-0030	1-16-04	Adopt	3-1-04
643-030-0040	1-16-04	Adopt	3-1-04
644-010-0005	1-8-04	Amend	2-1-04
644-010-0010	1-8-04	Amend	2-1-04
644-010-0015	1-8-04	Amend	2-1-04
644-010-0020	1-8-04	Amend	2-1-04
644-010-0025	1-8-04	Amend	2-1-04
644-030-0010	1-8-04	Adopt	2-1-04
644-030-0020	1-8-04	Adopt	2-1-04
644-030-0030	1-8-04	Adopt	2-1-04
644-030-0040	1-8-04	Adopt	2-1-04
645-010-0020	1-16-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
645-030-0010	1-16-04	Adopt	2-1-04
645-030-0020	1-16-04	Adopt	2-1-04
645-030-0030	1-16-04	Adopt	2-1-04
645-030-0040	1-16-04	Adopt	2-1-04
646-010-0030	1-16-04	Adopt	2-1-04
646-030-0010	1-16-04	Adopt	2-1-04
646-030-0020	1-16-04	Adopt	2-1-04
646-030-0030	1-16-04	Adopt	2-1-04
646-030-0040	1-16-04	Adopt	2-1-04
647-010-0020	1-16-04	Amend	2-1-04
647-015-0010	1-16-04	Adopt	2-1-04
647-015-0020	1-16-04	Adopt	2-1-04
647-015-0030	1-16-04	Adopt	2-1-04
655-015-0010	1-16-04	Adopt	2-1-04
655-015-0020	1-16-04	Adopt	2-1-04
655-015-0030	1-16-04	Adopt	2-1-04
656-030-0010	1-1-04	Adopt	1-1-04
656-030-0020	1-1-04	Adopt	1-1-04
656-030-0030	1-1-04	Adopt	1-1-04
656-030-0040	1-1-04	Adopt	1-1-04
657-030-0010	1-15-04	Adopt	1-1-04
657-030-0020	1-15-04	Adopt	1-1-04
657-030-0030	1-15-04	Adopt	1-1-04
658-010-0005	12-4-03	Amend	1-1-04
658-010-0006	12-4-03	Amend	1-1-04
658-010-0007	12-4-03	Adopt	1-1-04
658-030-0010	12-4-03	Adopt	1-1-04
658-030-0020	12-4-03	Adopt	1-1-04
658-030-0030	12-4-03	Adopt	1-1-04
664-010-0020	1-15-04	Amend	1-1-04
664-015-0010	1-15-04	Adopt	1-1-04
664-015-0020	1-15-04	Adopt	1-1-04
664-015-0030	1-15-04	Adopt	1-1-04
668-010-0010	1-15-04	Amend	2-1-04
668-030-0010	1-15-04	Adopt	2-1-04
668-030-0020	1-15-04	Adopt	2-1-04
668-030-0030	1-15-04	Adopt	2-1-04
668-030-0040	1-15-04	Adopt	2-1-04
669-010-0015	1-13-04	Amend	2-1-04
669-010-0020	1-13-04	Amend	2-1-04
669-010-0025	1-13-04	Amend	2-1-04
669-010-0030	1-13-04	Amend	2-1-04
669-010-0040	1-13-04	Amend	2-1-04
669-010-0050	1-13-04	Adopt	2-1-04
669-030-0010	1-13-04	Adopt	2-1-04
669-030-0020	1-13-04	Adopt	2-1-04
669-030-0030	1-13-04	Adopt	2-1-04
669-030-0040	1-13-04	Adopt	2-1-04
670-010-0020	1-15-04	Amend	2-1-04
670-030-0010	1-15-04	Adopt	2-1-04
670-030-0020	1-15-04	Adopt	2-1-04
670-030-0030	1-15-04	Adopt	2-1-04
679-010-0000	1-20-04	Amend	3-1-04
679-010-0010	1-20-04	Amend	3-1-04
679-010-0030	1-20-04	Amend	3-1-04
679-010-0050	1-20-04	Adopt	3-1-04
679-010-0060	1-20-04	Adopt	3-1-04
679-030-0010	1-20-04	Adopt	3-1-04
679-030-0020	1-20-04	Adopt	3-1-04
679-030-0030	1-20-04	Adopt	3-1-04
679-030-0040	1-20-04	Adopt	3-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Am. & Ren.	1-1-04
690-502-0160	12-4-03	Amend	1-1-04
690-502-0210	12-4-03	Adopt	1-1-04
695-020-0020	1-26-04	Amend	3-1-04
695-020-0092	1-26-04	Amend	3-1-04
695-020-0093	1-26-04	Amend	3-1-04
695-020-0094	1-26-04	Amend	3-1-04
695-020-0095	1-26-04	Amend	3-1-04
695-020-0096	1-26-04	Amend	3-1-04
695-020-0097	1-26-04	Amend	3-1-04
695-020-0098	1-26-04	Adopt	3-1-04
731-001-0000	12-11-03	Amend	1-1-04
731-001-0005	2-23-04	Amend	4-1-04
731-007-0050	1-20-04	Amend	3-1-04
731-007-0050(T)	1-20-04	Repeal	3-1-04
734-017-0005	1-20-04	Amend	3-1-04
734-051-0010	3-1-04	Amend	4-1-04
734-051-0020	3-1-04	Amend	4-1-04
734-051-0030	3-1-04	Am. & Ren.	4-1-04
734-051-0040	3-1-04	Amend	4-1-04
734-051-0050	3-1-04	Am. & Ren.	4-1-04
734-051-0060	3-1-04	Am. & Ren.	4-1-04
734-051-0070	3-1-04	Amend	4-1-04
734-051-0080	3-1-04	Amend	4-1-04
734-051-0085	3-1-04	Adopt	4-1-04
734-051-0090	3-1-04	Am. & Ren.	4-1-04
734-051-0100	3-1-04	Am. & Ren.	4-1-04
734-051-0105	3-1-04	Adopt	4-1-04
734-051-0110	3-1-04	Am. & Ren.	4-1-04
734-051-0120	3-1-04	Am. & Ren.	4-1-04
