RESUBSCRIPTION ISSUE

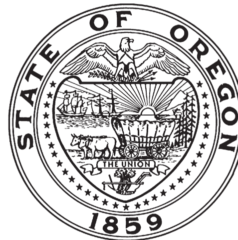
# OREGON BULLETIN

**Supplements the 2005 *Oregon Administrative Rules Compilation***

**Volume 44, No. 10**
**October 1, 2005**

**For August 16, 2005–September 15, 2005**

## USE THE ORDER FORM ON THE BACK COVER TO RE-SUBSCRIBE FOR 2006

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# 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 "any agency directive, standard, regulation or statement of general applicability that implements, interprets or prescribes law or policy, or describes the procedure or practice requirements of any agency" ORS 183.310(9). 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

## 2004–2005 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

| Submission Deadline | Publishing Date |
|---|---|
| December 15, 2004 | January 1, 2005 |
| January 14, 2005 | February 1, 2005 |
| February 15, 2005 | March 1, 2005 |
| March 15, 2005 | April 1, 2005 |
| April 15, 2005 | May 1, 2005 |
| May 13, 2005 | June 1, 2005 |
| June 15, 2005 | July 1, 2005 |
| July 15, 2005 | August 1, 2005 |
| August 15, 2005 | September 1, 2005 |
| September 15, 2005 | October 1, 2005 |
| October 14, 2005 | November 1, 2005 |
| November 15, 2005 | December 1, 2005 |

## Reminder for Agency Rules Coordinators

Each agency that engages in rulemaking must appoint a rules coordinator and file an "Appointment of Agency Rules Coordinator" form, ARC 910-2003, with the Administrative Rules Unit, Archives Division, Secretary of State. Agencies which delegate rulemaking authority to an officer or employee within the agency must also file a "Delegation of Rulemaking Authority" form, ARC 915-2005. It is the agency's responsibility to monitor the rulemaking authority of selected employees and to keep the appropriate forms updated. The Administrative Rules Unit does not verify agency signatures as part of the rulemaking process. Forms ARC 910-2003 and ARC 915-2005 are available from the Administrative Rules Unit, Archives Division, Secretary of State, 800 Summer Street NE, Salem, Oregon 97310, or are downloadable from the Oregon State Archives Website.

## Publication Authority

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

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## EXECUTIVE ORDER NO. 05-07

**AUTHORIZATION FOR THE OREGON STATE FAIR AND EXPOSITION CENTER TO LAW ENFORCEMENT DATA SYSTEM**

ORS 181.010(6) and OAR 257-010-0025(1)(b) authorize the Governor to allow Law Enforcement Data System access to designated state and local agencies which require such information “for agency employment purposes, licensing purposes or other demonstrated needs when designated by order of the Governor.” Executive Order No. 90-05 grants such access to a number of state agencies and establishes the conditions under which such access is authorized. Subsequent Executive Orders have authorized additional state agencies to access such information for various purposes.

The Oregon State Fair and Exposition Center (the “State Fair”) has requested access to the Oregon State Police criminal offender information system for the purpose of conducting background investigations on prospective employees where the protection of public safety or State Fair funds or assets makes such investigations advisable.

Enrolled House Bill 2157, signed by the Governor on August 17, 2005, establishes new authority and procedures through which state agencies may obtain criminal records information regarding prospective employees. HB 2157 requires that state agencies adopt certain rules regarding such background checks. Because HB 2157 was signed by the Governor less than one week before the date of this Executive Order, and because of the impending commencement of the fair, it is not practicable for the State Fair to adopt the necessary rules to utilize the procedures established under HB 2157 prior to the beginning of the fair. HB 2157 does not affect the pre-existing authority of the Governor to designate state agencies as “designated agencies” authorized to receive criminal offender information for employment purposes. Therefore, this Executive Order is issued for the limited purpose and for the limited time stated herein so that necessary background checks can be conducted before commencement of the fair, as allowed by HB 2157 and pre-existing law.

**THEREFORE, IT IS ORDERED AND DIRECTED:**

1. Pursuant to ORS 181.010(6) and OAR 257-010-0025(1)(B), I hereby authorize the Oregon State Police to provide the State Fair with access to the Oregon State Police criminal offender information system solely for the purpose of conducting background investigations on prospective employees for those positions where the State Fair concludes that protection of public safety or State Fair funds or assets makes such investigations advisable.

2. Executive Order No. 90-05, and all other applicable law, continue to govern the compilation, maintenance, and dissemination of criminal offender information as defined in ORS 181.010(3), and govern the access to the Oregon State Police criminal offender information system authorized by this Order.

3. This Order is effective immediately and expires September 30, 2005.

Done at Salem, Oregon, this 23rd day of August, 2005.

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

ATTEST

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

## EXECUTIVE ORDER NO. 05-08

**INVOCATION OF EMERGENCY CONFLAGRATION ACT FOR DEER CREEK FIRE IN JOSEPHINE COUNTY**

Pursuant to my authority as Governor of the State of Oregon, I find that:

A fire known as the “Deer Creek Fire” began in Josephine County on or around August 25, 2005.

The resources necessary for protection of life and property from the Deer Creek Fire are beyond local capabilities. Assistance with life, safety, and structural fire protection was requested by the Illinois Valley Rural Fire Protection District Fire Chief. The State Fire Marshal concurs with that request.

In accordance with ORS 476.510-476.610, I have determined that a threat to life, safety, and property exists due to the fire known as the Deer Creek Fire in Josephine County and the threat exceeds the firefighting capabilities of local fire-fighting personnel and equipment. Accordingly, I have invoked the Emergency Conflagration Act.

These findings were made at 8:45 p.m. on August 25, 2005 and I now confirm them with this Executive Order.

**NOW THEREFORE, IT IS HEREBY DIRECTED AND ORDERED:**

1. The Oregon Office of Homeland Security and the Office of State Fire Marshal shall mobilize fire resources statewide and coordinate with all appropriate Fire Defense Chiefs for the use of personnel and equipment in accordance with the Emergency Conflagration Act to suppress and contain this fire.

2. This emergency is declared only for the Deer Creek Fire in Josephine County.

3. This order was made by verbal proclamation at 8:45 p.m. on the 25th day of August, 2005 and signed this 29th day of August, 2005, in Salem, Oregon.

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

ATTEST

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

## EXECUTIVE ORDER NO. EO 05-09

**DETERMINATION OF A STATE OF EMERGENCY IN THE STATE OF OREGON DUE TO ACTIVATION AND SUPPORT OF HURRICANE KATRINA RELIEF EFFORTS**

Pursuant to ORS 401.055, I find that a threat to life and safety exists due to activation and support of Hurricane Katrina relief efforts, which began on August 29, 2005 and is continuing.

**IT IS ORDERED AND DIRECTED:**

The Oregon Military Department is authorized to deploy military personnel and equipment, and determine appropriate utilization of military facilities as necessary to assist and support response to the emergency.

The Office of Homeland Security’s Office of Emergency Management, in accordance with the Oregon Emergency Operations Plan is

designated as the State Coordinating Agency for the purpose of coordinating the response of state agency personnel and equipment in the performance of activities in support of relief efforts associated with Hurricane Katrina, except for law enforcement and military resources; and, to act as liaison with local governing bodies, private relief agencies, voluntary agencies and appropriate federal agencies.

All other departments are directed to provide appropriate resources as determined essential by the Office of Emergency Management.

This determination of a State of Emergency is limited to areas in Oregon impacted by the Hurricane Relief efforts.

Done at Portland, Oregon this 5th day of September, 2005.

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

ATTEST

/s/ Bill Bradbury
Bill Bradbury
SECRETARY OF STATE

## NOTICE FOR COMMENT ON PROPOSED CLEANUP APPROACH ROSS ISLAND SAND AND GRAVEL

**COMMENTS DUE:** October 31, 2005
**PROJECT LOCATION:** Ross and Hardtack Islands/Ross Island Lagoon, Willamette River Mile 15
**PROPOSAL:** As required by ORS 465.320, the Department of Environmental Quality (DEQ) invites public comment on the proposed cleanup approach for contaminated soils and sediments at the Ross Island site. The proposed approach includes capping and stabilization of contaminated soils and sediments, institutional controls to prevent disturbance of the caps, and long-term monitoring and evaluation. To the extent feasible the proposed cleanup would be integrated with the existing reclamation plan for this site.
**HIGHLIGHTS:** Ross Island Sand and Gravel Co. (RISG) mined and processed sand and gravel from the Willamette River at Ross Island from the early 1920s to 2001. From 1979 to 1999, RISG utilized material generated from various activities to backfill mined areas in compliance with reclamation required at the site. This material included waste from on-site processing, imported fill originating from maintenance dredging projects, and waste rock from a U.S. Army Corp of Engineers navigation project at Bonneville Locks. Some of this fill, originating from Port of Portland (Port) shipyards, was contaminated and required confinement in aquatic disposal cells created within the lagoon. In 1998 RISG mined into one of these cells and was subsequently required to recap the area.

Beginning in 1999, the Port and RISG completed several environmental investigations at the site. These investigations evaluated the effectiveness of the confined aquatic disposal cells in isolating contaminants from the aquatic environment, characterize contaminants present in other fill material and in surface sediments in the vicinity of the breach, and characterize contamination resulting from industrial activities at the site.

Based on the Port study that was completed November 2000, DEQ determined that the confined disposal cells were effective in isolating contaminants from the surrounding environment, but that some additional stabilizing of side slopes adjacent to the cells would be needed to ensure long-term stability of the cells. DEQ also indicated that a long-term monitoring and maintenance plan would be required to ensure the cells continued to be effective over time. A cleanup investigation of the site completed by RISG in 2002 identified several areas where contaminant levels warranted cleanup evaluation. These areas and the proposed cleanup actions are summarized below:

a) Arsenic- and zinc-contaminated surface soil in the vicinity of the RISG processing plant: additional characterization and capping with three feet of clean soil, long-term maintenance.

b) Soil contaminated with polycyclic aromatic hydrocarbons (PAHs) adjacent to the lagoon: stabilization and capping, long-term maintenance and monitoring.

c) Breach material containing elevated concentrations of tributyl tin (TBT) confined in former settling pond: long-term maintenance and monitoring.

d) PAH-contaminated groundwater adjacent to the lagoon: long-term monitoring to evaluate potential threat to lagoon.

e) PAH-, metal-, and PCB-contaminated sediment in the vicinity of the breach: capping with three feet of clean soil, long term maintenance and monitoring.

f) Lagoon shoreline areas with elevated pH: completion of capping pilot studies, capping and long-term maintenance and monitoring.

g) Confined aquatic disposal cells in the lagoon: stabilization of side slopes, long-term maintenance and monitoring.

**HOW TO COMMENT:** The DEQ's staff report on the proposed cleanup approach will be available for public review at the downtown and Sellwood-Moreland branches of the Portland Public Library, and DEQ's Northwest Region Office in Portland beginning October 1, 2005. The staff report will also be placed on DEQ's web page for the project http://www.deq.state.or.us/nwr/Ross_Island/index.htm. To schedule an appointment to review files in DEQ's Northwest Region office, call (503) 229-6729. The DEQ Project Manager is Jennifer Sutter, (503) 229-6148. Written comments should be sent to the Project Manager at the DEQ, Northwest Region, 2020 SW 4th Ave., Portland, OR 97201 or sutter.jennifer@deq.state.or.us by October 31, 2005.
**THE NEXT STEP:** DEQ will consider all public comments and the Regional Administrator will make and publish the final decision after consideration of these comments.

## PROPOSED APPROVAL OF CLEANUP AT PARCEL 2206 BRASSER TRUST KLAMATH FALLS, OREGON

**COMMENT DUE:** October 31, 2005
**PROJECT LOCATION:** Washburn Way and Laverne Street, Klamath Falls, Oregon
**PROPOSAL:** The Department of Environmental Quality (DEQ) intends to issue a No Further Action (NFA) finding for the subject property known as Parcel 2206 Adjacent to Midland Market Rail Yard, based upon completed site investigations and cleanup of soils contaminated by petroleum compounds.

A total of 9.92 tons of petroleum-contaminated soil were excavated and removed from the site and disposed off-site at a permitted solid waste facility. All residual contamination at this site is documented at levels below selected cleanup and/or screening standards established by the DEQ for this site. More information concerning this investigation and cleanup is available by contacting Mr. Cliff Walkey, DEQ's project manager located in Bend, Oregon.
**HOW TO COMMENT:** A public comment period will extend to October 31, 2005. 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 "No Further Action" determination.

## PROPOSED APPROVAL OF CLEANUP FORMER CALBAG METALS SITE 4927 NW FRONT AVENUE PORTLAND, OREGON

**COMMENT PERIOD:** October 1 to 31, 2005
**COMMENTS DUE:** October 31, 2005
**PROPOSAL:** The Oregon Department of Environmental Quality (DEQ) proposes to approve a cleanup of contaminated storm water sediment at the former Calbag Metals site.
**HIGHLIGHTS:** Environmental testing performed at the site identified metals, petroleum products, polychlorinated biphenyls, and phthalates in sediment within on- and off-site storm water piping systems that ultimately discharge to the Willamette River. The cleanup action included removal and off-site disposal of contaminated sediment, thus eliminating a potential source of contamination to Portland Harbor. DEQ recommends that the cleanup be approved and that no further action be required at the site except continued storm water monitoring to confirm acceptable levels.
**INFORMATION:** The project file is available for public review. To schedule an appointment call (503) 229-6729. For additional infor-

mation regarding the selected cleanup actions for the site, contact the DEQ project manager, Tom Gainer, at (503) 229-5326.
**THE NEXT STEP:** DEQ will consider all public comments before making the final decision.

**A CHANCE TO COMMENT ON PROPOSED CONSENT JUDGMENT FOR REMOVAL AND REMEDIAL ACTION AT NORTH RIDGE ESTATES IN KLAMATH FALLS, OREGON**

**COMMENTS DUE:** October 30, 2005
**PROJECT LOCATION:** North Ridge Estates (site of former U.S. Marine Barracks and former Oregon Technology Institute campus, Klamath Falls, Oregon)
**PROPOSAL:** The Department of Environmental Quality (DEQ) is proposing to enter into a Consent Judgment designed to expedite removal and remedial actions at North Ridge Estates located at and around Old Fort Road in Klamath Falls. The Consent Judgment is with numerous potentially responsible parties, and is part of a series of settlement agreements among all of the parties and the United States government. The Consent Judgment is intended to settle issues of alleged liability so that available funds can be spent in settling claims filed by affected homeowners and providing a pool of funds to be spent on removal and remedial action costs. Pursuant to the Consent Judgment, DEQ will forego cost recovery.
**HIGHLIGHTS:** The North Ridge Estates residential development was constructed on property that was heavily contaminated with asbestos-containing material. The developer of the site has filed for bankruptcy protection. It is a priority of the State of Oregon to assist the affected homeowners in relocation from the site. The Consent Judgment specifically provides liability protection to the potentially responsible parties so that their available funds will be used to assist in the relocation of the affected homeowners and, to some extent, for the removal and remedial actions at the North Ridge Estates Site. The United States government is also entering into a similar Consent Judgment with the parties for the same purpose.
**HOW TO COMMENT:** Written comments and questions concerning the Consent Judgment should be sent to Jennifer Braaten located at Department of Justice, 1162 Court St. NE, Salem Oregon 97301. The proposed Consent Judgment may be reviewed at DEQ's Headquarters office in Portland at 811 S.W. Sixth Avenue and with Dr. William Nettles, VP, Finance and Administration at the Oregon Institute of Technology, 3201 Campus Drive, Klamath Falls, OR 97601.
**THE NEXT STEP:** DEQ will consider all public comments. A final decision concerning the Consent Judgment will be made after consideration of public comments.

**NOTICE OF PROPOSED REMEDIAL ACTION AND CONDITIONAL NO FURTHER ACTION CHEVRON SERVICE STATION 9-0516 (FORMER) 275 SE BASELINE STREET, HILLSBORO, OREGON**

**PROJECT LOCATION:** 275 SE Baseline Street, Hillsboro, Oregon.

Pursuant to Oregon Revised Statute (ORS) 465.320, the Oregon Department of Environmental Quality (DEQ) is issuing this notice regarding the proposed remedial action and proposed conditional No Further Action (NFA) for the former Chevron Service Station 9-0516 located at 75 SE Baseline Street in Hillsboro.

The proposed remedial action is documented in the "*Conditional NFA Recommendation*" memo dated September 2005. The remedial action selected for this site is an institutional control in the form of an Equitable Easement and Servitude (EE&S). The EE&S will restrict the property use to commercial or industrial use, prohibit groundwater use, and require appropriate handling of any excavated soil and groundwater. Following the recordation of the EE&S, the site will be issued a Conditional No Further Action determination. DEQ will consider all public comments received before issuing the final approval of the proposed remedial action.
**INFORMATION:** The decision document and documentation of remedial actions performed at the site are available for public review by appointment at DEQ's Northwest Region Office. To schedule an appointment call (503) 229-6729. For additional information, contact DEQ Project Manager, Katie Robertson at (541) 278-4620 or by email at robertson.katie@deq.state.or.us. Interested persons should send comments by 5 p.m. October 31, 2005 to the DEQ project manager 700 SE Emigrant, Suite 330, Pendleton, OR 97801.