734-051-0130	3-1-04	Repeal	4-1-04
734-051-0140	3-1-04	Repeal	4-1-04
734-051-0150	3-1-04	Repeal	4-1-04
734-051-0160	3-1-04	Repeal	4-1-04
734-051-0170	3-1-04	Repeal	4-1-04
734-051-0180	3-1-04	Repeal	4-1-04
734-051-0190	3-1-04	Am. & Ren.	4-1-04
734-051-0200	3-1-04	Am. & Ren.	4-1-04
734-051-0210	3-1-04	Am. & Ren.	4-1-04
734-051-0220	3-1-04	Repeal	4-1-04
734-051-0230	3-1-04	Am. & Ren.	4-1-04
734-051-0235	3-1-04	Am. & Ren.	4-1-04
734-051-0240	3-1-04	Am. & Ren.	4-1-04
734-051-0250	3-1-04	Am. & Ren.	4-1-04
734-051-0260	3-1-04	Am. & Ren.	4-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
734-051-0270	3-1-04	Am. & Ren.	4-1-04
734-051-0280	3-1-04	Am. & Ren.	4-1-04
734-051-0290	3-1-04	Am. & Ren.	4-1-04
734-051-0300	3-1-04	Am. & Ren.	4-1-04
734-051-0310	3-1-04	Am. & Ren.	4-1-04
734-051-0320	3-1-04	Am. & Ren.	4-1-04
734-051-0330	3-1-04	Repeal	4-1-04
734-051-0340	3-1-04	Repeal	4-1-04
734-051-0350	3-1-04	Repeal	4-1-04
734-051-0360	3-1-04	Am. & Ren.	4-1-04
734-051-0370	3-1-04	Am. & Ren.	4-1-04
734-051-0380	3-1-04	Am. & Ren.	4-1-04
734-051-0390	3-1-04	Am. & Ren.	4-1-04
734-051-0400	3-1-04	Am. & Ren.	4-1-04
734-051-0410	3-1-04	Repeal	4-1-04
734-051-0420	3-1-04	Repeal	4-1-04
734-051-0430	3-1-04	Am. & Ren.	4-1-04
734-051-0440	3-1-04	Am. & Ren.	4-1-04
734-051-0450	3-1-04	Am. & Ren.	4-1-04
734-051-0460	3-1-04	Am. & Ren.	4-1-04
734-051-0470	3-1-04	Am. & Ren.	4-1-04
734-051-0480	3-1-04	Repeal	4-1-04
734-060-0025	1-1-04	Amend	1-1-04
734-082-0080	2-25-04	Adopt	4-1-04
735-010-0070	1-1-04	Amend	1-1-04
735-018-0020	12-15-03	Amend	1-1-04
735-018-0070	12-15-03	Amend	1-1-04
735-018-0080	12-15-03	Amend	1-1-04
735-018-0110	12-15-03	Amend	1-1-04
735-018-0120	1-1-04	Adopt(T)	1-1-04
735-020-0070	1-1-04	Adopt(T)	1-1-04
735-020-0080	1-1-04	Adopt(T)	1-1-04
735-024-0010	1-1-04	Amend(T)	1-1-04
735-024-0020	1-1-04	Amend(T)	1-1-04
735-024-0045	1-1-04	Adopt(T)	1-1-04
735-032-0010	1-1-04	Amend(T)	1-1-04
735-034-0010	1-1-04	Amend(T)	1-1-04
735-040-0050	1-1-04	Amend(T)	1-1-04
735-040-0055	1-1-04	Amend(T)	1-1-04
735-040-0061	1-1-04	Amend(T)	1-1-04
735-040-0080	1-1-04	Amend(T)	1-1-04
735-040-0095	1-1-04	Amend(T)	1-1-04
735-040-0097	1-1-04	Amend(T)	1-1-04
735-040-0100	1-1-04	Amend(T)	1-1-04
735-050-0060	1-1-04	Amend	1-1-04
735-050-0062	1-1-04	Amend	1-1-04
735-050-0064	1-1-04	Amend	1-1-04
735-050-0070	1-1-04	Amend	1-1-04
735-050-0080	1-1-04	Amend	1-1-04
735-050-0120	1-1-04	Amend	1-1-04
735-060-0000	11-18-03	Amend	1-1-04
735-060-0015	11-18-03	Am. & Ren.	1-1-04
735-060-0017	11-18-03	Am. & Ren.	1-1-04
735-060-0030	11-18-03	Amend	1-1-04
735-060-0040	11-18-03	Amend	1-1-04
735-060-0050	11-18-03	Amend	1-1-04
735-060-0050(10), (11))&(12)	11-18-03	Am. & Ren.	1-1-04
735-060-0050(9)&(13)	11-18-03	Am. & Ren.	1-1-04
735-060-0060	11-18-03	Amend	1-1-04
735-060-0065	11-18-03	Adopt	1-1-04
735-060-0070	11-18-03	Repeal	1-1-04
735-060-0080	11-18-03	Repeal	1-1-04
735-060-0090	11-18-03	Amend	1-1-04
735-060-0095	11-18-03	Amend	1-1-04
735-060-0100	11-18-03	Amend	1-1-04
735-060-0100(8), (9)&(10)	11-18-03	Am. & Ren.	1-1-04
735-060-0110	11-18-03	Amend	1-1-04
735-060-0115	11-18-03	Adopt	1-1-04
735-060-0120	11-18-03	Amend	1-1-04
735-060-0130	11-18-03	Amend	1-1-04
735-060-0140	11-18-03	Am. & Ren.	1-1-04
735-060-0150	11-18-03	Am. & Ren.	1-1-04
735-060-0160	11-18-03	Am. & Ren.	1-1-04
735-060-0170	11-18-03	Am. & Ren.	1-1-04
735-061-0010	1-15-04	Repeal	2-1-04
735-061-0020	1-15-04	Repeal	2-1-04
735-061-0030	1-15-04	Repeal	2-1-04
735-061-0040	1-15-04	Repeal	2-1-04
735-061-0050	1-15-04	Repeal	2-1-04
735-061-0060	1-15-04	Repeal	2-1-04
735-061-0070	1-15-04	Repeal	2-1-04
735-061-0080	1-15-04	Repeal	2-1-04