**PROPOSED REMEDIAL ACTION FOR FORMER UNOCAL SERVICE STATION #2963 KLAMATH FALLS, OR**

**COMMENTS DUE:** October 31, 2005
**PROJECT LOCATION:** 4078 South 6th Street, Klamath Falls
**PROPOSAL:** The Department of Environmental Quality (DEQ) is proposing to issue a No Further Action decision regarding cleanup activities at the above referenced site based upon an approval of work done to date and a proposed Risk-Based corrective action plan.
**HIGHLIGHTS:** The site operated as a gasoline service station from 1947 until 1988. The property is currently occupied by a used car dealership. Past activities at the site include the decommissioning by removal of four underground storage tanks (USTs) – two 10,000 gallon steel USTs which previously held motor fuel; one 550 gallon waste oil UST and one 550 gallon heating oil UST. Groundwater monitoring has been occurring at the site since 1988 with laboratory results showing no significantly detectable concentrations of petroleum constituents. By the spring of 2004, the site surface had been covered with 4 to 6 inches of crushed rock and sealed with a layer of asphalt paving.

A conceptual site model was developed and a risk assessment performed which showed that residual petroleum hydrocarbons in soil do not pose an unacceptable risk for construction and excavation workers for all reasonably likely current and future exposure pathways. The site is in an area zoned as General Commercial.

Based upon the consultant's findings, there are no pathways by which ecological receptors may be exposed to site-related contaminants. Residual contaminants at the site do not currently produce odors or other nuisance conditions.

If implemented as proposed, this risk-based corrective action plan will achieve protective conditions at the site as defined in OAR 340-122-0040.
**COMMENT:** All documents and reports pertaining to the recommendation of acceptance of the proposed remedial action may be reviewed by appointment, at DEQ's office in Bend, 2146 NE 4th Street, Suite 104, Bend, OR 97701. To schedule an appointment or make enquiries, contact the project manager, Joe Klemz at (541)388-6146, ext. 237.

Written comments should be sent to the attention of Mr. Klemz at the address listed above and must be received by October 31, 2005. Questions may also be directed to Mr. Klemz via email at klemz.joe@deq.state.or.us .
**NEXT STEP:** DEQ will consider all comments received. A final decision concerning the proposed remedial actions will be made after consideration of public comments.

**PUBLIC COMMENT PERIOD NOTICE OF NO FURTHER ACTION SI CASA FLORES RESTAURANT 235 E. BARNETT ROAD, SUITE 104, MEDFORD, OREGON**

**COMMENTS DUE:** November 1, 2005

**PROJECT LOCATION:** Si Casa Flores Restaurant, 235 E. Barnett Road, Suite 104, Medford, Oregon 97501
**PROPOSAL:** The Oregon Department of Environmental Quality (DEQ) is proposing that a chromium spill cleanup at the Si Casa Flores Restaurant is complete and requires no further action under ORS465.200, et.seq.
**HIGHLIGHTS:** Si Casa Flores is a Mexican restaurant located in a strip mall on the Winco shopping center on west side of Medford. During the construction of the restaurant, an acid concrete stain called QC Patina Stain, was applied to the floor. The excess stain residue was removed by washing and /or scrapping it from the floor, vacuuming up the wash water and residue in a shop vacuum and discharging the waste to the soil/gravel area in the back of the restaurant. The impacted area was a small part of a larger soil/gravel strip running between the back of the entire building housing the restaurant and the back of the Medford Inn Motel. The waste and impacted soils were removed and properly disposed of as hazardous waste. Confirmation sampling in the impacted area indicated that the removal was effective and remaining chromium concentrations are below industrial use levels. In the absence of significant human health or ecological risks associated with the chromium contamination stemming from the spill, DEQ recommends that no further investigation or remediation be undertaken for environmental impacts due to the historical release.
**HOW TO COMMENT:** Written comments on the proposed no further action may be submitted to Angie Obery at DEQ's Eugene office, 1102 Lincoln St., Suite 210, Eugene, OR 97401. Comments must be received by November 1, 2005. Questions may be directed to Angie Obery by calling her at 1-800-844-8467 x265.

A public meeting to answer questions and receive verbal comment on the proposed no further action will be held if there is significant public interest.
**THE NEXT STEP:** DEQ will consider all public comments prior to making a final decision.

### OPPORTUNITY FOR PUBLIC COMMENT RECOMMENDATION FOR NO FURTHER ACTION FORMER MEDITE SO-PLY FACILITY, GRANTS PASS

**COMMENTS DUE:** October 31, 2005
**PROJECT LOCATION:** Former Medite So-Ply Facility, 605 SE "J" Street, Grants Pass, Oregon
**PROPOSAL:** Pursuant to ORS 465.320 and Oregon Administrative Rules (OAR) 340-122-465, the Department of Environmental Quality (DEQ) requests public comment on its recommendation that no further investigation or cleanup action is required for contaminated soil at the former Medite So-Ply facility in Grants Pass.
**HIGHLIGHTS:** Investigations and a removal action have been performed at the Former Medite So-Ply facility to address the impact of petroleum hydrocarbons found in soil and groundwater. These chemicals originated from past practices at the facility. About 1,063 cubic yards of contaminated soil were removed from this area in July of 2005 and disposed of at Riverbend Landfill in McMinnville, Oregon. The remaining contaminated soils are covered by a cap of clean fill, and much of the site will ultimately be paved. With the cap in place, all residual soil contamination at this site is documented at levels below selected cleanup and/or screening standards established by the DEQ for this site. In order to protect human health and the environment, a deed restriction will be placed on the property prohibiting future drinking water wells on the site, requiring that the site remain zoned industrial and requiring that any soil removed from the site be properly disposed of.

DEQ has recommended that no further investigation or remediation is needed for environmental impacts from Petroleum-contaminated soils and groundwater at the former Medite So-Ply site in Grants Pass.
**HOW TO COMMENT:** The project files may be reviewed by appointment at DEQ's Eugene office, 1102 Lincoln, Suite 210, Eugene 97401. To schedule an appointment in Eugene, call (541)-686-7838. The TTY number for the hearing impaired is 541-687-5603.

A copy of the Staff Report will also be available at the Josephine County Main Library, 200 NW "C" Street, Grants Pass 97526

Please direct any questions or comments about this pending decision to:

Mindi English, DEQ project manager
Address: 1102 Lincoln Street, #210, Eugene, OR 97401
Phone: (541) 686-7838, ext. 269 (TTY 541-686-5603)
Email: english.mindi@deq.state.or.us

A public meeting will be held to receive verbal comments upon written request by ten or more persons, or by a group with ten or more members.
**THE NEXT STEP:** DEQ will consider all comments received before taking final action on this matter.

### OREGON DEPARTMENT OF ENVIRONMENTAL QUALITY (DEQ) INVITES PUBLIC COMMENT ON A PROPOSED NO FURTHER ACTION FINDING FOR A CLEANUP OF JET FUEL AND PETROLEUM HYDROCARBON CONTAMINATION AT ROGUE VALLEY INTERNATIONAL-MEDFORD AIRPORT, LOCATED NEAR THE MAIN TERMINAL BUILDING AT THE AIRPORT IN MEDFORD

DEQ has completed an environmental review of the investigation and cleanup of petroleum hydrocarbon contamination at the Rogue Valley International-Medford Airport. The airport has been operating at this location since the early 1940's and during construction of the concrete apron in front of the terminal, they encountered an area of petroleum contamination in February 1997. Furthermore, two previously unknown underground storage tanks were discovered nearby the area of petroleum contamination in June 1997.

Cleanup activities addressed the soil contamination associated with the release. In March 1997 approximately 325 cubic yards of soil was removed and was placed into a bioremediation cell on in a secured area on airport property. These soils were bioremediated and tested monthly. In June 1997 when the soil levels were acceptable, the remediated soil was placed within the fenced in portion of the southern part of airport property.

Groundwater monitoring was conducted for over one year in three groundwater monitoring wells. The levels of contamination are considered by DEQ to not be hazardous. Project documents for this site are available for public review at DEQ's Eugene office, 1102 Lincoln St., Suite 210, Eugene 97401. Contact the file specialist at (541) 686-7838 or 1-800-844-8467 (toll-free in Oregon) for an appointment. Please send written comments to Norman Read, at the listed above address or via email at read.norm@deq.state.or.us. DEQ must receive written comments by 5 p.m., October 31, 2005.

### PROPOSED NO FURTHER ACTION DETERMINATION MOUNTAIN FIR CHIP COMPANY SITE THE DALLES, OREGON

**COMMENTS DUE:** November 2, 2005
**PROJECT LOCATION:** 3636 Klindt Drive, The Dalles, Wasco County, Oregon
**PROPOSAL:** The Department of Environmental Quality is proposing to issue a No Further Action determination following excavation of petroleum-contaminated soil at the former Mountain Fir Chip Company site. This determination is based on approval of investigation and remedial measures conducted to date. Public notification is required by ORS 465.320.

**HIGHLIGHTS:** This 43-acre site was used for the production of wood chips from about 1972 until August 2002 when the facility was destroyed by fire. The site, which is part of the Port of the Dalles complex, is bounded on the south by other Port property and Chenoweth Creek. A Bonneville Power Administration substation lies to the west. The Columbia River is immediately east of the site, and other Port property borders the site to the north. The site was developed by Mountain Fir Chip in 1972, and the site improvements were purchased by Longview Fibre Company in the mid-1970s. According to Port personnel, the site had been previously used for farming.

Based on site inspections conducted in 2004, nine areas were identified for soil sampling. Sampling was following by two rounds of soil excavation in March 2005 to remove soil contaminated with petroleum. A total of 780 tons of petroleum-contaminated soil were removed and taken to the Wasco County Landfill for disposal.

Six confirmation samples were analyzed for volatile organic compounds (VOCs), polynuclear aromatic compounds (PAHs), cadmium, chromium and lead. No VOCs or PAHs were detected in five of the six samples. In the sixth sample, one VOC was found (p-isopropyltoluene at 4.15 mg/kg) and one PAH was found (fluoranthene at 0.15 mg/kg). Chromium and lead were detected in all samples, at maximum concentrations of 16.9 mg/kg and 28.2 mg/kg, respectively. Cadmium was detected in two of the six samples at a maximum concentration of 0.834 mg/kg. Residual contaminant concentrations were determined to be below safe levels.

Site investigations indicate that most contamination was the result of surface spilling of heavy oil. This contamination was removed to the extent practical. Much of the site has exposed basalt, and where soil cover is found, it extends to depth of only a few feet. Future development of the site would be served by the municipal water supply. For these reasons, DEQ did not require groundwater sampling at this site.

Based on the results of the investigation, DEQ has determined that no further action is required at this site.

**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. Written comments should be sent by Wednesday, November 2, 2005.

**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 DETERMINATION FORMER UNION OIL BULK PLANT THE DALLES, OREGON

**COMMENTS DUE:** November 2, 2005

**PROJECT LOCATION:** 215 Terminal Avenue, The Dalles, Oregon

**PROPOSAL:** The Department of Environmental Quality is proposing to issue a No Further Action determination for the former Union Oil bulk plant in The Dalles. This determination is based on approval of a site investigation report completed in August 2005. Public notification is required by ORS 465.320.

**HIGHLIGHTS:** The former Union Oil (Unocal) bulk plant occupies 1.53 acres in an industrial part of The Dalles. The site operated as a petroleum bulk plant from 1922 until 1977. It had six aboveground petroleum storage tanks (four 20,000-gallon tanks and two 10,000-gallon tanks) used to store gasoline and diesel. Site facilities also include a garage, loading rack area, and warehouse with loading dock. 55-gallon drums of various petroleum products were used in the warehouse. The storage tanks, lines, pumps, and loading rack were removed in 1997. There is a septic tank in the northeast corner of the site.

Eight soil samples were collected from the site in April 2004. All samples were analyzed for BTEX (benzene, toluene, ethylbenzene and xylenes), gasoline, diesel and heavy oil. The three most contaminated of these samples were also analyzed for polychlorinated biphenyls (PCBs), volatile organic compounds (VOCs), polynuclear aromatic hydrocarbons (PAHs), and total lead, cadmium and chromium.

In November 2004, Unocal's consultant installed three groundwater monitoring wells. These wells were sampled in November 2004 and February 2005. Two of these wells were also sampled a third time in April 2005. The water samples were analyzed for petroleum hydrocarbons, PAHs, VOCs and dissolved lead.

Soil and groundwater results indicate that residual contamination is below safe levels. DEQ is therefore intends to issue a No Further Action determination for this site.

**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. Written comments should be sent by Wednesday, November 2, 2005.

**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.

## Notices of Proposed Rulemaking and Proposed Rulemaking Hearings

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

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

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.

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

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

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### Appraiser Certification and Licensure Board
### Chapter 161

| Date: | Time: | Location: |
|---|---|---|
| 10-17-05 | 9 a.m. | West Coast Bank<br>2nd Flr. Community Conf. Rm.<br>301 Church St. NE<br>Salem, OR |

**Hearing Officer:** Craig Zell
**Stat. Auth.:** ORS 183.355(1)(a), 674.305(8) & 674.310(2)(b); Other Auth.: Title XI of Fed. Financial Reform, Recovery & Enforcement Act of 1989 (12 USC 3310 et seq.)
**Stats. Implemented:** ORS 674.305(8), 674.310(2)(a) & 674.352
**Proposed Adoptions:** 161-010-0085, 161-025-0025
**Proposed Amendments:** 161-001-0005, 161-002-0000, 161-003-0020, 161-006-0025, 161-010-0080, 161-015-0030, 161-020-0035, 161-025-0000, 161-025-0005, 161-025-0010, 161-025-0030, 161-025-0060, 161-050-0000, 161-050-0040
**Last Date for Comment:** 10-17-05, close of hearing
**Summary:** Proposed additions to Oregon Administrative Rules 161, Division 1 regarding rulemaking authority; Division 2 regarding definitions; Division 3 regarding fees; Division 6 regarding the Board's budget; Division 10 regarding licensure and certification requirements; Division 15 regarding submission of application; Division 20 regarding education courses, requirements and providers; Division 25 regarding scope of practice and procedures; and Division 50 regarding temporary non-resident registrations and address changes.
**Rules Coordinator:** Karen Turnbow
**Address:** Appraiser Certification and Licensure Board, 1860 Hawthorne Ave NE, Suite 200, Salem, OR 97303
**Telephone:** (503) 485-2555

### Board of Accountancy
### Chapter 801

| Date: | Time: | Location: |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | Board of Accountancy<br>3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 670.310, 673.040, 673.050 & 673.410
**Stats. Implemented:** ORS 673.165 & 673.210
**Proposed Amendments:** 801-040-0010, 801-040-0070, 801-040-0090
**Last Date for Comment:** 11-3-05
**Summary:** OAR 801-040 is being revised to clarify when the ethics requirement is to be reported, to clarify the requirements for verification of reported CPE programs, and requirements for reinstatement applications.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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| Date: | Time: | Location: |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | Board of Accountancy<br>3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 297.670, 297.680 & 297.740
**Stats. Implemented:** ORS 297.680 & 297.710
**Proposed Amendments:** 801-020-0720
**Last Date for Comment:** 11-3-05
**Summary:** OAR 801-020-0720 is revised to correct a typographical error that referenced the wrong rule number.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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| Date: | Time: | Location: |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | Board of Accountancy<br>3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 670.310, 673.050, 673.100, 673.410 & 673.153
**Stats. Implemented:** ORS 673.040, 673.153, 673.050, 673.100 & 673.410
**Proposed Amendments:** 801-010-0050, 801-010-0080
**Last Date for Comment:** 11-3-05
**Summary:** OAR 801-010-0050 is revised to clarify that CPA Exam candidates are required to graduate from a regionally accredited college. 801-010-0080 modifies rules for substantial equivalency to clarify timeline requirements for applying for and renewing the authorization.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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| Date: | Time: | Location: |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | 3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 673.410 & 183.332
**Stats. Implemented:** ORS 183.337, 673.410 & 673.170
**Proposed Adoptions:** 801-001-0055
**Proposed Amendments:** 801-001-0035
**Last Date for Comment:** 11-3-05
**Summary:** Division 001 is revised to add a new rule that requires respondents in administrative actions to state claims and defenses

prior to the hearing. The rule is also amended to update the effective date of professional standards to December 31, 2005.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | Board of Accountancy<br>3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 670.310 & 673.410
**Stats. Implemented:** ORS 673.160, 673.320, 673.345 & 673.445
**Proposed Amendments:** 801-030-0005, 801-030-0015, 801-030-0020
**Last Date for Comment:** 11-3-05
**Summary:** Definitions in OAR 801-030-0005 were moved to OAR 801, Division 005 to maintain uniformity, and a reference to the Oregon Division of Audits was removed from Section (1). The form of rule citation was corrected in OAR 801-030-0015. OAR 801-030-0020 is revised to include internet and e-mail under public communications, to clarify false, misleading, or deceptive statements, and to clarify the rules relating to firm names. Provisions that required suspension for school loan defaults is removed and the provisions relating to continuing violations are modified to provide notice to the licensee.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | Board of Accountancy<br>3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 673.455
**Stats. Implemented:** ORS 673.455
**Proposed Adoptions:** 801-050-0035, 801-050-0065
**Proposed Amendments:** 801-050-0005, 801-050-0010, 801-050-0020, 801-050-0030, 801-050-0040, 801-050-0060, 801-050-0070, 801-050-0080
**Proposed Repeals:** 801-050-0050
**Last Date for Comment:** 11-3-05
**Summary:** OAR 801-050 is revised to establish new requirements for firms that are subject to peer review. Modifications include new definitions and additions to services that are subject to peer review. The revisions establish minimum standards for peer review programs, clarify peer review enrollment requirements, establish reporting requirements for firms that receive substandard peer review reports, and document retention periods for peer review sponsors and also for firms that are subject to peer review requirements. OAR 801-050-0035 is a new section that describes the approval and oversight responsibilities of the Peer Review Oversight Committee.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-20-05 | 10 a.m.–12 p.m. | 3218 Pringle Rd. SE<br>Salem, OR 97302 |

**Hearing Officer:** Stuart Morris, Chair
**Stat. Auth.:** ORS 670.310
**Stats. Implemented:** ORS 670.310
**Proposed Amendments:** 801-005-0010
**Last Date for Comment:** 11-3-05
**Summary:** Division 005 is being amended to clarify the definitions for attest, commissions, contingent fees, referral fee and peer review, and to add a new definition of fees.
**Rules Coordinator:** Kimberly Bennett
**Address:** Board of Accountancy, 3218 Pringle Rd. SE, Suite 110, Salem, OR 97302
**Telephone:** (503) 378-4181, ext. 24

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## Board of Architect Examiners
## Chapter 806

**Stat. Auth.:** ORS 671.125
**Stats. Implemented:** ORS 671.050, 671.060, 671.065, 671.080 & 671.085
**Proposed Amendments:** 806-010-0015, 806-010-0037, 806-020-0020
**Last Date for Comment:** 10-21-05, 4:30 p.m.
**Summary:** These are housekeeping changes. One is the result of changes to the law from the 2003 Legislative Session that was overlooked; to change the wording from protecting life, health and property to health, safety, and welfare. Another one is adding the ability to use the Architect Emeritus title under the “title” rules. This was always an allowed use of the title, but was inadvertently left out of the title section of the rules. Another one is to clarify the language for who may use the title, which changes nothing but makes the wording more clear. The last one is to amend the address of the National Council of Architectural Registration Boards after their move.
**Rules Coordinator:** Carol Halford
**Address:** Oregon Board of Architect Examiners, 205 Liberty St. NE, Suite A, Salem, OR 97301
**Telephone:** (503) 763-0662, ext. 23

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## Board of Clinical Social Workers
## Chapter 877

| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-15-05 | 1–2 p.m. | Conf. Rm.<br>3218 Pringle Rd. SE<br>Suite #240<br>Salem, OR 97302-6310 |

**Hearing Officer:** Mark F. Oldham, LCSW
**Stat. Auth.:** ORS 675.510 - 675.600; Other Auth.: OAR 877
**Stats. Implemented:** ORS 675.530, 675.535, 675.537, 675.540, 675.560, 675.571, 675.583, 675.595 & 675.600
**Proposed Adoptions:** 877-020-0055, 877-030-0100, 877-035-0013
**Proposed Amendments:** 877-010-0025, 877-020-0000, 877-020-0005, 877-020-0009, 877-020-0010, 877-020-0012, 877-020-0013, 877-020-0015, 877-020-0016, 877-020-0020, 877-020-0030, 877-020-0031, 877-020-0046, 877-025-0000, 877-025-0005, 877-030-0040, 877-030-0070, 877-030-0090, 877-035-0012, 877-035-0015, 877-040-0015, 877-040-0050, 877-040-0055
**Proposed Repeals:** 877-020-0050, 877-040-0025, 877-040-0027, 877-040-0060, 877-040-0065, 877-040-0070
**Last Date for Comment:** 11-15-05, 2 p.m.
**Summary:** These changes accomplish the following: (1) Switch from a licensure renewal process at the end of the calendar year, to one connected with the Licensee’s birth-month; (2) Establish limits on how long a Candidate has to pass the prescribed licensure exams; (3) Slight fee increase for LCSW and CSWA annual renewal; (4) Decreases renewal fee for those on Inactive Status; (5) Establishes CE requirements for those returning to Active Status after time on Inactive Status; (6) Sets protocol for safety of clinical records in event of licensee’s death or impairment; (7) Allows the Board to require national FBI fingerprint background check for Applicants and other specific categories; and (8) Shortens time-line for self-reporting of DUII or other substance abuses.

Public comments may be provided to the Board through e-mail (Jon.Langenwalter@state.or.us), fax (503-373-1427), mail (Board address above), or in person at the Board meeting on Tuesday, November 15, 2005. Deadline for all comments is the close of the public hearing at 2:00 p.m. on Tuesday, November 15, 2005.
**Rules Coordinator:** Jon F. Langenwalter
**Address:** State Board of Clinical Social Workers, 3218 Pringle Rd. SE, Suite 240, Salem, OR 97302
**Telephone:** (503) 378-5735, ext. 34

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**Board of Geologist Examiners**
**Chapter 809**

**Stat. Auth.:** ORS 183, 192 & 672
**Stats. Implemented:** ORS 672.585
**Proposed Amendments:** 809-015-0000, 809-015-0005
**Last Date for Comment:** 10-31-05
**Summary:** Two minor rule adjustments are made to correctly reflect what the statute has always stated. These are not newly written or implemented, but rather are corrections to existing rules. Renewals are to be paid before the renewal date, not on or before the renewal date. A restoration fee is required with a lapsed registration payment.
**Rules Coordinator:** Susanna R. Knight
**Address:** Board of Geologist Examiners, 1193 Royvonne Ave. SE, #24, Salem, OR 97302
**Telephone:** (503) 566-2837

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**Board of Naturopathic Examiners**
**Chapter 850**

**Stat. Auth.:** ORS 685.125
**Stats. Implemented:** ORS 685
**Proposed Adoptions:** 850-050-0010
**Last Date for Comment:** 10-25-05
**Summary:** Clarifies sanctions for violations by the Board.
**Rules Coordinator:** Anne Walsh
**Address:** Board of Naturopathic Examiners, 800 NE Oregon St. - Suite 407, Portland, OR 97232
**Telephone:** (971) 673-0193

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**Stat. Auth.:** ORS 685.125
**Stats. Implemented:** ORS 685.030
**Proposed Adoptions:** Rules in 850-005, 850-030, 850-035, 850-040, 850-050, 850-060
**Proposed Renumberings:** 850-010-0175 to 850-005-0175, 850-010-0185 to 850-005-0185, 850-010-0010 to 850-030-0010, 850-010-0030 to 850-030-0030, 850-010-0035 to 850-030-0035, 850-010-0040 to 850-030-0040, 850-010-0055 to 850-030-0055, 850-010-0060 to 850-030-0060, 850-010-0070 to 850-030-0070, 850-010-0080 to 850-030-0080, 850-010-0090 to 850-030-0090, 850-010-0195 to 850-030-0195, 850-010-0230 to 850-035-0230, 850-010-0210 to 850-040-0210, 850-010-0110 to 850-050-0110, 850-010-0120 to 850-050-0120, 850-010-130 to 850-050-0130, 850-010-0140 to 850-050-0140, 850-010-0150 to 850-050-0140, 850-010-0190 to 850-050-0190, 850-010-0212 to 850-060-0212, 850-010-0215 to 850-060-0215, 850-010-0220 to 850-060-0220, 850-010-0225 to 850-060-0225, 850-010-0226 to 850-060-0226
**Last Date for Comment:** 10-25-05
**Summary:** Increase the divisions and renumber the rules to put in a more orderly manner.
**Rules Coordinator:** Anne Walsh
**Address:** Board of Naturopathic Examiners, 800 NE Oregon St. - Suite 407, Portland, OR 97232
**Telephone:** (971) 673-0193

**Board of Nursing**
**Chapter 851**

| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-17-05 | 9 a.m. | Portland State Office Bldg.<br>800 NE Oregon St.<br>Rm. 120-C<br>Portland, OR 97232 |

**Hearing Officer:** Marguerite Gutierrez, Board President
**Stat. Auth.:** ORS 678.021 & 678.040
**Stats. Implemented:** ORS 678.021 & 678.040
**Proposed Amendments:** 851-031-0006, 851-031-0045
**Last Date for Comment:** 11-15-05, 5 p.m.
**Summary:** These rules establish the standards for licensure of Registered Nurses and Licensed Practical Nurses. This rule amendment updates English language proficiency minimum standards for foreign nurses.
**Rules Coordinator:** KC Cotton
**Address:** Board of Nursing, 800 NE Oregon St. - Suite 465, Portland, OR 97232-2162
**Telephone:** (971) 673-0638

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-17-05 | 9 a.m. | 800 NE Oregon St.<br>Rm. 120-C<br>Portland, OR 97232 |

**Hearing Officer:** Marguerite Gutierrez, Board President
**Stat. Auth.:** ORS 678.117 & 183.745
**Stats. Implemented:** ORS 678.117
**Proposed Amendments:** 851-045-0025
**Last Date for Comment:** 11-15-05, 5 p.m.
**Summary:** These rules cover the standards and scope of practice for the Licensed Practical Nurse and Registered Nurse and also the imposition of civil penalties.

This rule amendment is to clarify the calculation of civil penalties imposed against licensees who continue to practice after their license has expired. Additionally, this amendment includes advance practice nursing impostors and the appropriate civil penalty for Certified Registered Nurse Anesthetists (CRNAs) who continue to practice with a current Oregon license, but without the requisite valid national certification.
**Rules Coordinator:** KC Cotton
**Address:** Board of Nursing, 800 NE Oregon St. - Suite 465, Portland, OR 97232-2162
**Telephone:** (971) 673-0638

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-17-05 | 9 a.m. | Portland State Office Bldg.<br>800 NE Oregon St.<br>Rm. 120-C<br>Portland, OR 97232 |

**Hearing Officer:** Marguerite Gutierrez, Board President
**Stat. Auth.:** ORS 678.440 & 678.444
**Stats. Implemented:** ORS 678.440 & 678.444
**Proposed Amendments:** 851-061-0090
**Last Date for Comment:** 11-15-05, 5 p.m.
**Summary:** These rules cover the standards for training programs for Nursing Assistants and Medication Aides. This rule amendment adds residential care facilities as possible clinical sites for medication aide training programs.
**Rules Coordinator:** KC Cotton
**Address:** Board of Nursing, 800 NE Oregon St. - Suite 465, Portland, OR 97232-2162
**Telephone:** (971) 673-0638

| Date: | Time: | Location: |
|---|---|---|
| 11-17-05 | 9 a.m. | Portland State Office Bldg.<br>800 NE Oregon St.<br>Rm. 120-C<br>Portland, OR 97232 |

**Hearing Officer:** Marguerite Gutierrez, Board President
**Stat. Auth.:** ORS 678.440 & 678.442
**Stats. Implemented:** ORS 678.442
**Proposed Amendments:** 851-062-0010
**Last Date for Comment:** 11-15-05
**Summary:** These rules cover the standards for certification of Nursing Assistants and Medication Aides. This rule amendment to the definitions of "monitoring" and "supervision" would help clarify the difference between working under monitoring in a community-based setting and working under supervision in a hospital or nursing home.
**Rules Coordinator:** KC Cotton
**Address:** Board of Nursing, 800 NE Oregon St. - Suite 465, Portland, OR 97232-2162
**Telephone:** (971) 673-0638

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| Date: | Time: | Location: |
|---|---|---|
| 11-17-05 | 9 a.m. | Portland State Office Bldg.<br>800 NE Oregon St.<br>Rm. 120-C<br>Portland, OR 97232 |

**Hearing Officer:** Marguerite Gutierrez, Board President
**Stat. Auth.:** ORS 678.385
**Stats. Implemented:** ORS 678.375, 678.385
**Proposed Amendments:** 851-050-0131
**Last Date for Comment:** 11-15-05, 5 p.m.
**Summary:** 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. This amendment adds the September, October and November 2005 updates to Drug Facts and Comparisons to the formulary, with specific drugs proposed for inclusion or deletion. The Board may also petition to add currently excluded drugs to the Nurse Practitioner Formulary.
**Rules Coordinator:** KC Cotton
**Address:** Board of Nursing, 800 NE Oregon St. - Suite 465, Portland, OR 97232-2162
**Telephone:** (971) 673-0638

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**Board of Optometry**
**Chapter 852**

| Date: | Time: | Location: |
|---|---|---|
| 12-2-05 | 1 p.m. | 2nd Flr. Conference Rm.<br>1900 Hines St. SE<br>Salem, OR 97302 |

**Hearing Officer:** John Reslock, O.D.
**Stat. Auth.:** ORS 182 & 683
**Stats. Implemented:** ORS 683.140 & 683.170
**Proposed Ren. & Amends:** Rules in 852-010 to 852-060
**Last Date for Comment:** 12-2-05
**Summary:** Rename division 852-060; Renumber rules in 852-010 to 852-060 because the content of the rules in division 10 more closely pertains to subject matter of division 60.

Amend the rules in 852-060 to reflect legislative changes.
**Rules Coordinator:** David W. Plunkett
**Address:** Board of Optometry, PO Box 13967, Salem, OR 97309
**Telephone:** (503) 399-0662, ext. 23

**Department of Administrative Services**
**Chapter 125**

**Stat. Auth.:** ORS 184.305, 184.340 & 279A.140; Other Auth.: Health Ins. Portability & Accountability Act of 1996 (42 USC 1320d-1320d-8, sec. 262 & 264), 45 CFR 164.314
**Stats. Implemented:** ORS 192.519 & 279A.140
**Proposed Amendments:** 125-055-0100, 125-055-0105, 125-055-0115, 125-055-0120, 125-055-0125, 125-055-0130
**Last Date for Comment:** 10-21-05, 5 p.m.
**Summary:** State agencies that are subject to the Health Insurance Portability and Accountability Act (HIPAA) requirements must, in some cases, utilize specific contractual terms if a business associate relationship will be present. DAS has adopted OAR 125-055-0100 to 125-055-0130 to implement those contract requirements for agencies that contract with a business associate. It is necessary to amend and file permanent rules to incorporate additional federal requirements in contracts involving business associates imposed by the HIPAA Security Rules, 45 CFR 164.314, that became effective on April 20, 2005.
**Rules Coordinator:** Kristin Keith
**Address:** Department of Administrative Services, 155 Cottage St. NE U90, Salem, OR 97301-3972
**Telephone:** (503) 378-2349, ext. 325

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**Stat. Auth.:** Uniform Electronic Transactions Act (UETA) & ORS 84.064; Other Auth.: 2001 HB 2112
**Stats. Implemented:** ORS 84, 84.049, 84.052, 84.055 & 84.064
**Proposed Adoptions:** 125-600-0005
**Last Date for Comment:** 10-21-05, 5 p.m.
**Summary:** The Department of Administrative Services is directed by ORS 84.064 to make determinations and adopt standards for state agencies to implement UETA. This rule addresses the electronic signature provisions of the act.
**Rules Coordinator:** Kristin Keith
**Address:** Department of Administrative Services, 155 Cottage St. NE U90, Salem, OR 97301-3972
**Telephone:** (503) 378-2349, ext. 325

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**Department of Agriculture,**
**Oregon Bartlett Pear Commission**
**Chapter 606**

| Date: | Time: | Location: |
|---|---|---|
| 10-25-05 | 10 a.m. | 4382 SE International Way<br>Suite A<br>Milwaukie, OR 97222-4635 |

**Hearing Officer:** Linda Bailey
**Stat. Auth.:** ORS 576.305(12) & 576.325
**Stats. Implemented:** ORS 576.305 & 576.325
**Proposed Amendments:** 606-010-0015
**Last Date for Comment:** 10-25-05, close of hearing
**Summary:** The Oregon Bartlett industry is reducing assessments through the state commission to zero, as all pear assessments are now collected through a federal marketing order. The federal marketing order is preferred as the pear industry in Oregon and Washington works together to collect assessments and market pears from the Northwest.
**Rules Coordinator:** Linda Bailey
**Address:** Department of Agriculture, Bartlett Pear Commission, 4382 SE International Way - Suite A, Milwaukie, OR 97222-4635
**Telephone:** (503) 652-9720

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**Department of Agriculture,**
**Oregon Strawberry Commission**
**Chapter 668**

**Stat. Auth.:** ORS 576.304(14); Other Auth.: OAR 668-030-0020
**Stats. Implemented:** ORS 576.206(4)

**Proposed Amendments:** 668-030-0020
**Last Date for Comment:** 11-4-05, 5 p.m.
**Summary:** The industry has been substantially reduced, consequently there is not a large enough pool of Handlers to attract more than one representative to sit on the commission. The proposed rule would reduce the required number of handlers from two to one.
**Rules Coordinator:** Rachel Denue
**Address:** 4845 B SW Dresden, Corvallis, OR 97333
**Telephone:** (541) 758-4043

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

| Date: | Time: | Location: |
|---|---|---|
| 10-18-05 | 9:30 a.m. | 1535 Edgewater St. NW<br>Salem, OR 97309 |

**Hearing Officer:** John W. Powell
**Stat. Auth.:** ORS 479.730
**Stats. Implemented:** ORS 479.730
**Proposed Amendments:** Rules in 918-305
**Last Date for Comment:** 10-21-05
**Summary:** This proposed rule clarifies construction requirements for SR-1 Occupancies, under the Oregon Electrical Specialty Code.
**Rules Coordinator:** Nicole M. Jantz
**Address:** Department of Consumer and Business Services, Building Codes Division, PO Box 14470, Salem, OR 97309
**Telephone:** (503) 373-7438