735-061-0090	1-15-04	Repeal	2-1-04
735-061-0100	1-15-04	Repeal	2-1-04
735-061-0110	1-15-04	Repeal	2-1-04
735-061-0120	1-15-04	Repeal	2-1-04
735-061-0130	1-15-04	Repeal	2-1-04
735-061-0140	1-15-04	Repeal	2-1-04
735-061-0150	1-15-04	Repeal	2-1-04
735-061-0160	1-15-04	Repeal	2-1-04
735-061-0170	1-15-04	Repeal	2-1-04
735-061-0180	1-15-04	Repeal	2-1-04
735-061-0190	1-15-04	Repeal	2-1-04
735-061-0200	1-15-04	Repeal	2-1-04
735-062-0005	1-1-04	Amend	1-1-04
735-062-0020	1-1-04	Amend	1-1-04
735-062-0030	1-1-04	Amend(T)	1-1-04
735-062-0075	1-1-04	Amend	1-1-04
735-062-0095	1-1-04	Amend	1-1-04
735-062-0110	1-1-04	Amend	1-1-04
735-064-0020	1-1-04	Amend	1-1-04
735-064-0060	1-1-04	Amend	1-1-04
735-064-0220	1-1-04	Amend(T)	1-1-04
735-064-0220	2-23-04	Amend	4-1-04
735-064-0220(T)	2-23-04	Repeal	4-1-04
735-070-0130	1-1-04	Amend	1-1-04
735-080-0010	11-18-03	Amend	1-1-04
735-080-0030	11-18-03	Amend	1-1-04
735-116-0000	1-15-04	Amend	2-1-04
735-150-0040	1-1-04	Amend(T)	1-1-04
735-150-0070	1-1-04	Amend(T)	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
735-150-0250	12-15-03	Adopt(T)	1-1-04
735-150-0260	12-15-03	Adopt(T)	1-1-04
735-154-0005	1-1-04	Adopt(T)	1-1-04
735-170-0000	1-1-04	Amend	1-1-04
735-170-0010	1-1-04	Amend	1-1-04
735-170-0020	1-1-04	Amend	1-1-04
735-170-0030	1-1-04	Amend	1-1-04
735-170-0050	1-1-04	Amend	1-1-04
735-170-0060	1-1-04	Amend	1-1-04
735-170-0070	1-1-04	Amend	1-1-04
735-170-0090	1-1-04	Amend	1-1-04
735-170-0100	1-1-04	Amend	1-1-04
735-170-0110	1-1-04	Adopt	1-1-04
735-170-0120	1-1-04	Adopt	1-1-04
735-170-0140	1-1-04	Adopt	1-1-04
735-174-0000	1-1-04	Amend	1-1-04
735-174-0010	1-1-04	Amend	1-1-04
735-174-0020	1-1-04	Amend	1-1-04
735-174-0030	1-1-04	Amend	1-1-04
735-174-0040	1-1-04	Adopt(T)	1-1-04
735-176-0000	1-15-04	Amend	2-1-04
735-176-0010	1-15-04	Amend	2-1-04
735-176-0015	1-15-04	Adopt	2-1-04
735-176-0018	1-15-04	Adopt	2-1-04
735-176-0020	1-15-04	Amend	2-1-04
735-176-0030	1-15-04	Amend	2-1-04
735-176-0040	1-15-04	Amend	2-1-04
736-001-0000	1-15-04	Amend	2-1-04
736-002-0020	1-15-04	Adopt	2-1-04
736-002-0030	1-15-04	Adopt	2-1-04
736-002-0040	1-15-04	Adopt	2-1-04
736-002-0060	1-15-04	Adopt	2-1-04
736-002-0070	1-15-04	Adopt	2-1-04
736-002-0080	1-15-04	Adopt	2-1-04
736-002-0090	1-15-04	Adopt	2-1-04
736-002-0100	1-15-04	Adopt	2-1-04
736-010-0022	1-15-04	Amend(T)	2-1-04
736-010-0022	4-15-04	Amend	4-1-04
738-001-0001	2-17-04	Amend	4-1-04
738-001-0006	2-17-04	Amend	4-1-04
738-001-0025	2-17-04	Amend	4-1-04
738-001-0030	2-17-04	Amend	4-1-04
738-015-0015	2-17-04	Amend	4-1-04
738-025-0001	2-17-04	Amend	4-1-04
738-025-0010	2-17-04	Amend	4-1-04
738-030-0005	2-17-04	Repeal	4-1-04
738-030-0010	2-17-04	Repeal	4-1-04
738-030-0015	2-17-04	Repeal	4-1-04
738-030-0020	2-17-04	Repeal	4-1-04
738-030-0025	2-17-04	Repeal	4-1-04
738-090-0030	2-17-04	Amend	4-1-04
738-090-0040	2-17-04	Amend	4-1-04
738-100-0010	2-17-04	Amend	4-1-04
738-110-0010	2-17-04	Repeal	4-1-04
738-110-0020	2-17-04	Repeal	4-1-04
738-110-0030	2-17-04	Repeal	4-1-04
738-110-0040	2-17-04	Repeal	4-1-04
738-110-0050	2-17-04	Repeal	4-1-04
740-060-0030	1-1-04	Amend(T)	1-1-04
740-060-0050	1-1-04	Amend(T)	1-1-04
740-060-0055	1-1-04	Adopt(T)	1-1-04
740-100-0010	1-1-04	Amend	1-1-04
740-100-0015	1-15-04	Adopt	2-1-04
740-100-0060	1-1-04	Amend	1-1-04
740-100-0070	1-1-04	Amend	1-1-04
740-100-0080	1-1-04	Amend	1-1-04
740-100-0090	1-1-04	Amend	1-1-04
740-110-0010	1-1-04	Amend	1-1-04
740-115-0010	1-1-04	Repeal	1-1-04
740-115-0020	1-1-04	Repeal	1-1-04
740-115-0030	1-1-04	Repeal	1-1-04
740-115-0040	1-1-04	Repeal	1-1-04
740-115-0050	1-1-04	Repeal	1-1-04
740-115-0060	1-1-04	Repeal	1-1-04
740-115-0070	1-1-04	Repeal	1-1-04
740-120-0010	1-1-04	Repeal	1-1-04
740-120-0020	1-1-04	Repeal	1-1-04
740-120-0030	1-1-04	Repeal	1-1-04
740-120-0040	1-1-04	Repeal	1-1-04
740-125-0010	1-1-04	Repeal	1-1-04
740-125-0020	1-1-04	Repeal	1-1-04
740-125-0030	1-1-04	Repeal	1-1-04
740-125-0040	1-1-04	Repeal	1-1-04
740-130-0010	1-1-04	Repeal	1-1-04
740-130-0020	1-1-04	Repeal	1-1-04
740-130-0030	1-1-04	Repeal	1-1-04
740-130-0040	1-1-04	Repeal	1-1-04
740-130-0050	1-1-04	Repeal	1-1-04
740-130-0060	1-1-04	Repeal	1-1-04
740-130-0070	1-1-04	Repeal	1-1-04
740-130-0080	1-1-04	Repeal	1-1-04
740-130-0090	1-1-04	Repeal	1-1-04
740-135-0010	1-1-04	Repeal	1-1-04
740-135-0020	1-1-04	Repeal	1-1-04
740-135-0030	1-1-04	Repeal	1-1-04
740-135-0040	1-1-04	Repeal	1-1-04
740-140-0010	1-1-04	Repeal	1-1-04
740-140-0020	1-1-04	Repeal	1-1-04
740-140-0030	1-1-04	Repeal	1-1-04
740-140-0040	1-1-04	Repeal	1-1-04
740-140-0050	1-1-04	Repeal	1-1-04
740-140-0060	1-1-04	Repeal	1-1-04
740-145-0010	1-1-04	Repeal	1-1-04
740-145-0020	1-1-04	Repeal	1-1-04
740-145-0030	1-1-04	Repeal	1-1-04
740-145-0040	1-1-04	Repeal	1-1-04
740-145-0050	1-1-04	Repeal	1-1-04
740-145-0060	1-1-04	Repeal	1-1-04
740-150-0010	1-1-04	Repeal	1-1-04
740-150-0020	1-1-04	Repeal	1-1-04
740-150-0030	1-1-04	Repeal	1-1-04
740-150-0040	1-1-04	Repeal	1-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
740-150-0050	1-1-04	Repeal	1-1-04
740-155-0010	1-1-04	Repeal	1-1-04
740-155-0020	1-1-04	Repeal	1-1-04
740-155-0030	1-1-04	Repeal	1-1-04
740-155-0040	1-1-04	Repeal	1-1-04
740-155-0050	1-1-04	Repeal	1-1-04
740-155-0060	1-1-04	Repeal	1-1-04
740-160-0010	1-1-04	Repeal	1-1-04
740-160-0020	1-1-04	Repeal	1-1-04
740-160-0030	1-1-04	Repeal	1-1-04
740-160-0040	1-1-04	Repeal	1-1-04
740-160-0050	1-1-04	Repeal	1-1-04
740-160-0060	1-1-04	Repeal	1-1-04
740-160-0070	1-1-04	Repeal	1-1-04
740-165-0010	1-1-04	Repeal	1-1-04
740-165-0020	1-1-04	Repeal	1-1-04
740-165-0030	1-1-04	Repeal	1-1-04
740-165-0040	1-1-04	Repeal	1-1-04
740-200-0010	1-1-04	Amend	1-1-04
740-200-0020	1-1-04	Amend	1-1-04
740-200-0040	1-1-04	Amend	1-1-04
740-300-0035	1-1-04	Adopt(T)	1-1-04
800-025-0025	2-1-04	Amend	3-1-04
800-030-0025	2-1-04	Amend	3-1-04
801-001-0005	1-1-04	Amend	2-1-04
801-001-0010	1-1-04	Amend	2-1-04
801-001-0015	1-1-04	Amend	2-1-04
801-001-0020	1-1-04	Amend	2-1-04
801-001-0035	1-1-04	Adopt	2-1-04
801-001-0050	1-1-04	Adopt	2-1-04
801-005-0010	1-1-04	Amend	2-1-04
801-010-0010	1-1-04	Amend	2-1-04
801-010-0045	1-1-04	Amend	2-1-04
801-010-0050	1-1-04	Amend	2-1-04
801-010-0050	3-15-04	Amend(T)	4-1-04
801-010-0060	1-1-04	Amend	2-1-04
801-010-0075	1-1-04	Amend	2-1-04
801-010-0080	1-1-04	Amend	2-1-04
801-010-0085	1-1-04	Amend	2-1-04
801-010-0110	1-1-04	Amend	2-1-04
801-010-0115	1-1-04	Amend	2-1-04
801-010-0125	1-1-04	Amend	2-1-04
801-010-0345	1-1-04	Amend	2-1-04
801-020-0700	1-1-04	Amend	2-1-04
801-030-0005	1-1-04	Amend	2-1-04
801-030-0015	1-1-04	Amend	2-1-04
801-030-0020	1-1-04	Amend	2-1-04
801-040-0070	1-1-04	Amend	2-1-04
801-040-0090	1-1-04	Amend	2-1-04
801-040-0100	1-1-04	Amend	2-1-04
801-040-0160	1-1-04	Amend	2-1-04
801-050-0080	1-1-04	Amend	2-1-04
806-010-0035	3-2-04	Amend	4-1-04
806-010-0037	3-2-04	Adopt	4-1-04
806-010-0060	3-2-04	Amend	4-1-04
806-020-0080	1-28-04	Amend	3-1-04
808-002-0100	2-1-04	Amend	3-1-04
808-002-0200	2-1-04	Amend	3-1-04
808-002-0210	2-1-04	Adopt	3-1-04
808-002-0220	2-1-04	Amend	3-1-04
808-002-0298	2-1-04	Adopt	3-1-04
808-002-0448	2-1-04	Repeal	3-1-04
808-002-0500	2-1-04	Amend	3-1-04
808-002-0540	1-1-04	Amend(T)	2-1-04
808-002-0620	2-1-04	Amend	3-1-04
808-002-0665	2-1-04	Amend	3-1-04