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

| Date: | Time: | Location: |
|---|---|---|
| 11-3-05 | 10 a.m. | CR E - 350 Winter St. NE<br>Salem, OR 97309 |

**Hearing Officer:** Pat Locnikar
**Stat. Auth.:** ORS 697.632 & 697.692; Other Auth.: 2005 OL Ch. 309
**Stats. Implemented:** ORS 697.632, 697.682, 697.692, 697.732 & 697.782
**Proposed Adoptions:** 441-910-0092, 441-910-0093
**Proposed Amendments:** 441-910-0000, 441-910-0010, 441-910-0020, 441-910-0030, 441-910-0040, 441-910-0050, 441-910-0080, 441-910-0090, 441-910-0095, 441-910-0110, 441-910-0120
**Proposed Repeals:** 441-910-0060, 441-910-0070, 441-910-0130
**Proposed Ren. & Amends:** 441-910-0100 to 441-910-0055
**Last Date for Comment:** 11-3-05
**Summary:** New rules are proposed to implement new fees authorized by the 2005 Legislature. Other changes are intended to update and clarify rules, and to repeal rules no longer deemed necessary.
**Rules Coordinator:** Berri Leslie
**Address:** Department of Consumer and Business Services, Finance and Corporate Securities, 350 Winter St. NE - Rm. 410, Salem, OR 97309
**Telephone:** (503) 947-7478

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**Department of Consumer and Business Services,**
**Insurance Division**
**Chapter 836**

| Date: | Time: | Location: |
|---|---|---|
| 10-27-05 | 2 p.m. | Conference Rm. E<br>Basement<br>350 Winter St. NE<br>Salem, OR |

**Hearing Officer:** Lewis Littlehales
**Stat. Auth.:** ORS 731.244, 744.077 & 744.650
**Stats. Implemented:** ORS 737.205, 742.009, 744.077, 744.650 & 746.015
**Proposed Adoptions:** 836-071-0263
**Proposed Amendments:** 836-071-0277
**Last Date for Comment:** 11-9-05
**Summary:** This rulemaking proposes to permanently adopt temporary rulemaking that established minimum terms of disclosure when an insurance consumer pays compensation to an insurance producer and the transaction is not subject to ORS 735.455, 744.091 or 744.093, or pays compensation to an insurance consultant who also receives other compensation.
**Rules Coordinator:** Sue Munson
**Address:** Department of Consumer and Business Services, Insurance Division, 350 Winter St. NE, Rm. 440, Salem, OR 97301
**Telephone:** (503) 947-7272

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

| Date: | Time: | Location: |
|---|---|---|
| 10-28-05 | 9:30 a.m. | WCB Salem Office<br>2601 25th St. SE<br>Ste. 150<br>Salem, OR 97302 |

**Hearing Officer:** Roger C. Pearson
**Stat. Auth.:** ORS 656.726(5)
**Stats. Implemented:** ORS 183, 656, House Bill 2294 (2005), ORS 656.267, 656.278, 656.283, 656.295 & 656.298
**Proposed Amendments:** 438-005-0005, 438-005-0011, 438-005-0050, 438-005-0053, 438-005-0055, 438-012-0001, 438-012-0018, 438-012-0020, 438-012-0030, 438-012-0035, 438-012-0036, 438-012-0037, 438-012-0050, 438-012-0055, 438-012-0060
**Proposed Repeals:** 438-012-0024, 438-012-0070, 438-012-0075, 438-012-0080, 438-012-0085, 438-012-0090, 438-012-0095, 438-012-0100
**Last Date for Comment:** 10-28-05
**Summary:** Repeal and amend Division 012 rules to implement House Bill 2294 (2005) (HB 2294), regarding the processing of "post-aggravation rights" new or omitted medical condition claims under ORS 656.267. Consistent with these changes, amends "Own Motion" claim processing for "worsened condition" and "post-aggravation rights" new or omitted medical condition claims, after disputed condition has "been determined to be compensable." Amends Division 005 rules by updating the period for timely issuance of responsibility denials under ORS 656.262, amending the Board's zip code in "notices," and amending references to renumbered statutes. Amends the "effective date" for both Division 005 and 012 rules to "January 1, 2006."
**Rules Coordinator:** Vicky Scott
**Address:** Department of Consumer and Business Services, Workers' Compensation Board, 2601 25th St. SE, Suite 150, Salem, OR 97302-1280
**Telephone:** (503) 378-3308

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**Department of Consumer and Business Services,**
**Workers' Compensation Division**
**Chapter 436**

| Date: | Time: | Location: |
|---|---|---|
| 11-1-05 | 10:30 a.m. | Rm. 260 (2nd Flr.,<br>Labor & Industries Bldg.)<br>350 Winter St. NE<br>Salem, OR |

**Hearing Officer:** Fred Bruyns
**Stat. Auth.:** ORS 656.726(4)
**Stats. Implemented:** ORS 656, primarily: ORS 656.704, Enrolled House Bill (HB) 2091 – Oregon Laws (OL) 2005, Ch. 26; ORS 656.268, Enrolled HB 2404 – OL 2005, Ch. 569; ORS 656.273, Enrolled HB 2405 – OL 2005, Ch. 50; ORS 656.726, Enrolled HB 2408 – OL 2005, Ch. 653; ORS 656.262, Enrolled HB 2718 – OL 2005, Ch. 189; Enrolled HB 3318 – OL 2005, Ch. 511; ORS 656.262, 656.313, 656.605, 656.622, Enrolled Senate Bill (SB) 119

– OL 2005, Ch. 588; ORS 656.268, 656.745, Enrolled SB 172 – OL 2005, Ch. 221; ORS 656.325, Enrolled SB 311 – OL 2005, Ch. 675; ORS 656.206, 656.268, 656.319, 656.605, 656.319, Enrolled SB 386 – OL 2005, Ch. 461; ORS 656.260, Enrolled SB 670 – OL 2005, Ch. 364

**Proposed Adoptions:** 436-055-0085, 436-060-0137, 436-060-0510, 436-120-0755

**Proposed Amendments:** Rules in 436-010, 436-060, 436-015-0008, 436-015-0030, 436-015-0040, 436-015-0070, 436-015-0080, 436-015-0110, 436-030-0002, 436-030-0003, 436-030-0005, 436-030-0007, 436-030-0009, 436-030-0015, 436-030-0020, 436-030-0023, 436-030-0034, 436-030-0055, 436-030-0065, 436-030-0115, 436-030-0155, 436-030-0165, 436-030-0175, 436-030-0185, 436-030-0575, 436-030-0580, 436-035-0005, 436-035-0007, 436-035-0008, 436-035-0009, 436-035-0011, 436-035-0012, 436-035-0016, 436-035-0017, 436-035-0019, 436-035-0110, 436-035-0190, 436-035-0230, 436-035-0330, 436-035-0340, 436-035-0350, 436-035-0360, 436-035-0380, 436-035-0390, 436-035-0395, 436-035-0400, 436-035-0410, 436-035-0420, 436-035-0430, 436-035-0500, 436-050-0003, 436-050-0008, 436-050-0100, 436-050-0110, 436-050-0170, 436-050-0220, 436-050-0230, 436-055-0070, 436-055-0100, 436-105-0003, 436-105-0500, 436-110-0002, 436-110-0005, 436-110-0310, 436-110-0326, 436-110-0327, 436-110-0335, 436-110-0337, 436-110-0345, 436-120-0003, 436-120-0008, 436-120-0320, 436-120-0900, 436-160-0003, 436-160-0005

**Last Date for Comment:** 11-7-05

**Summary:** Proposed amendment of workers' compensation rules affecting injured workers, employers, medical providers, insurers, and others.

Changes directly related to 2005 legislation are marked with asterisks *. Some changes apply only to injuries that occur on or after 1/1/2006. Proposed substantive amendments affect:

• *Hearings on workers' compensation matters currently processed by the Office of Administrative Hearings – moved to the Workers' Compensation Board, for all hearings held on or after January 2, 2006.

• *Independent medical examinations (IME)s – including a worker's right to contest the location of the exam and associated increase to 90 days for the insurer to accept or deny the claim if the worker prevails; penalty to worker for failure to attend; penalty to medical provider for failure to forward diagnostic records to the IME provider; requirement (effective 7/1/2006) for the director to develop a list of medical providers who are authorized to perform IMEs and for all IMEs to be scheduled with a physician on the list.

• *The reporting and processing of aggravation claims;

• Elective surgery notification;

• Types of care that are reimbursable after the worker becomes medically stationary (clarification only);

• *Requirements that managed care organizations submit copies of their treatment standards and protocols to the director for review and approval;

• Closure notice requirements in fatal claims;

• Reduced insurer reporting requirements for claims in which workers have no permanent impairment;

• *Permanent total disability – including limitations on benefits if the worker incurs a new injury; criteria for re-examination or reduction; required vocational evaluations and suspension of benefits for failure to attend or non-cooperation; appeals of termination; automatic eligibility for vocational assistance upon termination of permanent total disability (by final order);

• The reconsideration record – video recordings, duplicate records;

• *Penalties upon reconsideration – limitations;

• *Insurer data reporting necessary for the Workers' Compensation Division to assess the impact of legislative changes on permanent partial disability awards;

• *The effect of a regular work release on awards of work disability and social/vocational factors;

• Requirements to round percentages of impairment – hearing and vision no longer taken to the 100th of a percent;

• Rating of impairment for skin disorders – signs and symptoms need not be present upon examination;

• Insurer's notice to employer of policy cancellation to include a statement that the guaranty contract will terminate;

• Insurers' reporting of names or positions of key contacts to the Workers' Compensation Division;

• *The right of self-insured public utilities with assets in excess of $500 million to obtain excess workers' compensation insurance coverage from an eligible surplus lines insurer;

• *Required training for certified claims examiners on interactions with independent medical exam providers;

• Adjustments – up and down – of insurer claims processing compliance thresholds (affecting penalties);

• *The dollar amount employers can pay for medical services on non-disabling claims;

• *Requirement (effective 7/1/2006) that Worker Requested Medical Examinations be conducted by a medical provider on the list of authorized independent medical examination providers maintained by the director;

• Increase of certain maximum penalty amounts to the $2,000 statutory maximum;

• Eligibility for Preferred Worker Program benefits – workers must be authorized to work in the United States;

• *Reimbursement from the Workers' Benefit Fund of permanent total disability (PTD) payments made by the insurer during an appeal of termination of PTD – if the insurer prevails;

• For the purposes of reimbursement of wage subsidies under the Employer-at-Injury Program, allowance for supplemental documentation to clarify information not fully explained by the payroll record;

• *Provision for direct assistance to workers under ORS 656.622 to promote re-employment;

• *Reimbursement from the Workers' Benefit Fund of the insurer's vocational assistance costs incurred after the insurer appeals an administrative order to provide such assistance (if the insurer prevails);

• Deletion of the penalty matrix for three types of violations of the vocational assistance rules;

• Requirement that insurers submit the legal name of the employer (not a "doing business as" name, etc.), whether reporting by paper or electronically;

• Provision for the director to impose a civil penalty for violation of ORS chapter 656, in addition to violation of rules and orders of the director.

Address questions to: Fred Bruyns, Rules Coordinator; phone 503-947-7717; fax 503-947-7581; e-mail fred.h.bruyn@2state.or.us

Proposed rules are available on the Workers' Compensation Division's Web site: http://wcd.oregon.gov/policy/rules/rules.html#proprules or from WCD Publications, 503-947-7627 or fax 503-947-7630.

**Rules Coordinator:** Fred Bruyns

**Address:** Department of Consumer and Business Services, Workers' Compensation Division, 350 Winter St. NE, Salem, OR 97301-3879

**Telephone:** (503) 947-7717

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**Department of Energy**
**Chapter 330**

| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-1-05 | 2 p.m. | Oregon Dept. of Energy<br>625 Marion St. NE<br>Salem, OR |
| 12-1-05 | 2 p.m. | Oregon Dept. of Energy<br>625 Marion St. NE<br>Salem, OR |

**Hearing Officer:** Suzanne Dillard

**Stat. Auth.:** ORS 469.160 - 469.180

**Stats. Implemented:** ORS 469.160 - 469.180
**Proposed Amendments:** 330-070-0010 – 330-070-0097
**Last Date for Comment:** 12-7-05
**Summary:** The main purpose of this rulemaking is to address implementation of changes in the following areas:

**Solar:** • Implement Senate Bill 31 which increases the tax credit for solar photovoltaic systems under the Residential Energy Tax Credit. • Require solar contractors to be certified by the Oregon Department of Energy in order for customers to receive a solar tax credit under the Residential Energy Tax Credit program. • Revise solar space heating tax credit rules to differentiate between solar water heating based systems and passive solar space heating systems.

**Hybrid Vehicles:** • Modify rules to respond to the market introduction of new hybrid models.

**Tax-credit Certified Contractors:** • Clarify certification process for tax-credit contractors for solar, geothermal, duct and HVAC. • Better define process for the Oregon Department of Energy to revoke contractor certification.

**HVAC:** • Revise diagnostic process for heat pump and air conditioning systems installation and testing. • Revise eligibility criteria and upgrade specifications for heat pumps and air conditioning systems. • Limit number of qualified air conditioning systems, heat pumps and furnaces eligible per dwelling per calendar year.

**Appliances:** • Update eligibility standards for clothes washers. • Modify water heater qualifications.

**Wind:** • Clarify and update guidelines for the Residential Energy Tax Credit for wind systems.

**Housekeeping:** • Housekeeping changes will be considered including reformatting definitions for clarification and changing language to improve the application review process or other changes required to better meet the objectives of Oregon Revised Statute 469.160 through 180.

**Rules Coordinator:** Michael W. Grainey
**Address:** Department of Energy, 625 Marion St. NE, Salem, OR 97301-3737
**Telephone:** (503) 378-5489

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| Date: | Time: | Location: |
|---|---|---|
| 10-1-05 | 10 a.m. | Oregon Dept. of Energy<br>625 Marion St. NE<br>Salem, OR |
| 11-1-05 | 10 a.m. | Oregon Dept. of Energy<br>625 Marion St. NE<br>Salem, OR |

**Hearing Officer:** Suzanne Dillard
**Stat. Auth.:** ORS 469.185, 315.350 & 315.356
**Stats. Implemented:** ORS 469.185, 315.350 & 315.356
**Proposed Amendments:** 330-090-0105 – 330-090-0150
**Last Date for Comment:** 12-7-05
**Summary:** The main purpose of this rulemaking session is to address implementation of changes in the following areas:

**Hybrid Vehicles:** • Modify rules to take into account introduction of new hybrid models.

**Building Controls:** • Clarify rules to ensure energy efficiency in building controls.

**Boilers:** • Update eligibility for boilers based on current technology.

**Transportation:** • Establish cost-effectiveness criteria for transportation projects.• Clarify eligibility for transportation services projects. • Revise definitions of eligible commuter pool vehicles.

**Final Certification:** • Restore the intended meaning of the rule that a final certification transferred to pass-through partner may not be revoked. This will align the rule with ORS 315.345(4)(b). The word "not" was inadvertently omitted in the rules.

**Housekeeping:** Housekeeping changes will be considered including reformatting definitions for clarification and changing language to improve the application review process or other changes required to better meet the objectives of Oregon Revised Statute 469.185; 315.354; 315.356.