808-002-0880	2-1-04	Amend	3-1-04
808-002-0890	2-1-04	Adopt	3-1-04
808-002-0920	2-1-04	Amend	3-1-04
808-003-0010	2-1-04	Amend	3-1-04
808-003-0015	2-1-04	Amend	3-1-04
808-003-0018	2-1-04	Amend	3-1-04
808-003-0030	2-1-04	Amend	3-1-04
808-003-0035	2-1-04	Amend	3-1-04
808-003-0040	12-1-03	Amend(T)	1-1-04
808-003-0040	2-1-04	Amend	3-1-04
808-003-0040(T)	2-1-04	Repeal	3-1-04
808-003-0045	2-1-04	Amend	3-1-04
808-003-0050	2-1-04	Amend	3-1-04
808-003-0055	2-1-04	Amend	3-1-04
808-003-0060	2-1-04	Amend	3-1-04
808-003-0065	2-1-04	Amend	3-1-04
808-003-0070	2-1-04	Amend	3-1-04
808-003-0080	2-1-04	Amend	3-1-04
808-003-0081	2-1-04	Amend	3-1-04
808-003-0085	2-1-04	Amend	3-1-04
808-003-0112	2-1-04	Adopt	3-1-04
808-003-0125	2-1-04	Amend	3-1-04
808-003-0130	2-1-04	Amend	3-1-04
808-004-0210	1-1-04	Adopt	2-1-04
808-004-0320	2-1-04	Amend	3-1-04
808-004-0400	2-1-04	Amend	3-1-04
808-005-0020	2-1-04	Amend	3-1-04
808-008-0020	1-1-04	Amend(T)	2-1-04
808-008-0030	1-1-04	Amend(T)	2-1-04
808-008-0050	1-1-04	Adopt	2-1-04
808-008-0060	1-1-04	Amend(T)	2-1-04
808-008-0085	1-1-04	Amend(T)	2-1-04
808-008-0140	1-1-04	Amend(T)	2-1-04
808-008-0240	1-1-04	Suspend	2-1-04
808-008-0280	1-1-04	Amend(T)	2-1-04
808-008-0290	1-1-04	Adopt(T)	2-1-04
808-008-0400	1-1-04	Amend(T)	2-1-04
808-008-0420	1-1-04	Amend(T)	2-1-04
808-008-0425	1-1-04	Amend(T)	2-1-04
808-008-0430	1-1-04	Amend(T)	2-1-04
808-008-0440	1-1-04	Amend(T)	2-1-04
808-008-0460	1-1-04	Amend(T)	2-1-04
808-008-0500	1-1-04	Amend(T)	2-1-04
808-008-0510	1-1-04	Adopt(T)	2-1-04
808-008-0520	1-1-04	Adopt(T)	2-1-04
808-009-0020	2-1-04	Amend	3-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
811-010-0085	12-11-03	Amend	1-1-04
811-010-0095	12-11-03	Amend	1-1-04
811-015-0010	12-11-03	Amend	1-1-04
811-035-0005	12-11-03	Amend	1-1-04
811-035-0015	12-11-03	Amend	1-1-04
812-001-0000	3-1-04	Amend	4-1-04
812-001-0015	3-1-04	Amend	4-1-04
812-001-0020	12-5-03	Amend	1-1-04
812-001-0020	12-9-03	Amend(T)	1-1-04
812-001-0020	1-1-04	Amend(T)	2-1-04
812-001-0020	3-1-04	Amend	4-1-04
812-001-0020(T)	3-1-04	Repeal	4-1-04
812-001-0022	1-1-04	Adopt(T)	2-1-04
812-001-0022	3-1-04	Adopt	4-1-04
812-001-0022(T)	3-1-04	Repeal	4-1-04
812-002-0130	12-5-03	Adopt	1-1-04
812-002-0200	12-5-03	Amend	1-1-04
812-002-0240	12-5-03	Repeal	1-1-04
812-002-0240(T)	12-5-03	Repeal	1-1-04
812-002-0380	2-2-04	Amend	3-1-04
812-002-0420	12-5-03	Amend	1-1-04
812-002-0420(T)	12-5-03	Repeal	1-1-04
812-002-0440	12-5-03	Amend	1-1-04
812-002-0540	12-5-03	Amend	1-1-04
812-002-0540(T)	12-5-03	Repeal	1-1-04
812-003-0000	12-5-03	Amend	1-1-04
812-003-0000	7-1-04	Amend	4-1-04
812-003-0000(T)	12-5-03	Repeal	1-1-04
812-003-0015	2-2-04	Amend	3-1-04
812-003-0015	3-1-04	Amend	4-1-04
812-003-0020	12-5-03	Amend	1-1-04
812-003-0020(T)	12-5-03	Repeal	1-1-04
812-003-0025	12-5-03	Amend	1-1-04
812-003-0025(T)	12-5-03	Repeal	1-1-04
812-004-0110	12-5-03	Adopt	1-1-04
812-004-0110	1-1-04	Amend(T)	2-1-04
812-004-0110	3-1-04	Amend	4-1-04
812-004-0110(T)	3-1-04	Repeal	4-1-04
812-004-0210	12-5-03	Adopt	1-1-04
812-004-0250	1-1-04	Amend(T)	2-1-04
812-004-0250	3-1-04	Amend	4-1-04
812-004-0250(T)	3-1-04	Repeal	4-1-04
812-004-0320	12-5-03	Amend	1-1-04
812-004-0340	12-5-03	Amend	1-1-04
812-004-0400	12-5-03	Amend	1-1-04
812-004-0440	1-1-04	Amend(T)	2-1-04
812-004-0440	3-1-04	Amend	4-1-04
812-004-0440(T)	3-1-04	Repeal	4-1-04
812-004-0535	12-5-03	Amend	1-1-04
812-004-0535	3-1-04	Amend	4-1-04
812-004-0540	3-1-04	Amend	4-1-04
812-004-0550	3-1-04	Amend	4-1-04
812-005-0005	12-5-03	Amend	1-1-04
812-006-0020	12-5-03	Amend	1-1-04
812-008-0050	3-1-04	Amend	4-1-04
812-009-0100	3-1-04	Amend	4-1-04
812-009-0120	3-1-04	Amend	4-1-04
812-010-0020	12-5-03	Amend	1-1-04
812-010-0030	12-5-03	Amend	1-1-04
812-010-0050	12-5-03	Adopt	1-1-04
812-010-0060	12-5-03	Amend	1-1-04
812-010-0085	12-5-03	Amend	1-1-04
812-010-0140	12-5-03	Amend	1-1-04
812-010-0240	12-5-03	Repeal	1-1-04
812-010-0280	12-5-03	Amend	1-1-04
812-010-0290	12-5-03	Adopt	1-1-04
812-010-0400	12-5-03	Amend	1-1-04
812-010-0420	12-5-03	Amend	1-1-04
812-010-0425	12-5-03	Amend	1-1-04
812-010-0430	12-5-03	Amend	1-1-04
812-010-0440	12-5-03	Amend	1-1-04
812-010-0460	12-5-03	Amend	1-1-04
812-010-0500	12-5-03	Amend	1-1-04
812-010-0510	12-5-03	Adopt	1-1-04
812-010-0520	12-5-03	Adopt	1-1-04
813-300-0010	12-19-03	Amend	2-1-04
813-300-0120	12-19-03	Amend	2-1-04
820-010-0010	1-26-04	Amend	3-1-04
820-010-0200	1-26-04	Amend	3-1-04
820-010-0225	1-26-04	Amend	3-1-04
820-010-0450	1-26-04	Amend	3-1-04
820-010-0500	1-26-04	Amend	3-1-04
820-010-0623	1-26-04	Adopt	3-1-04
820-015-0026	1-26-04	Amend	3-1-04
836-009-0007	12-19-03	Amend	1-1-04
836-011-0000	12-3-03	Amend	1-1-04
836-031-0755	1-1-04	Amend	2-1-04
836-031-0760	1-1-04	Amend	2-1-04
836-031-0855	11-26-03	Adopt(T)	1-1-04
836-042-0045	1-1-04	Amend	1-1-04
836-051-0101	1-1-04	Amend	2-1-04
836-051-0106	1-1-04	Adopt	2-1-04
836-052-0700	2-3-04	Amend	3-1-04
836-053-0430	2-20-04	Amend	4-1-04
836-071-0180	12-19-03	Amend	1-1-04
837-012-0645	1-14-04	Amend	2-1-04
837-012-0720	1-14-04	Amend	2-1-04
837-012-0830	1-14-04	Amend	2-1-04
837-012-0850	1-14-04	Amend	2-1-04
837-012-1210	1-14-04	Amend	2-1-04
837-012-1220	1-14-04	Amend	2-1-04
837-012-1260	1-14-04	Amend	2-1-04
837-012-1290	1-14-04	Amend	2-1-04
837-012-1300	1-14-04	Amend	2-1-04
837-012-1320	1-14-04	Amend	2-1-04
837-012-1340	1-14-04	Amend	2-1-04
837-030-0130	1-14-04	Amend	2-1-04
837-030-0220	1-14-04	Amend	2-1-04
837-030-0230	1-14-04	Amend	2-1-04
837-030-0240	1-14-04	Amend	2-1-04
837-030-0250	1-14-04	Amend	2-1-04
837-030-0280	1-14-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
839-001-0200	1-1-04	Adopt	2-1-04
839-001-0420	1-1-04	Amend	2-1-04
839-001-0470	1-1-04	Amend	2-1-04
839-001-0490	1-1-04	Adopt	2-1-04
839-016-0700	1-5-04	Amend	2-1-04
839-017-0004	1-1-04	Amend	2-1-04
839-017-0500	1-1-04	Adopt	2-1-04
839-017-0505	1-1-04	Adopt	2-1-04
839-017-0510	1-1-04	Adopt	2-1-04
839-017-0515	1-1-04	Adopt	2-1-04
839-017-0520	1-1-04	Adopt	2-1-04
839-020-0027	1-1-04	Adopt	2-1-04
839-020-0030	1-1-04	Amend	2-1-04
839-020-0115	1-1-04	Amend	2-1-04
839-020-0125	1-1-04	Amend	2-1-04
839-020-0150	2-1-04	Amend	2-1-04
845-003-0590	2-10-04	Amend	1-1-04
845-003-0670	12-1-03	Amend	1-1-04
845-005-0304	1-1-04	Amend	2-1-04
845-005-0445	1-1-04	Amend(T)	2-1-04
845-006-0441	12-1-03	Amend	1-1-04
845-007-0015	6-1-04	Amend	4-1-04
845-009-0015	12-1-03	Amend	1-1-04
845-015-0140	3-21-04	Amend	3-1-04
847-008-0015	1-27-04	Amend	3-1-04
847-008-0050	12-8-03	Amend	1-1-04
847-008-0055	1-27-04	Amend	3-1-04
847-012-0000	1-27-04	Amend	3-1-04
847-020-0170	1-27-04	Amend	3-1-04
847-020-0180	1-27-04	Amend	3-1-04
847-035-0030	1-27-04	Amend	3-1-04
850-010-0130	2-11-04	Amend	3-1-04
850-010-0225	12-5-03	Amend	1-1-04
850-010-0226	12-5-03	Amend	1-1-04
851-002-0040	2-26-04	Amend	4-1-04
851-021-0010	12-9-03	Amend	1-1-04
851-031-0010	12-9-03	Amend	1-1-04
851-047-0000	2-26-04	Amend	4-1-04
851-047-0010	2-26-04	Amend	4-1-04
851-047-0020	2-26-04	Amend	4-1-04
851-047-0030	2-26-04	Amend	4-1-04
851-047-0040	2-26-04	Amend	4-1-04
851-050-0131	12-9-03	Amend	1-1-04
851-050-0131	2-26-04	Amend	4-1-04
851-050-0133	12-23-03	Amend(T)	2-1-04
851-050-0134	12-23-03	Amend(T)	2-1-04
851-050-0145	12-23-03	Amend(T)	2-1-04
851-050-0150	12-23-03	Suspend	2-1-04