**Rules Coordinator:** Michael W. Grainey
**Address:** Department of Energy, 625 Marion St. NE, Salem, OR 97301-3737
**Telephone:** (503) 378-5489

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**Department of Fish and Wildlife**
**Chapter 635**

| Date: | Time: | Location: |
|---|---|---|
| 11-4-05 | 8 a.m. | Columbia Co. Fairgrounds<br>Pavilion Building<br>58892 Saulser Rd.<br>St. Helens, OR |

**Hearing Officer:** Fish & Wildlife Commission
**Stat. Auth.:** ORS 506.109, 506.119 & 506.129; Other Auth.: HB 3472
**Stats. Implemented:** ORS 508.760, 508.762 & 508.936
**Proposed Adoptions:** Rules in 635-005, 635-006
**Proposed Amendments:** Rules in 635-005, 635-006
**Proposed Repeals:** Rules in 635-005, 635-006
**Last Date for Comment:** 11-4-05
**Summary:** Adopt rules that may be necessary to implement new statutory provisions enacted with passage of House Bill 3472, an Act relating to commercial fishing. Specifically for the commercial Dungeness crab fishery, define "undue hardship" applicable to permit transfer waiver requests of boat length requirements. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
**Rules Coordinator:** Marci Wightman
**Address:** Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
**Telephone:** (503) 947-6034

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| Date: | Time: | Location: |
|---|---|---|
| 11-4-05 | 8 a.m. | Columbia Co. Fairgrounds<br>Pavilion Bldg.<br>58892 Saulser Rd.<br>St. Helens, OR |

**Hearing Officer:** Fish & Wildlife Commission
**Stat. Auth.:** ORS 506.036, 506.109, 506.119, 506.129 & 506.450 - 506.465
**Stats. Implemented:** ORS 506.036, 506.109, 506.119, 506.129 & 506.450 - 506.465
**Proposed Adoptions:** Rules in 635-005, 635-006
**Proposed Amendments:** Rules in 635-005, 635-006
**Proposed Repeals:** Rules in 635-005, 635-006
**Last Date for Comment:** 11-4-05
**Summary:** Remove bay clams from developmental fisheries species list and adopt rules establishing limited entry system for the commercial bay clam dive fishery. Housekeeping and technical corrections to the regulations may occur to ensure rule consistency.
**Rules Coordinator:** Marci Wightman
**Address:** Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
**Telephone:** (503) 947-6034

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| Date: | Time: | Location: |
|---|---|---|
| 11-4-05 | 8 a.m. | Columbia Co. Fairgrounds<br>Pavilion Bldg.<br>58892 Saulser Rd.<br>St. Helens, OR 97053 |

**Hearing Officer:** Fish & Wildlfe Commission
**Stat. Auth.:** ORS 496.012, 496.138, 496.146, 497.28, 497.308, 497.312, 497.318, 498.022, 498.029, 498.052, 498.222 & 498.242
**Stats. Implemented:** ORS 496.012, 496.138, 496.146, 497.28, 497.308, 497.312, 497.318, 498.022, 498.029, 498.052, 498.222 & 498.242

**Proposed Amendments:** Rules in 635-044
**Last Date for Comment:** 11-4-05
**Summary:** Rules will be amended to waive the testing requirements for licensed veterinarian to become a licensed rehabilitator.
**Rules Coordinator:** Marci Wightman
**Address:** Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
**Telephone:** (503) 947-6034

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| Date: | Time: | Location: |
|---|---|---|
| 11-4-05 | 8 a.m. | Columbia Co. Fairgrounds<br>Pavilion Bldg.<br>58892 Saulser Rd.<br>St. Helens, OR |

**Hearing Officer:** Fish & Wildlife Commission
**Stat. Auth.:** ORS 496.012, 496.138, 496.146 & 496.162
**Stats. Implemented:** ORS 496.171 - 496.192, 497.297, 497.308, 498.002, 498.006, 498.012, 498.026
**Proposed Amendments:** Rules in 635-110
**Last Date for Comment:** 11-4-05
**Summary:** Amend those portions of the Oregon Wolf Conservation and Management Plan that call for legislative action. This change would not alter the substance of the Plan adopted February 11, 2005. Instead, this change would simply move certain portions of the Plan (the proposals for legislative action, and references to those proposals) to an appendix. The purpose of moving these items to an appendix is to make clear that the 2005 Legislative Assembly did not act on these calls for legislative action (although the Fish and Wildlife commission continues to call for such action). Note: this rulemaking will deal only with this proposed amendment of the Plan (moving the legislative items to an appendix). This rulemaking will not consider changes to the substance of the Plan.
**Rules Coordinator:** Marci Wightman
**Address:** Department of Fish and Wildlife, 3406 Cherry Ave. NE, Salem, OR 97303
**Telephone:** (503) 947-6034

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**Department of Geology and Mineral Industries**
**Chapter 632**

| Date: | Time: | Location: |
|---|---|---|
| 11-3-05 | 10 a.m. | State Capitol - Rm. 167a<br>Salem, OR |

**Hearing Officer:** Gary Lynch
**Stat. Auth.:** ORS 517.740 & 517.840
**Stats. Implemented:** ORS 517.800 as amended by Enrolled HB 2120 (2005)
**Proposed Amendments:** 632-030-0022
**Last Date for Comment:** 11-10-05
**Summary:** Enrolled HB 2120 (2005) restructured the fees for permits under the Mineral Land Regulation and Reclamation Act. The proposed rule will amend OAR 632-030-0022 to make the rule consistent with these statutory amendments. The statute and proposed rule raise the application fee from $1,200 to $1,260 and change the annual fee to a formula with a base fee of $635 plus $.0075 per ton extracted.

The agency did not use an advisory committee because the statutory amendment is self-executing with respect to the proposed rule changes. Additional rule making will be initiated to implement the remaining portion of HB 2120 and an advisory committee will be appointed at that time.
**Rules Coordinator:** Gary W. Lynch
**Address:** Department of Geology and Mineral Industries, 229 Broadalbin St. SW, Albany, OR 97321
**Telephone:** (541) 967-2039, ext. 23

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**Department of Human Services,**
**Child Welfare Programs**
**Chapter 413**

| Date: | Time: | Location: |
|---|---|---|
| 10-25-05 | 8:30 a.m. | Rm. 257<br>500 Summer St. NE<br>Salem, OR |

**Hearing Officer:** Annette Tesch
**Stat. Auth.:** ORS 418.005
**Stats. Implemented:** ORS 418.005
**Proposed Repeals:** 413-080-0100, 413-080-0110, 413-080-0120, 413-080-0130, 413-080-0140, 413-080-0150
**Last Date for Comment:** 10-25-05
**Summary:** These Family Foster Care rules allow for the placement of children in relative homes which are not certified. This is in conflict with other administrative rule, policy and practice. Children in state custody need to be placed in certified homes.
**Rules Coordinator:** Annette Tesch
**Address:** Department of Human Services, Child Welfare Programs, 550 Summer St. NE, E48, Salem, OR 97301
**Telephone:** (503) 945-6067

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

| Date: | Time: | Location: |
|---|---|---|
| 10-17-05 | 10:30 a.m.–12 p.m. | Rm. 137 B<br>500 Summer St. NE<br>Salem, OR |

**Hearing Officer:** Darlene Nelson
**Stat. Auth.:** ORS 409.010 & 409.110
**Stats. Implemented:** ORS 414.065
**Proposed Amendments:** 410-141-0070
**Last Date for Comment:** 10-17-05, 12 p.m.
**Summary:** The Oregon Health Plan (OHP-Division 141) Administrative rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to clients. OMAP will amend 410-141-0070 to specify guidelines and standards for OMAP to "carve out" a prescription drug from capitation. The rule is also amended to include the drug Depakote, which was previously carved out in contract language and Lamictal. Both qualify as carved out drugs under the amended standards.
**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

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| Date: | Time: | Location: |
|---|---|---|
| 10-17-05 | 10:30 a.m.–12 p.m. | Rm. 137 B<br>500 Summer St. NE<br>Salem, OR |

**Hearing Officer:** Darlene Nelson
**Stat. Auth.:** ORS 409.010 & 409.110
**Stats. Implemented:** ORS 414.065
**Proposed Amendments:** 410-120-0000, 410-120-1200, 410-120-1210, 410-121-0147, 410-141-0000, 410-141-0060, 410-141-0070, 410-141-0080, 410-141-0120, 410-141-0160, 410-141-0220
**Last Date for Comment:** 10-17-05, 12 p.m.
**Summary:** The General Rules (Division 120), Pharmaceutical Services (Division 121) and Oregon Health Plan (OHP-Division 141) programs administrative rules govern the Office of Medical Assistance Programs' payment for services rendered to clients. The proposed amendments for Division 120, 121, and 141 administrative rules relate to changes in coverage based upon the Medicare Modernization Act (MMA) Part D Prescription coverage. MMA is a federal law creating new prescription drug benefits for Medicare eligi-

ble individuals. The new Medicare drug coverage to be effective January 1, 2006 effectively shifts prescription coverage that was previously covered under Medicaid to Medicare for fully dual eligible clients. OMAP will amend rules as follows: 410-120-0000 and 410-141-0000 to add definitions of fully dual eligible and Medicare Part D; 410-120-1200 to add exclusion of Medicare part D drugs and classes of drugs to the medical assistance programs' exclusions and limitations; 410-120-1210 to add the benefit package changes necessary under MMA Part D for the fully dual eligible clients; 410-141-0060 and 410-141-0120 to replace "Dual Eligible" with "Fully Dual Eligible" for consistency with other program rules; 410-141-0070 and 410-121-0147 to add Medicare part D covered drugs to the list of OMAP exclusions. OMAP will also amend these rules to take care of necessary housekeeping changes.
**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

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-17-05 | 10:30 a.m.–12 p.m. | Rm. 137 B<br>500 Summer St. NE<br>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:** 10-17-05, 12 p.m.
**Summary:** The Pharmaceutical Services program rules govern Office of Medical Assistance Programs' (OMAP) payments for pharmaceutical products and services provided to clients. OMAP will amend 410-121-0030 Practitioner Managed Prescription Drug Plan (Table 121-0030-1 Plan Drug List) as it relates to Alzheimer's Drugs, Beta-Blockers, Oral Hypoglycemics, Proton Pump Inhibitors, and Triptan Drugs.
**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

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-2-05 | 2 p.m. | 500 Summer St. NE<br>Rms. 137AB<br>Salem, OR |

**Hearing Officer:** Jana Fussell
**Stat. Auth.:** ORS 179.040, 409.010 & 409.050; Other Auth.: HB 3047 (2005 Legislative Session)
**Stats. Implemented:** ORS 179.040, 426.385, 427.031, 430.210, 430.735 & 430.765
**Proposed Ren. & Amends:** Rules in 309-116 to 410-011
**Last Date for Comment:** 11-2-05, 5 p.m.
**Summary:** Chapter 410, Division 11, Abuse of Individuals Living in State Hospitals and Residential Training Centers rules are proposed to incorporate the following changes permanently:

A. Adds definitions for Administrator, Department, Individual, Inconclusive, Not Substantiated and Substantiated.

B. Updates the rule to include statutory changes effective January 1, 2004 by adding neglect to the definition of abuse and requiring thorough and unbiased investigations.

C. Revises preliminary screening procedures for abuse and neglect reports received by the Superintendent to require notification of the Office of Investigations and Training (OIT) within two hours after receipt by the Superintendent. Revises procedure so that the Office of Investigations and Training makes the initial determination of whether the allegation meets the definition of abuse within 24-hours in consultation with the Superintendent.

D. Updates the rule to include current Department structure and designation for clusters Children, Adults and Families (CAF), Seniors and People with Disabilities (SPD) and Office of Mental Health and Addiction Services (OMHAS).

E. Establishes timeline and procedure of the abuse investigation report requiring completion in 30 calendar days, a special report format, review and consultation of the draft report by the Office of Investigations and Training and the Superintendent, a decision and recommendations to prevent further abuse and a final report by OIT within 15 calendar days.

F. Conforms release of completed abuse reports to Health Insurance Portability and Accountability Act (HIPAA) confidentiality requirements.

G. Provides that the Office of Investigations and Training may perform an investigation when law enforcement is conducting an investigation unless OIT is advised it will interfere with the criminal investigation.
**Rules Coordinator:** Christina Hartman
**Address:** Department of Human Services, 800 NE Oregon St., Suite 930, Portland, OR 97232
**Telephone:** (503) 731-4405

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**Stat. Auth.:** ORS 409.010 & 409.110
**Stats. Implemented:** ORS 414.065
**Proposed Amendments:** 410-121-0300
**Last Date for Comment:** 10-17-05, 12 p.m.
**Summary:** The Pharmaceutical Rules govern Office of Medical Assistance Programs' payment for pharmaceutical products provided to clients. OMAP will permanently amend 410-121-0300 to update Transmittal #37, with Title XIX State Agency Letter Number 05-004, dated June 21, 2005, changes to the list, effective for services rendered on or after July 21, 2005, to revise drug products information in compliance with federal regulations from Centers for Medicare and Medicaid Services (CMS).
**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

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**Stat. Auth.:** ORS 409.010 & 409.110
**Stats. Implemented:** ORS 414.065
**Proposed Amendments:** 410-121-0157
**Last Date for Comment:** 10-17-05, 12 p.m.
**Summary:** The Pharmaceutical Services program rules govern Office of Medical Assistance Programs' (OMAP) payments for services provided to clients. OMAP will amend rule 410-121-0157 to reference the updated information regarding participating pharmaceutical companies to the Medicaid Drug Rebate Program, in compliance with federal regulations. Releases and updates are included to ensure a 24-month time period for billing is covered, using the appropriate effective dates in all Releases. The most current changes include information from CMS Release #137 (dated May 13, 2005) and #138 (dated August 5, 2005), and the OMAP Master Pharmaceutical Rebate Lists, updated June 23, 2005 and August 19, 2005.
**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**

| Date: | Time: | Location: |
|---|---|---|
| 10-10-05 | 1 p.m. | Portland State Office Bldg.<br>Rm. 918<br>800 NE Oregon St.<br>Portland, OR |
| 10-26-05 | 1 p.m. | Portland State Office Bldg.<br>Rm. 918<br>800 NE Oregon St.<br>Portland, OR |

**Hearing Officer:** Jana Fussell
**Stat. Auth.:** ORS 291.003, 431.110, 431.250 & 409.600; Other Auth.: 7 CFR 246.12, Public Law 108-265
**Stats. Implemented:** ORS 409.600
**Proposed Amendments:** 333-054-0000, 333-054-0010, 333-054-0020, 333-054-0030, 333-054-0040, 333-054-0050, 333-054-0060, 333-054-0070
**Proposed Repeals:** 333-054-0010(T), 333-054-0020(T), 333-054-0030(T), 333-054-0050(T), 333-054-0060(T), 333-054-0100(T)
**Last Date for Comment:** 10-26-05, 5 p.m.
**Summary:** The United States Department of Agriculture recently handed down new requirements mandating that Women, Infants and Children (WIC) state programs implement certain provisions regarding authorized WIC vendors. The rule changes focus on:

• Requiring all vendors to maintain and provide documentation of food sales for the duration of the agreement period;
• Identifying stores that derive more than 50% of their food sales from WIC food sales as “MT 50’s”;
• Allowing “MT50’s” to only offer incentive items to shoppers if they were obtained at no cost to the vendor.
• Not allowing “MT50’s” to offer delivery service to shoppers.
• Notifying all vendors of the first violation of a sanction that requires a pattern before documenting any other violations unless notification would jeopardize the investigation;
• Allowing vendors, other than “MT 50’s” limited delivery service to shoppers;
• Requiring all vendors to purchase infant formula from a state authorized infant formula provider;
• Requiring all vendors to maintain and provide documentation of formula purchases for the duration of the agreement period; and
• Changing the monetary calculations for state implemented sanctions requiring a civil money penalty in lieu of disqualification.
• Allowing abbreviated, as well as, full administrative reviews for certain adverse actions taken by DHS against WIC vendors.

**Rules Coordinator:** Christina Hartman
**Address:** Department of Human Services, Public Health, 800 NE Oregon St., Suite 930, Portland, OR 97232
**Telephone:** (503) 731-4405

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| Date: | Time: | Location: |
|---|---|---|
| 10-28-05 | 3 p.m. | Portland State Office Bldg.<br>800 NE Oregon St., Suite 140<br>Portland, OR 97232-2162 |
| 11-1-05 | 11 a.m. | City Council Chamber<br>City of Eugene<br>777 Pearl St.<br>Eugene, OR 97407 |

**Hearing Officer:** Jana Fussell
**Stat. Auth.:** ORS 475.309(2) & 475.338
**Stats. Implemented:** ORS 475.300 - 475.346
**Proposed Amendments:** 333-008-0020
**Last Date for Comment:** 11-1-05, 5 p.m.
**Summary:** Proposes a change in fee structure for applications and renewals for the Oregon Medical Marijuana 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

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**Department of Justice**
**Chapter 137**

| Date: | Time: | Location: |
|---|---|---|
| 10-18-05 | 3 p.m. | 800 NE Oregon St.<br>Portland, OR 97232-2162 |

**Hearing Officer:** Ross Laybourn
**Stat. Auth.:** ORS 128.876
**Stats. Implemented:** ORS 128.670(7)
**Proposed Amendments:** 137-010-0030
**Last Date for Comment:** 10-31-05
**Summary:** The proposed rule change would fully implement ORS 128.670(7) which requires collection of a fee in conjunction with the filing of an annual charitable corporation or trust report. If adopted, this change will require the payment of a $10 fee by organizations filing a Form CT-12 only.
**Rules Coordinator:** Carol Riches
**Address:** Department of Justice, 1162 Court St. NE, Salem, OR 97301
**Telephone:** (503) 947-4096

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**Department of Oregon State Police,**
**Office of State Fire Marshal**
**Chapter 837**

| Date: | Time: | Location: |
|---|---|---|
| 10-27-05 | 10 a.m. | 4760 Portland Rd. NE<br>Mt. Hood Rm.<br>Salem, OR |

**Hearing Officer:** John Caul
**Stat. Auth.:** ORS 476.033 & 480.410 - 480.460
**Stats. Implemented:** ORS 476.033 & 480.410 - 480.460
**Proposed Adoptions:** 837-030-0235
**Proposed Amendments:** 837-030-0120, 837-030-0130, 837-030-0190, 837-030-0200, 837-030-0280
**Last Date for Comment:** 10-27-05, 5 p.m.
**Summary:** OAR 837-030-0120 has added a new definition, for Company License and types of fitter licenses.

OAR 837-030-0130 was amended to clean up punctuation and update the referenced Oregon Fire Code and edition year.

OAR 837-030-0190 was amended to correct section (4) subsections and punctuation, add some clarifying language to section (7), and add a new section (9) and (12) failing an examination.

OAR 837-030-0200 was amended to add clarifying language to section (6).

OAR 837-030-0235 is to implement a plan review fee of $100 for certain storage tanks and clarify ORS 480.450 subsection (2).

OAR 837-030-0280 was amended to add a new subsection (1)(d) and renumber accordingly.

**Rules Coordinator:** Pat Carroll
**Address:** Oregon State Police, Office of State Fire Marshal, 4760 Portland Rd. NE, Salem, OR 97305
**Telephone:** (503) 373-1540, ext. 276

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**Stat. Auth.:** ORS 476.030 & 480.010 - 480.290
**Stats. Implemented:** ORS 480.010 - 480.290
**Proposed Amendments:** 837-012-1230
**Last Date for Comment:** 10-21-05
**Summary:** To rescind the explosive fee increases from the 2003-2005 biennium, due to the fees not being ratified by the 2005 Legislature.
**Rules Coordinator:** Pat Carroll
**Address:** Oregon State Police, Office of State Fire Marshal, 4760 Portland Rd. NE, Salem, OR 97305
**Telephone:** (503) 373-1540, ext. 276

**Department of State Lands**
**Chapter 141**

| Date: | Time: | Location: |
|---|---|---|
| 10-19-05 | 10 a.m.–12 p.m. | Land Board Rm.<br>Dept. of State Lands<br>Salem, OR |

**Hearing Officer:** Jeff Kroft
**Stat. Auth.:** ORS 36.224
**Stats. Implemented:** ORS 36.220 - 36.238, 183.335(5), 673.410 & SB 311 (Chapter 253, OL 2003)
**Proposed Adoptions:** 141-001-0020
**Proposed Amendments:** 141-001-0000, 141-001-0005
**Last Date for Comment:** 11-1-05
**Summary:** The Department of State Lands occasionally conducts mediation to resolve a contested case related to a Removal Fill enforcement action. These rules will replace the temporary rules that were filed prior to mediation earlier this year. The temporary rules expire on November 15, 2005. Adoption of this rule is necessary to allow for the confidential mediation of which the Department of State Lands is a party. Without such a rule the agency would have limited ability to conduct candid, confidential settlement negotiations in mediation. Mediation has the potential for resolving lawsuits less expensively than a jury trial and for achieving more satisfactory outcomes. 141-001-0020 contains the text of the Attorney General's model "Combined Rule—Confidentiality and Inadmissibility of Mediation Communications."

SB 311 (Chapter 253 Oregon Laws 2003), enacted during the 2003 session, changed the name of the Division of State Lands to the Department of State Lands (DSL)

The draft proposed rules will be available on the Department's website, www.oregonstatelands.us, on or about October 1, 2005.
**Rules Coordinator:** Nicole Kielsmeier
**Address:** Department of State Lands, 775 Summer St. NE, Salem, OR 97301-1279
**Telephone:** (503) 378-3805, ext. 239

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

**Stat. Auth.:** ORS 184.616, 184.619, 802.010, 807.050, 807.110, 807.150, 807.160, 807.390, 807.400 & 813.110
**Stats. Implemented:** ORS 802.010, 807.110, 807.160, 807.220, 807.230, 807.280, 807.390, 807.400, 809.310, 809.320, 813.100 & 813.110
**Proposed Amendments:** 735-062-0030, 735-062-0105, 735-062-0110, 735-062-0115, 735-062-0120, 735-062-0135, 735-070-0010
**Last Date for Comment:** 10-21-05
**Summary:** Section 1, Chapter 59, Oregon Laws 2005 (HB 2106) amends ORS 807.160 to require the department to establish by administrative rule the reasons for issuing a replacement driver license, driver permit or identification card. DMV is amending OAR 735-062-0110 to set forth the reasons a replacement driver license, driver permit or identification card may be issued by DMV. Section 4 of HB 2106 amends ORS 807.390 to authorize waiver of a fee for replacement of a driver permit under the circumstances described. DMV is also amending OAR 735-062-0105, which describes fee waiver requirements, to implement these statutory amendments.

OAR 735-062-0030, 735-062-0105, 735-062-0115, 735-062-0120, 735-062-0135 and 735-070-0010 are amended to remove references to "duplicate." The term is deleted by amended ORS 807.160, and, therefore, is no longer relevant to these rules.

Because the legislative change went into effect May 18, 2005, DMV filed temporary amendments to these rules in June of 2005, with the intent of later amending the rules permanently. DMV now proposes to permanently amend the rules.

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

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**Stat. Auth.:** ORS 183.430, 184.616, 184.619, 802.010, 802.030, 802.031, 802.370, 803.530, 803.600, 803.625, 821.060, 821.080 & 822.005 - 822.080
**Stats. Implemented:** ORS 183.430, 802.031, 803.565, 803.600, 803.602, 823.645, 821.060, 821.080 & 822.005 - 822.080
**Proposed Adoptions:** 735-150-0033
**Proposed Amendments:** 735-150-0010, 735-150-0040, 735-150-0050, 735-150-0055, 735-150-0110, 735-150-0120, 735-150-0130, 735-150-0140
**Last Date for Comment:** 10-21-05
**Summary:** OAR Chapter 735, Division 150, establishes procedures and requirements for the administration and enforcement of laws relating to the regulation of Oregon vehicle dealers. DMV is proposing to update Division 150 rules to bring them into compliance with statutory changes made during the 2005 Legislative Session. An explanation of legislative changes and proposed DMV rule changes is included.

Many Oregon consumers choose to purchase vehicles directly from motor vehicle brokers to avoid the work of locating a vehicle and negotiating the best sales price. For consumer protection purposes, the legislature amended ORS 822.047 to specify the responsibilities of a dealer who is providing brokerage services. Oregon Laws 2005, chapter 190 (HB 2740). DMV proposes to amend OAR 735-150-0010, OAR 735-150-0110, 735-150-0120, 735-150-0130 and OAR 735-150-0140 to conform its rules to these legislative amendments. Specifically, adding new definitions, sanctions and changing civil penalty and sanction schedules.

Current law requires a vehicle dealer to obtain a supplemental certificate if the dealer opens an additional place of business or uses a vehicle as part of an advertisement at a location other than the dealer's principal place of business. The fee for a supplemental certificate is $230 per location. Some dealers display vehicles for sale at retail stores and shopping malls strictly for purposes of advertisement - vehicles are not sold at the display site. A customer interested in purchasing a display vehicle is referred to the dealer whose vehicle is on display. Chapter 133, Oregon Laws 2005 (HB 3089), clarifies that the display of vehicles for purposes of advertising is permitted without obtaining a supplemental dealer certificate. In addition, the law change authorizes DMV to adopt rules to establish display requirements. Accordingly, DMV is proposing to adopt OAR 735-150-0033, and to amend OAR 735-150-0110 and OAR 735-150-0140 to establish the requirements for the display of vehicles for purposes of advertising and to change the schedule of violation penalties to include a violation of display requirements.

Sections 1 & 2, chapter 375, Oregon Laws 2005 (SB 997) amends ORS 802.033 which authorizes DMV to adopt rules to limit the fee amounts that a licensed vehicle dealer may charge to prepare title and registration documents on behalf of a buyer or lessee. DMV proposes to amend ORS 735-150-0055 to limit the dealer service fee to a maximum of $75, if the dealer submits title and registration information to DMV using an integrator - a third party independent contractor facilitating the electronic submission of title and registration paperwork between a dealer and DMV – or a maximum of $50 if the dealer does not use an integrator and prepares hardcopy title and registration documents submitted to DMV. DMV also proposes to amend OAR 735-150-0040 and 735-150-0050 to clarify the responsibility of dealers who, as DMV's agent, collect and submit fees on behalf of DMV.

The rule changes also update terms and definitions consistent with the legislative amendments and make other non-substantive changes to simplify rule language.

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

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**Department of Veterans' Affairs**
**Chapter 274**

**Stat. Auth.:** ORS 183, 406.030 & 407; Other Auth.: Article XI-A OR Const.
**Stats. Implemented:** ORS 407.115, 407.125, 407.169, 407.177, 407.179, 407.225, 407.275 & 407.335
**Proposed Amendments:** 274-020-0345, 274-020-0348, 274-020-0380, 274-025-0070, 274-028-0015, 274-045-0080, 274-045-0090, 274-045-0280, 274-045-0431
**Last Date for Comment:** 10-21-05
**Summary:** For the purposes of clarification, references to the Federal National Mortgage Association (FNMA) and the FNMA Selling Guide are being replaced with more specific text which identifies the criteria and industry standards used by the Agency in its Home Loan Programs.
**Rules Coordinator:** Herbert D. Riley
**Address:** Department of Veterans' Affairs, 700 Summer St. NE, Salem, OR 97301-1285
**Telephone:** (503) 373-2055

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**Economic and Community Development Department**
**Chapter 123**

**Stat. Auth.:** ORS 285A.075(5), 285A.110(1), 285C.503(3) & 285C.506(4)&(6)
**Stats. Implemented:** ORS 285C.500 - 285C.506, 316.778 & 317.391 (2003), OL 2005 Ch. 595, Sec. (1)-(3)
**Proposed Adoptions:** Rules in 123-155
**Proposed Amendments:** Rules in 123-155
**Last Date for Comment:** 11-4-05
**Summary:** These rules revise and update specification of procedures and criteria for implementing a certification program to approve businesses for an income and corporate excise taxable income exemption, especially with respect to amendments by chapter 374, Oregon Laws 2003.
**Rules Coordinator:** Paulina Bernard
**Address:** Economic and Community Development Department, 775 Summer St. NE, Suite 200, Salem, OR 97301-1280
**Telephone:** (503) 986-0036

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**Oregon Department of Education**
**Chapter 581**

| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-18-05 | 3 p.m. | Public Service Bldg.<br>255 Capitol St. NE<br>Rm. 251-A<br>Salem, OR |

**Hearing Officer:** Staff
**Stat. Auth.:** ORS 337.050
**Stats. Implemented:** ORS 337.050
**Proposed Adoptions:** 581-011-0210
**Last Date for Comment:** 10-18-05
**Summary:** Adoption of instructional materials as specified in ORS 337.050 is done through the administrative rule making process. The adoption of OAR 581-011-0210 will add to the reference list programs in the Arts in the following categories: (1) Visual Art Education Grades K-5/6, (2) Visual Art Education Grades 6-8, (3) Music Education Grades K-5/6, (4) Music Education Grades 6-8, (5) Visual/Performing Arts Grades 9-12.

For a copy of these rules, please contact Debby Ryan at (503) 378-3600, ext. 2348 or e-mail debby.ryan@state.or.us. If you would like further information about these rules, please contact Randy Harnisch at (503) 378-3600, ext. 2348 or e-mail randy.harnish@state.or.us
**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

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**Oregon Liquor Control Commission**
**Chapter 845**

| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-26-05 | 10 a.m.–12 p.m. | 9079 SE McLoughlin Blvd.<br>Portland, OR 97222 |

**Hearing Officer:** Katie Hilton
**Stat. Auth.:** ORS 471, 471.030, 471.040 & 471.730(1)&(5)
**Stats. Implemented:** ORS 471.030, 471.430, 471.040, 471.115, 471.360, 471.410, 471.412 & 471.730(1)
**Proposed Amendments:** 845-006-0430
**Last Date for Comment:** 11-9-05
**Summary:** This rule sets minimum standards to help licensees manage large public events, ensuring that minors and visibly intoxicated persons do not get or consume alcohol.

The Commission has received a petition requesting that section (6) of the rule be amended. This section of the rule sets standards and limits for container size and serving or sample tasting size for alcoholic beverages served at large public events regulated by this rule. The rule currently allows distilled spirits to be served in a cup no larger than 9 ounces. The petition requests that we amend the rule to allow distilled spirits to be served in a cup no smaller than 9 ounces.

The Commission initiated action to consider changing the maximum container size in (6)(a)(C)(ii) to either 12 or 16 ounces.
**Rules Coordinator:** Katie Hilton
**Address:** Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222-7355
**Telephone:** (503) 872-5004

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 11-17-05 | 10 a.m.–12 p.m. | 9079 SE McLoughlin Blvd.<br>Portland, OR 97222 |

**Hearing Officer:** Katie Hilton
**Stat. Auth.:** ORS 471, 471.030, 471.040 & 471.730(1)&(5)
**Stats. Implemented:** ORS 471.313 & 471.315
**Proposed Amendments:** 845-006-0301
**Last Date for Comment:** 12-1-05
**Summary:** This rule describes precisely who the Commission considers to be an applicant or licensee, depending on the type of ownership structure. New rule language will specifically address licensee responsibilities in licensing and violation proceedings.
**Rules Coordinator:** Katie Hilton
**Address:** Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222-7355
**Telephone:** (503) 872-5004

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| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-27-05 | 10 a.m.–12 p.m. | 9079 SE McLoughlin Blvd.<br>Portland, OR 97222 |

**Hearing Officer:** Katie Hilton
**Stat. Auth.:** ORS 471, 471.030 & 471.730(1)&(5)
**Stats. Implemented:** ORS 192.440(3)
**Proposed Amendments:** 845-004-0020
**Last Date for Comment:** 11-10-05
**Summary:** This rule describes various fees for products and services the Commission provides. House Bill 2545 limits the types of records and review for which the agency may charge a fee, and limits such fee to $25 unless the public body first provides the requester with a written notification of the estimated amount of the fee and the requester confirms that they want the public body to proceed with making the record available. We need to make changes to this rule to reflect new statutory language arising from HB 2545.
**Rules Coordinator:** Katie Hilton

**Address:** Oregon Liquor Control Commission, 9079 SE McLoughlin Blvd., Portland, OR 97222-7355
**Telephone:** (503) 872-5004

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**Oregon Public Employees Retirement System**
**Chapter 459**

| Date: | Time: | Location: |
|---|---|---|
| 10-25-05 | 2 p.m. | Boardroom<br>PERS Headquarters<br>11410 SW 68th Pkwy.<br>Tigard, OR |

**Hearing Officer:** David K. Martin
**Stat. Auth.:** ORS 238.650
**Stats. Implemented:**
**Proposed Amendments:** 459-020-0025
**Last Date for Comment:** 11-1-05
**Summary:** OAR 459-020-0025, which describes the penalty for employers that fail to timely submit reports, remittances of contributions, or remittances of administrative expense related to social security reporting, must be amended to be consistent with penalty provisions of OAR 459-070-0100 and 459-070-0110.

Copies of the proposed rules are available to any person upon request. The rules are also available at www.pers.state.or.us. Public comment may be mailed to the above address or sent via email to David.Martin@state.or.us
**Rules Coordinator:** David K. Martin
**Address:** Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281-3700
**Telephone:** (503) 603-7713

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| Date: | Time: | Location: |
|---|---|---|
| 10-25-05 | 2 p.m. | Boardroom<br>PERS Headquarters<br>11410 SW 68th Pkwy.<br>Tigard, OR |

**Hearing Officer:** David K. Martin
**Stat. Auth.:** ORS 238.650
**Stats. Implemented:** ORS 238.015, 243.800 & 353.250
**Proposed Amendments:** 459-010-0003, 459-010-0014
**Last Date for Comment:** 11-28-05
**Summary:** Modifications to OAR 459-010-0003 and 459-010-0014 are necessary to articulate the administration and the granting of membership eligibility and creditable service.