851-050-0155	12-23-03	Amend(T)	2-1-04
851-050-0161	12-23-03	Adopt(T)	2-1-04
851-050-0170	12-23-03	Amend(T)	2-1-04
851-061-0010	2-12-04	Amend	3-1-04
851-061-0020	2-12-04	Amend	3-1-04
851-061-0030	2-12-04	Amend	3-1-04
851-061-0040	2-12-04	Amend	3-1-04
851-061-0050	2-12-04	Amend	3-1-04
851-061-0070	2-12-04	Amend	3-1-04
851-061-0080	2-12-04	Amend	3-1-04
851-061-0090	2-12-04	Amend	3-1-04
851-061-0100	2-12-04	Amend	3-1-04
851-061-0110	2-12-04	Amend	3-1-04
851-061-0130	2-12-04	Adopt	3-1-04
851-062-0005	2-12-04	Adopt	3-1-04
851-062-0010	2-12-04	Amend	3-1-04
851-062-0010	2-20-04	Amend	4-1-04
851-062-0015	2-12-04	Adopt	3-1-04
851-062-0016	2-12-04	Adopt	3-1-04
851-062-0020	2-12-04	Amend	3-1-04
851-062-0040	2-12-04	Repeal	3-1-04
851-062-0050	2-12-04	Amend	3-1-04
851-062-0055	2-12-04	Adopt	3-1-04
851-062-0060	2-12-04	Repeal	3-1-04
851-062-0070	2-12-04	Amend	3-1-04
851-062-0070	2-20-04	Amend	4-1-04
851-062-0075	2-12-04	Adopt	3-1-04
851-062-0080	2-12-04	Amend	3-1-04
851-062-0090	2-12-04	Amend	3-1-04
851-062-0100	2-12-04	Amend	3-1-04
851-062-0110	2-12-04	Amend	3-1-04
851-062-0120	2-12-04	Amend	3-1-04
851-062-0130	2-12-04	Amend	3-1-04
851-063-0010	2-12-04	Amend	3-1-04
851-063-0020	2-12-04	Amend	3-1-04
851-063-0030	2-12-04	Amend	3-1-04
851-063-0040	2-12-04	Amend	3-1-04
851-063-0050	2-12-04	Amend	3-1-04
851-063-0060	2-12-04	Amend	3-1-04
851-063-0070	2-12-04	Amend	3-1-04
851-063-0080	2-12-04	Amend	3-1-04
851-063-0100	2-12-04	Amend	3-1-04
852-001-0001	3-8-04	Amend	4-1-04
852-001-0002	3-8-04	Amend	4-1-04
852-020-0029	3-8-04	Adopt	4-1-04
852-020-0031	3-8-04	Adopt	4-1-04
852-020-0060	3-8-04	Amend	4-1-04
853-010-0060	1-30-04	Amend	3-1-04
855-031-0015	3-12-04	Amend	4-1-04
855-031-0045	3-12-04	Amend	4-1-04
855-043-0210	12-31-03	Adopt(T)	2-1-04
858-010-0030	3-2-04	Amend(T)	4-1-04
858-050-0125	3-2-04	Amend(T)	4-1-04
860-012-0100	1-8-04	Adopt	2-1-04
860-012-0190	1-8-04	Adopt	2-1-04
860-021-0200	1-9-04	Amend(T)	2-1-04
860-024-0020	11-28-03	Amend	1-1-04
860-024-0021	11-28-03	Amend	1-1-04
860-027-0048	12-11-03	Adopt	1-1-04
860-028-0895	11-28-03	Adopt(T)	1-1-04
860-032-0510	1-15-04	Adopt	2-1-04
860-032-0520	1-15-04	Adopt	2-1-04
860-034-0010	1-9-04	Amend(T)	2-1-04
860-034-0140	1-9-04	Amend(T)	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
860-035-0010	1-15-04	Repeal	2-1-04
860-035-0020	1-15-04	Repeal	2-1-04
860-035-0030	1-15-04	Repeal	2-1-04
860-035-0040	1-15-04	Repeal	2-1-04
860-035-0050	1-15-04	Repeal	2-1-04
860-035-0060	1-15-04	Repeal	2-1-04
860-035-0070	1-15-04	Repeal	2-1-04
860-035-0080	1-15-04	Repeal	2-1-04
860-035-0090	1-15-04	Repeal	2-1-04
860-035-0100	1-15-04	Repeal	2-1-04
860-035-0110	1-15-04	Repeal	2-1-04
860-035-0120	1-15-04	Repeal	2-1-04
860-035-0130	1-15-04	Repeal	2-1-04
860-036-0010	12-10-03	Amend(T)	1-1-04
860-036-0040	1-9-04	Amend(T)	2-1-04
860-036-0330	12-10-03	Suspend	1-1-04
860-036-0370	12-10-03	Adopt(T)	1-1-04
860-036-0380	12-10-03	Adopt(T)	1-1-04
860-036-0412	12-10-03	Adopt(T)	1-1-04
860-036-0420	12-10-03	Adopt(T)	1-1-04
860-036-0757	12-10-03	Adopt(T)	1-1-04
860-036-0900	12-10-03	Amend(T)	1-1-04
860-036-0905	12-10-03	Amend(T)	1-1-04
860-036-0910	12-10-03	Amend(T)	1-1-04
860-036-0915	12-10-03	Amend(T)	1-1-04
860-037-0001	1-29-04	Amend	3-1-04
860-037-0010	1-29-04	Amend	3-1-04
860-037-0015	1-29-04	Amend	3-1-04
860-037-0020	1-29-04	Amend	3-1-04
860-037-0025	1-29-04	Amend	3-1-04
860-037-0030	1-29-04	Amend	3-1-04
860-037-0035	1-9-04	Amend(T)	2-1-04
860-037-0035	1-29-04	Amend	3-1-04
860-037-0040	1-29-04	Amend	3-1-04
860-037-0045	1-29-04	Amend	3-1-04
860-037-0050	1-29-04	Amend	3-1-04
860-037-0055	1-29-04	Amend	3-1-04
860-037-0060	1-29-04	Amend	3-1-04
860-037-0065	1-29-04	Amend	3-1-04
860-037-0067	1-29-04	Adopt	3-1-04
860-037-0070	1-29-04	Amend	3-1-04
860-037-0075	1-29-04	Amend	3-1-04
860-037-0080	1-29-04	Amend	3-1-04
860-037-0101	1-29-04	Adopt	3-1-04
860-037-0105	1-29-04	Amend	3-1-04
860-037-0110	1-29-04	Amend	3-1-04
860-037-0115	1-29-04	Amend	3-1-04
860-037-0120	1-29-04	Amend	3-1-04
860-037-0125	1-29-04	Amend	3-1-04
860-037-0205	1-29-04	Amend	3-1-04
860-037-0210	1-29-04	Amend	3-1-04
860-037-0215	1-29-04	Amend	3-1-04
860-037-0220	1-29-04	Amend	3-1-04
860-037-0225	1-29-04	Amend	3-1-04
860-037-0230	1-29-04	Amend	3-1-04
860-037-0235	1-29-04	Amend	3-1-04
860-037-0240	1-29-04	Amend	3-1-04
860-037-0245	1-29-04	Amend	3-1-04
860-037-0305	1-29-04	Repeal	3-1-04
860-037-0307	1-29-04	Adopt	3-1-04
860-037-0308	12-10-03	Adopt(T)	1-1-04
860-037-0309	12-10-03	Adopt(T)	1-1-04
860-037-0310	1-29-04	Amend	3-1-04
860-037-0315	1-29-04	Repeal	3-1-04
860-037-0405	1-29-04	Amend	3-1-04
860-037-0407	12-10-03	Adopt(T)	1-1-04
860-037-0410	1-29-04	Amend	3-1-04
860-037-0415	1-29-04	Amend	3-1-04
860-037-0425	1-29-04	Amend	3-1-04
860-037-0430	1-29-04	Amend	3-1-04
860-037-0435	1-29-04	Amend	3-1-04
860-037-0440	1-29-04	Amend	3-1-04
860-037-0445	1-29-04	Amend	3-1-04
860-037-0450	1-29-04	Amend	3-1-04
860-037-0505	1-29-04	Amend	3-1-04
860-037-0510	1-29-04	Amend	3-1-04
860-037-0515	1-29-04	Amend	3-1-04
860-037-0517	1-29-04	Adopt	3-1-04
860-037-0520	1-29-04	Amend	3-1-04
860-037-0525	1-29-04	Amend	3-1-04
860-037-0530	1-29-04	Amend	3-1-04
860-037-0535	1-29-04	Amend	3-1-04
860-037-0540	1-29-04	Amend	3-1-04
860-037-0545	1-29-04	Amend	3-1-04
860-037-0547	12-10-03	Adopt(T)	1-1-04
860-037-0550	1-29-04	Amend	3-1-04
860-037-0555	1-29-04	Amend	3-1-04
860-037-0560	1-29-04	Amend	3-1-04
860-037-0565	1-29-04	Amend	3-1-04
860-037-0567	1-29-04	Adopt	3-1-04
860-037-0570	12-10-03	Adopt(T)	1-1-04
860-037-0605	1-29-04	Amend	3-1-04
860-037-0610	1-29-04	Amend	3-1-04
860-037-0615	1-29-04	Amend	3-1-04
860-037-0620	1-29-04	Amend	3-1-04
860-037-0625	1-29-04	Amend	3-1-04
860-037-0630	1-29-04	Amend	3-1-04
860-038-0540	1-15-04	Amend	2-1-04
860-038-0580	12-11-03	Amend	1-1-04
863-015-0015	1-1-04	Amend(T)	2-1-04
863-015-0055	1-15-04	Amend(T)	2-1-04
863-015-0080	1-1-04	Amend(T)	2-1-04
863-015-0200	1-1-04	Amend(T)	2-1-04
863-050-0000	1-1-04	Adopt	2-1-04
863-050-0015	1-1-04	Amend	2-1-04
863-050-0020	1-1-04	Amend	2-1-04
863-050-0025	1-1-04	Amend	2-1-04
863-050-0035	1-15-04	Adopt(T)	2-1-04
863-050-0040	1-1-04	Adopt	2-1-04
863-050-0050	1-1-04	Amend	2-1-04
863-050-0055	1-1-04	Amend	2-1-04
863-050-0060	1-1-04	Amend	2-1-04

OAR REVISION CUMULATIVE INDEX

OAR Number	Effective	Action	Bulletin
863-050-0065	1-1-04	Amend	2-1-04
863-050-0100	1-1-04	Amend	2-1-04
863-050-0108	1-1-04	Repeal	2-1-04
863-050-0110	1-1-04	Repeal	2-1-04
863-050-0115	1-1-04	Amend	2-1-04
863-050-0150	1-1-04	Amend	2-1-04
877-020-0020	12-1-03	Amend	1-1-04
918-008-0030	1-29-04	Amend(T)	3-1-04
918-030-0100	4-1-04	Adopt	3-1-04
918-030-0900	4-1-04	Adopt	3-1-04
918-050-0010	1-1-04	Amend	2-1-04
918-050-0020	1-1-04	Amend	2-1-04
918-225-0691	3-8-04	Amend(T)	4-1-04
918-225-0920	3-8-04	Amend(T)	4-1-04
918-440-0015	1-1-04	Amend	1-1-04
918-440-0040	1-1-04	Amend	1-1-04
918-440-0050	1-1-04	Amend	1-1-04
918-674-0025	1-1-04	Amend	1-1-04
918-674-0033	1-1-04	Amend	1-1-04
918-780-0035	1-1-04	Adopt	2-1-04
918-780-0120	1-1-04	Repeal	2-1-04
951-001-0000	3-15-04	Adopt(T)	4-1-04
951-001-0005	4-15-04	Adopt	4-1-04
972-010-0030	1-16-04	Adopt	2-1-04
972-030-0010	1-16-04	Adopt	2-1-04
972-030-0020	1-16-04	Adopt	2-1-04
972-030-0030	1-16-04	Adopt	2-1-04
972-030-0040	1-16-04	Adopt	2-1-04