Copies of the proposed rules are available to any person upon request. The rules are also available at www.pers.state.or.us. Public comment may be mailed to the above address or sent via email to David.Martin@state.or.us
**Rules Coordinator:** David K. Martin
**Address:** Oregon Public Employees Retirement System, PO Box 23700, Tigard, OR 97281-3700
**Telephone:** (503) 603-7713

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**Oregon State Lottery**
**Chapter 177**

**Stat. Auth.:** OR Const., Art. XV, §4(4) & ORS 461
**Stats. Implemented:** ORS 461.300
**Proposed Amendments:** 177-040-0017
**Last Date for Comment:** 10-31-05
**Summary:** The proposed amendment removes the requirement that an applicant for a video lottery retailer contract establish the viability of the business by operating continuously for nine months prior to entering into a Lottery retailer contract.
**Rules Coordinator:** Mark W. Hohlt
**Address:** Oregon State Lottery, 500 Airport Rd. SE, Salem, OR 97301
**Telephone:** (503) 540-1417

**Oregon State Treasury**
**Chapter 170**

**Stat. Auth.:** ORS 295.105
**Stats. Implemented:** ORS 295.105
**Proposed Adoptions:** 170-030-0055
**Last Date for Comment:** 10-24-05
**Summary:** Rule outlines procedures for Oregon State Treasury and affected Oregon public officials in the event an Oregon depository is closed by the Comptroller of the Currency or the Director of the Department of Consumer and Business Services.
**Rules Coordinator:** Sally Furze
**Address:** Oregon State Treasury, 350 Winter St. NE , Suite 100, Salem, OR 97301
**Telephone:** (503) 378-4990

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**Oregon Wine Board**
**Chapter 619**

**Stat. Auth.:** ORS 576.766(1)
**Stats. Implemented:** ORS 576.768(2)(b)
**Proposed Adoptions:** 619-001-0010, 619-001-0020, 619-001-0030, 619-001-0040, 619-001-0050, 619-001-0060
**Last Date for Comment:** 10-21-05
**Summary:** The proposed rules describe the procedural requirements for creating additional rules, drafting an annual budget, and drafting an annual plan.
**Rules Coordinator:** Tara Anderson
**Address:** Oregon Wine Board, 1200 NW Naito Parkway, Suite 400, Portland, OR 97209
**Telephone:** (503) 228-8336

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**Oregon Youth Authority**
**Chapter 416**

**Stat. Auth.:** ORS 420A.025
**Stats. Implemented:** ORS 137.076, 161.325 & 416C.473
**Proposed Amendments:** 416-465-0000, 416-465-0010, 416-465-0030
**Last Date for Comment:** 10-20-05
**Summary:** OAR 416-465-0000 will have a new purpose statement; OAR 416-465-0010 will have definitions reformatted and ‘offender’ clarified; OAR 416-465-0030 process shall change to will and (b) deleted. 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 97301-3765
**Telephone:** (503) 378-3864

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**Public Utility Commission**
**Chapter 860**

| Date: | Time: | Location: |
|---|---|---|
| 10-19-05 | 9:30 a.m. | Public Utility Commission<br>Small Hearing Rm.<br>550 Capitol St. NE<br>Salem, OR |

**Hearing Officer:** Kathryn Logan
**Stat. Auth.:** ORS 183, 756 & 759
**Stats. Implemented:** ORS 290, OL 2005 (Senate Bill 983)
**Proposed Adoptions:** 860-021-0550, 860-034-0275
**Last Date for Comment:** 10-24-05
**Summary:** These rules implement Senate Bill 983, which was passed by the 2005 Oregon Legislative Assembly and signed by the Governor on June 9, 2005. The rules prohibit the termination of local exchange residential telephone service if the termination would significantly endanger a customer, or a member of the customer’s household, who is at risk of domestic violence or abuse. The rules

require the customer to submit to the telecommunications utility an affidavit and a copy of a court order that restrains another person from contact with the customer or member of the customer's household. The rules do not excuse the at risk customer from paying for telecommunications service; the qualifying customer is entitled by the rules to enter into a reasonable payment agreement with the utility if overdue balances exist.
**Rules Coordinator:** Diane Davis
**Address:** Public Utility Commission of Oregon, 550 Capitol St. NE, Suite 215, Salem, OR 97301-2551
**Telephone:** (503) 378-4372

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| Date: | Time: | Location: |
|---|---|---|
| 10-26-05 | 1:30 p.m. | Public Utility Commission<br>Small Hearing Rm.<br>550 Capitol St. NE, 2nd Flr.<br>Salem, OR |

**Hearing Officer:** Michael Grant
**Stat. Auth.:** ORS 183, 756 & 757; Other Auth.: Energy Policy Act of 2005, Sec. 1252 (Smart Metering)
**Stats. Implemented:** ORS 756.040, 757.250 & 757.760
**Proposed Amendments:** 860-021-0120, 860-021-0405
**Last Date for Comment:** 10-26-05
**Summary:** Advanced metering and communication technologies allow energy utilities to read their customers' meters at frequent intervals - each hour, for example, rather than simply once a month. Additionally, advanced metering and communication technologies provide the option for automated disconnection and reconnection of service, without a visit to the customer's site. To facilitate the use of these technologies, the Commission proposes to amend its rules related to meter readings and bill forms. To specify the manner in which energy utilities must provide a final notice to customers for pending disconnection once these technologies are utilized, the Commission proposes to amend its rules related to notice of pending disconnection of service.
**Rules Coordinator:** Diane Davis
**Address:** Public Utility Commission of Oregon, 550 Capitol St. NE, Suite 215, Salem, OR 97301-2551
**Telephone:** (503) 378-4372

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**Stat. Auth.:** ORS 756.036
**Stats. Implemented:** ORS 756.036 & 279A.050
**Proposed Adoptions:** 860-011-0036
**Last Date for Comment:** 10-24-05
**Summary:** The Commission has statutory authority to contract for experts and for technical or other professional services as it may require for the discharge of its duties. The Public Contracting Code implemented March 1, 2005, requires that agencies with statutory authority must adopt either the Department of Administrative Services (DAS) Purchasing Rules or the Attorney General Model Rules. The Commission has been operating under and following the DAS procedures. Staff's proposed rule specifies that the Commission adopts DAS Purchasing Rules with two exceptions. The exceptions allow the Commission to revise the DAS contract forms and to approve contracts as they relate to personal services.
**Rules Coordinator:** Diane Davis
**Address:** Public Utility Commission of Oregon, 550 Capitol St. NE, Suite 215, Salem, OR 97301-2551
**Telephone:** (503) 378-4372

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## Secretary of State, Corporation Division Chapter 160

| Date: | Time: | Location: |
|---|---|---|
| 10-26-05 | 8 a.m. | Corporation Division<br>Conference Rm.<br>Salem, OR |

**Hearing Officer:** Kristine T. Hume
**Stat. Auth.:** ORS 194.335
**Stats. Implemented:** ORS 194.031
**Proposed Adoptions:** 160-100-0170
**Last Date for Comment:** 10-26-05
**Summary:** The rule sets forth the requirements for applying for a concurrent, duplicate official notary public seal. It requires the notary to declare the circumstances that would otherwise hinder or prevent carrying out notarial duties in more than one location. It limits the notary to one concurrent seal kept in a single location. It applies all other requirements of the official seal to the concurrent, duplicate seal.
**Rules Coordinator:** Kristine T. Hume
**Address:** Secretary of State, Corporation Division, 255 Capitol St. NE, Suite 151, Salem, OR 97310
**Telephone:** (503) 986-2356

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**Stat. Auth.:** ORS 58.187
**Stats. Implemented:** ORS 58.185 & 58.187
**Proposed Amendments:** 160-010-0400
**Last Date for Comment:** 10-28-05
**Summary:** As directed by ORS Ch. 58.187, this rule adjusts the dollar limit on joint and several liability of professional corporations for the effects of inflation.
**Rules Coordinator:** Kristine T. Hume
**Address:** Secretary of State, Corporation Division, 255 Capitol St. NE, Suite 151, Salem, OR 97310
**Telephone:** (503) 986-2356

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## Secretary of State, Elections Division Chapter 165

| Date: | Time: | Location: |
|---|---|---|
| 10-27-05 | 9–9:30 a.m. | 900 Court St.<br>Rm. 257<br>Salem, OR 97310 |

**Hearing Officer:** Brenda Bayes
**Stat. Auth.:** ORS 246.150, 254.465 & 254.470
**Stats. Implemented:** ORS 247 & 254
**Proposed Adoptions:** 165-007-0280
**Last Date for Comment:** 10-27-05, 5 p.m.
**Summary:** This proposed rule adopts notification and translation requirements for county clerks who choose to prepare and make available an official ballot translated into Spanish for any election.
**Rules Coordinator:** Brenda Bayes
**Address:** Secretary of State, Elections Division, 141 State Capitol, Salem, OR 97310-0722
**Telephone:** (503) 986-1518

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| Date: | Time: | Location: |
|---|---|---|
| 10-27-05 | 9–9:30 a.m. | 900 Court St.<br>Rm. 257<br>Salem, OR 97310 |

**Hearing Officer:** Brenda Bayes
**Stat. Auth.:** ORS 246.150, 250.215, 250.315 & 255.175
**Stats. Implemented:** ORS 250.215, 250.315 & 255.175
**Proposed Amendments:** 165-014-0110
**Last Date for Comment:** 10-27-05, 5 p.m.
**Summary:** The proposed rule amendment for OAR 165-014-0110 would incorporate into the Appendix for statistical sampling procedures for local petitions an accounting for triplicate signatures. Additionally to avoid confusion with the appendix for statistical sampling procedures for state petitions the local petition Appendix is now designated as Appendix 2.
**Rules Coordinator:** Brenda Bayes
**Address:** Secretary of State, Elections Division, 141 State Capitol, Salem, OR 97310-0722
**Telephone:** (503) 986-1518

**Teacher Standards and Practices Commission**
**Chapter 584**

| **Date:** | **Time:** | **Location:** |
|---|---|---|
| 10-14-05 | 3 p.m. | TSPC Conf. Rm.<br>Salem, OR |

**Hearing Officer:** Victoria Chamberlain
**Stat. Auth.:** ORS 342.165
**Stats. Implemented:** ORS 342.125, 342.127, 342.223 & 181.539
**Proposed Amendments:** 584-036-0055, 584-038-0004, 584-040-0005, 584-100-0046
**Proposed Repeals:** 584-017-0110, 584-060-0011, 584-060-0021
**Last Date for Comment:** 10-14-05, 5 p.m.
**Summary:** AMEND: 584-036-0055 *Fees*: Amends the administrative rule governing fees and incorporates the following fee increases due to finger printing cost increases with the Oregon State Police. Amends current finger print fees from $42 to $62. Amends charter school registration fees from $50 to $75, fingerprint fees inclusive.

584-038-0004 *Adding Endorsements to a Basic or Standard License*: Allows TSPC to add middle-level endorsements onto Basic and Standard Teaching Licenses to assist educators to meet the federal definitions of “highly qualified teacher” under the federal No Child Left Behind Act.

584-040-0005 *Standard Teaching License Requirements*: Amends definition of acceptable Master’s degree to make consistent with acceptable master’s degree allowed for Initial and Continuing Teaching licenses.

584-100-0046 *Preliminary Teaching Licenses*: Amends when candidates are eligible to receive Preliminary Teaching Licenses. Previously they were limited to new hires into federal No Child Left Behind Act Title I funded positions. Amendments expand the access to the license to all teachers who otherwise qualify as being highly qualified, but do not immediately qualify for the Initial Teaching License.

REPEAL: 584-017-0110 *Early Childhood Authorization*: Should have been repealed when OAR 584-017-0115 was adopted in January, 2005. It was an oversight not to repeal at that time.

584-060-0011 *Initial Teaching License*: Should have been repealed effective July 1, 2005. It was an oversight not to repeal at that time.

584-060-0021 *Continuing Teaching License*: Should have been repealed effective July 1, 2005. It was an oversight not to repeal at that time.

**Rules Coordinator:** Victoria Chamberlain
**Address:** Teacher Standards and Practices Commission, 465 Commercial St. NE, Salem, OR 97301
**Telephone:** (503) 378-6813

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**Veterinary Medical Examining Board**
**Chapter 875**

**Stat. Auth.:** ORS 686.210
**Stats. Implemented:** ORS 686.020, 686.045 & 686.075
**Proposed Adoptions:** 875-005-0005, 875-010-0000, 875-010-0021, 875-010-0026
**Proposed Amendments:** 875-010-0030, 875-030-0010, 875-030-0020, 875-030-0025
**Last Date for Comment:** 10-21-05
**Summary:** These amendments are needed to update standards in conformance with current practices.
**Rules Coordinator:** Lori V. Makinen
**Address:** Veterinary Medical Examining Board, 800 NE Oregon St. #21, Suite 407, Portland, OR 97232
**Telephone:** (971) 673-0224

**Board of Architect Examiners**
**Chapter 806**

**Adm. Order No.:** BAE 4-2005
**Filed with Sec. of State:** 8-29-2005
**Certified to be Effective:** 8-30-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 806-010-0075, 806-010-0078
**Subject:** Rule amendment elaborates on with whom the agreement or contract may be between for providing architectural services.
**Rules Coordinator:** Carol Halford—(503) 763-0662

**806-010-0075**
**The Practice of Architecture**

(1) The "Practice of Architecture" is defined in ORS 671.010(6) and relates to the professional activities of the registered architect. These activities include all analysis, calculations, research, graphic presentation, literary expression, and advice essential to the preparation of necessary documents for the design and construction of buildings, structures and their related environment whether interior or exterior.

(2) With the exception of the setting described in ORS 671.030(g) and OAR 806-010-0078, the primary contract or agreement to provide architectural services for an architectural project must be between the architect or firm providing architectural services and the person or entity for which architectural services are provided (see also direct control and supervision as defined in OAR 806-010-0045).

Stat. Auth.: ORS 670 & 671
Stats. Implemented: ORS 671.010
Hist.: AE 5, f. 12-22-64; AE 1-1979, f. 5-31-79, ef. 6-1-79; AE 1-1984, f. & ef. 8-22-84; BAE 4-2005, f. 8-29-05, cert. ef. 8-30-05

**806-010-0078**
**Construction Contractor Offering Architectural Services**

(1) For purposes of this rule, the following definitions apply:

(a) "Offering services" means manifesting a willingness to provide services, either orally or in writing, such that another person may reasonably believe that their assent to the services is invited and will establish an agreement.

(b) "Appurtenant" services are those services that relate to the construction trade, which include constructing, altering, repairing, or improving real estate.

(2) The architect and firm registration requirements of ORS 671.010 to 671.220 do not prevent a construction contractor from offering services constituting the practice of architecture when all of the following conditions are met:

(a) The construction contractor holds an active license under ORS Chapter 701;

(b) The services offered by the construction contractor, constituting the practice of architecture, are appurtenant to construction services to be provided by the contractor;

(c) The services constituting the practice of architecture are performed by an architect or architects registered under ORS 671.010 to 671.220; and

(d) The offer by the construction contractor discloses in writing that the contractor is not an architect and identifies the registered architect or architects that will perform the services constituting the practice of architecture.

(3) For the purposes of meeting the requirements of OAR 806-010-0075(2), the primary contract or agreement to provide architectural services for such an architectural project may be between the general contractor and the architect or firm providing architectural services.

(4) An architect performing or identified as an architect that will perform the services constituting the practice of architecture as provided in subsection (2) of this rule must notify the Board, in writing, within thirty (30) days if, after the contractor is retained by the owner, the architect ceases to provide the architectural services identified in the offer by the construction contractor.

(5) Construction contractors who violate any portion of this rule may be practicing architecture or using the architect title in violation of ORS 671.020. As such, the contractor may be subject, under ORS 671.220, to sanctions and civil penalties of up to $5,000 per violation.

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.020, 671.030, 671.100 & 671.220
Hist.: BAE 6-2002, f. 8-14-02 cert. ef. 8-15-02; BAE 4-2005, f. 8-29-05, cert. ef. 8-30-05

**Adm. Order No.:** BAE 5-2005
**Filed with Sec. of State:** 8-29-2005
**Certified to be Effective:** 8-30-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 806-010-0080, 806-010-0110
**Subject:** Rule amendment outlines the parameters for using a number in a firm name.
**Rules Coordinator:** Carol Halford—(503) 763-0662

**806-010-0080**
**Architectural Firms**

(1) As used in this rule and OAR 806-010-0105 (Schedule of Actual Fees), architectural firm is defined as any firm that provides architectural services in the state of Oregon including:

(a) Corporations (refer to OAR 806-010-0110 for specific rules relating to corporate or assumed business names);

(b) Partnerships;

(c) Limited liability companies;

(d) Individuals practicing under an assumed business name (refer to OAR 806-010-0110 for specific rules relating to corporate or assumed business names).

(2) Prior to practicing architecture in this state, an architectural firm must apply for and obtain registration with the Board.

(3) An architectural firm must be identified as being engaged in the practice of architecture. If the firm name uses the plural form of "architect," the firm must have more than one architect registered in any NCARB recognized jurisdiction associated with the firm as a principal, partner, or employee.

(4) An architectural firm name may contain numbers, as long as the firm name is not misleading to the public (i.e., "Three Oregon Architects" must have three architects registered in Oregon).

(5) Additional requirements for registration are as follows:

(a) Corporations: At least 2/3 of the Board of Directors must be architects or engineers registered in any NCARB recognized jurisdiction. At least 1/3 of the Board of Directors must be registered as architects in any NCARB recognized jurisdiction. At least one director of the corporation must be an Oregon registered architect and make architectural decisions and sign/stamp all plans on Oregon architectural projects. If a corporation was in continuous existence since September 29, 1991, and at least 51% of the corporation is owned by an Oregon registered architect or engineer, the corporation is exempt from typical ownership requirements, but must still meet all other firm name requirements.

(b) Partnerships: At least 2/3 of the partners must be architects or engineers registered in any NCARB recognized jurisdiction and represent at least 2/3 ownership interest in the partnership. At least 1/3 of the partners must be registered as architects in any NCARB recognized jurisdiction. At least one partner must be an Oregon registered architect and make architectural decisions and sign/stamp all plans on Oregon architectural projects.

(c) Limited Liability Companies (LLC): At least 2/3 of the members of an LLC must be architects or engineers registered in any NCARB recognized jurisdiction and represent at least 2/3 ownership interest in the LLC. At least 1/3 of the members must be registered as architects in any NCARB recognized jurisdiction. At least one member of the LLC must be an Oregon registered architect and make architectural decisions and sign/stamp all plans on Oregon architectural projects.

(6) Application for registration of an architectural firm, whose existence required registration with the state in which it was formed, must include a certificate of existence, not more than 60 days old, from the Secretary of State of the state in which the architectural firm was formed.

(7) Upon receipt of an application with the supporting documentation and proof of compliance with the firm registration and name requirements and upon receipt of the registration fee, the Board will issue a certificate of registration which will remain in effect until January 31st of the year following the date initial certification is granted (See Schedule of Actual Fees, OAR 806-010-0105(5)).

(8) On or before January 31st of each year, an architectural firm shall submit an application for annual renewal accompanied by the renewal fee (See Schedule of Actual Fees, OAR 806-010-0105). The renewal application shall list:

(a) The names and addresses of all directors, members, or partners in the firm.

(b) Whether the directors, members, or partners are registered or licensed architects or engineers; and

(c) The jurisdictions in which the directors, members, or partners are registered or licensed.

(9) An architectural firm may renew firm registration not later than 30 days after the renewal deadline without penalty, upon submission of the renewal application and payment of the renewal fee.

(a) An architectural firm may renew firm registration between 31 and 60 days after the renewal deadline, upon submission of the renewal application, payment of the renewal fee, plus a penalty equal to the amount of the renewal fee.

(b) On the 61st day following the renewal deadline, the architectural firm who fails to pay the renewal fee plus the penalty shall forfeit the firm registration and shall not practice architecture under the firm name.

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.041
Hist.: AE 11, f. 2-15-74, ef. 3-11-74; AE 16(Temp), f. & ef. 5-17-77; AE 17, f. & ef. 9-22-77; AE 2-1978, f. & ef. 2-6-78; AE 1-1979, f. 5-31-79, ef. 6-1-79; 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 2-1998, f. & cert. ef. 6-22-98; BAE 3-2000, f. & cert. ef. 7-24-00; BAE 4-2001, f. & cert. ef. 10-4-01; BAE 1-2002, f. & cert. ef. 4-30-02; BAE 3-2003, f. & cert. ef. 4-11-03; BAE 5-2004, f. & cert. ef. 5-5-04; BAE 5-2005, f. 8-29-05, cert. ef. 8-30-05

**806-010-0110**
**Corporate/Assumed Business Names**

(1) Architects practicing under an "assumed" or a "corporate" name must file such name annually with the Board as part of their firm renewal application process. Such filing shall include any changes to the names of all stockholders of the corporation or all principals or partners of the firm or partnership.

(2) A name is considered to be "assumed" when it is other than the real and true name of each person conducting business in this state or having an interest therein (e.g., J. L. Smith; Smith, Smith and Jones; Architectonics and the like).

(3) When wording is used in a corporate or assumed business name to suggest the existence of additional principals, directors, partners or associates, the reference must be to existing persons currently within the firm, corporation, limited liability company, or partnership.

(a) Wording which suggests the existence of additional principals within the meaning of this rule includes "Associated," "Group," "& Associates," "Partners" and the like.

(b) Use of such wording requires at least one architect and at least two design-related professionals associated with the firm as principals, partners, or employees in order to be registered by the Board as a firm allowed to provide architectural services.

(4) The corporate or assumed business name must identify the corporation, firm or partnership as being engaged in the practice of architecture (e.g., "Architects," "An Architectural P.C.," "Architecture and Planning" and the like).

(5) The corporate or assumed business name may not include the surname of any person not presently or previously associated in the practice of architecture or engineering in any jurisdiction recognized by NCARB with the named entity or its members or predecessors.

(6) An architectural firm, corporation (professional or general); limited liability company; or partnership may not use the position or title "Principal" or "Partner" unless the title refers to a person who has a financial interest in the entity.

(7) An architectural firm may use the plural form of architect in the firm name only if the firm has more than one architect, actively registered in any state or territory of the United States or Canadian Province, associated with the firm as principals, partners, or employees; and at least one of the architects is actively registered in Oregon under ORS 671.010 to 671.220.

(8) An architectural firm name may contain numbers as long as the firm name is not misleading to the public (i.e., "Three Oregon Architects" must have three architects registered in Oregon).

Stat. Auth.: ORS 671.125
Stats. Implemented: ORS 671.041
Hist.: AE 1-1984, f. & ef. 8-22-84; AE 1-1987, f. & ef. 3-30-87; 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 6-2001, f. & cert. ef. 10-24-01; BAE 8-2002, f. & cert. ef. 10-8-02; BAE 3-2003, f. & cert. ef. 4-11-03; BAE 5-2005, f. 8-29-05, cert. ef. 8-30-05

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## Board of Clinical Social Workers
## Chapter 877

**Adm. Order No.:** BCSW 1-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 10-1-05 thru 3-30-06
**Notice Publication Date:**
**Rules Amended:** 877-020-0020, 877-020-0030, 877-020-0046, 877-025-0005, 877-035-0015
**Subject:** These Rule changes implement a modification in the annual licensure renewal process from a December 31 deadline to a process based on the licensee's birth month. The changes also incorporate a slight fee increase for the annual renewal of Licenses and Certificates, and a decrease in the annual renewal fee for Inactive Licenses.

It is necessary to implement these changes on October 1, 2005 for all new applicants after that date and in preparation for the annual licensure renewal process which starts the first week of November, 2005.

**Rules Coordinator:** Jon F. Langenwalter—(503) 378-5735, ext. 34

**877-020-0020**
**Fees for Associate Certification and Licensing**

The Board shall collect the following fees for application, certification, licensing, annual renewal of Certificates and Licenses, and delinquent renewal fees. Applicants for licensing shall pay a fee for the written examination to the organization that administers the examination.

(1) The application fee for Certificates and Licenses shall be $100.

(2) The fee for initial certification as a Clinical Social Work Associate shall be determined based on an annual fee of $48, prorated for the length of time of the first Certificate.

(3) The fee for annual renewal of the Associate Certificate shall be $60. For renewals filed and accepted by the Board from October 1, 2005 to March 31, 2006, the fee for this Certificate shall be prorated based on the renewal period being for other than one year.

(4) The fee for initial licensing as a Licensed Clinical Social Worker shall be determined based on an annual fee of $66, prorated for the length of time of the first License.

(5) The fee for annual renewal of a License shall be $90. For renewals filed and accepted by the Board from October 1, 2005 to March 31, 2006, the fee for this License shall be prorated based on the renewal period being for other than one year.

(6) The annual renewal fee for Inactive status shall be $48.00. If a person returns to Active status they shall pay the prorated difference between the Inactive and Active renewal fees.

(7) The Board may impose a delinquent renewal fee of $50 for Certificates and Licenses renewed after January 1, 2006 and prior to March 31, 2006.

(8) After April 1, 2006, the Board may impose a delinquent renewal fee of $50 for each renewal that is not filed with and accepted by the Board by the last day of the licensee's birth month.

(9) All fees under ORS 675.510 through 675.600 and OAR chapter 877 are non-refundable.

Stat. Auth.: ORS 675.510 - 675.600 & 675.990
Stats. Implemented: ORS 675.571
Hist.: BCSW 1-1982, f. & ef. 1-29-82; BCSW 1-1986, f. & ef. 7-7-86; BCSW 1-1988, f. & cert. ef. 11-15-88; BCSW 2-1990, f. & cert. ef. 7-13-90; BCSW 2-1993, f. & cert. ef. 10-13-93; BCSW 1-1995, f. 6-26-95, cert. ef. 7-1-95; BCSW 2-1999(Temp), f. & cert. ef. 7-1-99 thru 11-1-99; BCSW 3-1999, f. & cert. ef. 10-13-99; BCSW 1-2003(Temp), f. 5-15-03, cert. ef. 7-1-03 thru 12-28-03; BCSW 2-2003, f. 11-21-03, cert. ef. 12-1-03; BCSW 1-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-30-06

**877-020-0030**
**Renewal of Certificate and License**

(1) Clinical Social Work Associates who have completed a Plan of Supervision must renew their Certificate until licensed under OAR 877-020-0015. Renewal of a Certificate of Clinical Social Work Associate may be obtained:

(a) Upon payment of the appropriate fee.

(b) All evaluation reports are current with the dates of the approved Plan.

(2) Renewal of a License may be obtained:

(a) Upon payment of the appropriate fee and submission of a sworn statement by the licensee, on a form provided by the Board, that the licensee has been actively engaged in clinical social work during the licensing period and that there exists no reason for denial of the renewal.

(b) The Board shall require evidence of continuing education as a requirement for renewal of License in order to ensure the highest quality of professional services to the public.

(3) Prior to April 1, 2006, if a License or Certificate holder has not completed the renewal process by March 31, 2006, the License or Certificate is lapsed and reapplication is necessary.

(4) After April 1, 2006, if a License or Certificate holder has not completed the renewal process within 30 days of the last day of the licensee's

birth month, the license or Certificate is lapsed and re-application is necessary.

Stat. Auth.: ORS 675.510 - 675.600, 675.900 & 675.990
Stats. Implemented: ORS 675.560
Hist.: BCSW 1-1982, f. & ef. 1-29-82; BCSW 1-1986, f. & ef. 7-7-86; BCSW 1-1987, f. & ef. 12-29-87; BCSW 2-1991, f. & cert. ef. 5-30-91; BCSW 2-1993, f. & cert. ef. 10-13-93; BCSW 1-1997, f. & cert. ef. 3-25-97; BCSW 1-2001, f. & cert. ef. 5-4-01; BCSW 1-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-30-06

**877-020-0046**
**Inactive Status for Licensees**

(1) Inactive status describes a Licensed Clinical Social Worker who does not practice clinical social work for an extended period of time. Licensed Clinical Social Workers who qualify for Inactive status may be:

(a) Retired;

(b) On maternity leave;

(c) On military duty and not in clinical practice;

(d) Suffering from a major illness and not working;

(e) On sabbatical from active clinical social work practice.

(f) Not practicing clinical social work in the State of Oregon.

(2) Licensed Clinical Social Workers who have attained Inactive status may retain their License without fulfilling the annual continuing education requirement. At the time of License renewal, a Licensed Clinical Social Worker may request Inactive status by submitting the fee and a signed statement on a prescribed form declaring that he/she will not use the title of Licensed Clinical Social Worker for that Licensed Clinical Social Worker's renewal period. This statement must be submitted annually with each renewal for the period of the Inactive status.

(3) A Licensed Clinical Social Worker on Inactive status must comply with all provisions under ORS 675.510 et. seq. and OAR chapter 877, except ORS 675.567 and OAR 877-025-0000.

Stat. Auth.: ORS 675.510 - 675.600 & 675.900
Stats. Implemented: ORS 675.510 - 675.600 & 675.900
Hist.: BCSW 2-1993, f. & cert. ef. 10-13-93; BCSW 1-1997, f. & cert. ef. 3-25-97; BCSW 1-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-30-06

**877-025-0005**
**Reports and Enforcement**

With each annual renewal, Licensed Clinical Social Workers shall certify to the Board that they are engaged in continuing education activities.

(1) Continuing education hours shall be reported every two years except as otherwise required by the Board. Licensed Clinical Social Workers whose Licenses end in an even number shall file their continuing education report with their renewal application in each year ending in an even number. Licensed Clinical Social Workers whose Licenses end in an odd number shall file their continuing education report with their renewal application in each year ending in an odd number. The Continuing Education report shall be filed on a form prescribed by the Board.

(2) The accrual and reporting of continuing education requirements will begin with the first renewal period after initial licensure.

(3) In the reporting year, the Continuing Education report is considered part of the renewal of license and is due with the renewal application. Each report form shall contain the number of continuing education hours received and the identity of the credentialing body.

(4) The Board may allow credit for continuing education activities provided or approved by mental health professional bodies recognized and approved by the Board. Activities may include conferences, seminars, or workshops either in-person or by web cast. The Board accepts pre-approved, proctored, and post-tested video or audio tapes as formal continuing education. Social work courses or their equivalent offered by an accredited college or university are also acceptable.

(5) The Board may allow up to 10 hours of credit per reporting period for continuing education activities not approved by a mental health professional body. The activities must be clinical in nature and relevant to the licensee's social work practice. The licensee must apply for Board acceptance at least 90 days prior to renewal of their License in the continuing education reporting year. Application for approval shall include date(s) of the event, title of the event (and a brief description of the course), name and credentials of the presenter(s), number of continuing education units requested, and a copy of the Certificate of Completion.

(6) If a Licensed Clinical Social Worker reports fewer than the required number of continuing education hours the Board may deny renewal until the deficiency is corrected.

(7) Licensed Clinical Social Workers shall maintain attendance certificates for use in completing biannual reports and shall retain these certificates for a period of 36 months. The Board may audit continuing education reports.

(8) A licensee may carry over up to a maximum of 10 formal hours of continuing education from one reporting period to the next reporting period.

(9) Study groups are authorized for up to 20 continuing education hours per reporting period. A study group is defined as having at least five Licensed mental health professionals who meet for a minimum of an hour on a scheduled basis to discuss topics directly related to the field of Clinical Social Work. Such groups shall focus on a presentation or discussion about a book or article from a professional publication. The topics must be directly related to established mental health care, and should be something that would likely be presented in an accredited social work program as relevant to good practice. Up to two hours of continuing education are authorized per group meeting and preparation time cannot be counted. Names of group members and topics discussed must be submitted upon request for continuing education verification. Plans for such study groups shall be submitted to the Board for pre-approval.

(10) For those Licensed Clinical Social Workers who develop and present Board-approved continuing education training, workshops, or seminars, the Board may grant a one-time continuing education credit in recognition of the licensee's efforts.

(11) The Board will accept continuing education credits from accredited colleges and universities without specifically identifying the continuing education as graduate level or equivalent. Continuing education credits earned from community or junior colleges will not be accepted as equivalent unless outside accreditation from a Board recognized credentialing body took place.

(12) Falsification of continuing education reports may be grounds for disciplinary proceedings.

Stat. Auth.: ORS 675.510 - 675.600 & 675.900
Stats. Implemented: ORS 675.560(4)
Hist.: BCSW 2-1982, f. & ef. 10-11-82; BCSW 1-1986, f. & ef. 7-7-86; BCSW 1-1988, f. & cert. ef. 11-15-88; BCSW 1-1990, f. & cert. ef. 4-20-90; BCSW 2-1993, f. & cert. ef. 10-13-93; BCSW 1-1999, f. & cert. ef. 4-9-99; BCSW 1-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-30-06

**877-035-0015**
**Procedure for Evaluation of Competency**

(1) On its own motion or upon complaint by any person the Board may require any person licensed under ORS 675.510 et seq. to undergo evaluation and/or rehabilitative therapy for impairment as defined above.

(2) The Board of Clinical Social Workers may impose one or more of the disciplinary penalties designated in ORS 675.540(2) against any social worker found to be an impaired social worker who:

(a) Refuses to cooperate with an evaluation ordered by the Board.

(b) Refuses to enter a rehabilitation program or ongoing monitoring recognized by the Board.

(c) Fails to sign a release allowing the Board to fully communicate with the rehabilitation program regarding the clinical social worker's progress or lack thereof.

(d) Fails to complete a rehabilitation program or ongoing monitoring recognized by the Board.

(e) Is found by the Board not to be capable of rehabilitation because of the severity of his or her impairment.

(3) The evaluation will be performed by a drug and evaluation center or professional of the Board's choosing. The evaluator shall have access to all material regarding the Clinical Social Work Associate or Licensed Clinical Social Worker in the Board's files and will have additional authority to contact all persons who have previously communicated to the Board regarding the alleged impaired status of the Clinical Social Work Associate or Licensed Clinical Social Worker.

Stat. Auth.: ORS 675.510 - 675.600 & 675.900
Stats. Implemented: ORS 675.510 - 675.600 & 675.900
Hist.: BCSW 1-1990, f. & cert. ef. 4-20-90; BCSW 2-1991, f. & cert. ef. 5-30-91; BCSW 1-1997, f. & cert. ef. 3-25-97; BCSW 1-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-30-06

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## Board of Examiners for Speech Pathology and Audiology
## Chapter 335

**Adm. Order No.:** SPA 1-2005
**Filed with Sec. of State:** 9-13-2005
**Certified to be Effective:** 9-13-05
**Notice Publication Date:** 8-1-05
**Rules Adopted:** 335-095-0055
**Rules Amended:** 335-005-0025, 335-060-0010, 335-060-0060, 335-070-0040, 335-070-0060, 335-070-0080, 335-070-0085
**Rules Repealed:** 335-095-0020

**Subject:** Rule 335-095-0055 is a new rule outlining the process for a speech-language pathologist licensed by the Teachers Standards and Practices Commission to apply for and gain permission to supervise speech-language pathology assistants in schools.

Amended rule 335-005-0025(11)(c) eliminates the requirement for audiology licensees to submit records of hours worked at various business locations at the time of licensure renewal.

Amended rule 335-060-0010 outlines new fees for applications, delinquency fees, audiology and speech-language pathology licenses.

Amended rule 335-060-0060 outlines the procedure for applicants that do not have a social security number.

Amended rule 335-070-0040 restricts professional development credit for a particular activity to only once during a licensing period even if a licensee repeats the activity.

Other amended rules in division 70 attempt to clarify the professional development reporting requirements for new licensees and deletes outdated requirements.

Repealed rule in division 95 removes outdated text.

**Rules Coordinator:** Brenda Felber—(971) 673-0220

**335-005-0025**
**Accurate Representation**

(1) Individuals shall not misrepresent their credentials, competence, education, training, or experience.

(2) Individuals shall not misrepresent the credentials of assistants and shall inform those they serve professionally of the name and professional credentials of persons providing services.

(3) Individuals shall not transfer to a noncertified individual any responsibility which requires the unique skills, knowledge, and judgement that is within the scope of practice of that professional.

(4) Individuals shall not misrepresent diagnostic information, services rendered, or products dispensed or engage in any scheme or artifice to defraud in connection with obtaining payment or reimbursement for such services or products.

(5) Individuals' statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, and about professional services.

(6) Individuals' statements to the public advertising, announcing, and marketing their professional services, reporting research results, and promoting products shall adhere to prevailing professional standards and shall not contain misrepresentations.

(7) Individuals shall not engage in any scheme or enter into any arrangement whereby clients are referred to or from any person or business entity in return for any remuneration of any kind, including referrals back to the person or business entity.

(8) Individuals shall not engage in dishonesty, fraud, misrepresentation, or any form of conduct that adversely reflects on the individual's fitness to serve persons professionally.

(9) Individuals' statements to colleagues about professional services, research results, and products shall contain no misrepresentations.

(10) At any time the licensee is disciplined or convicted of a crime, the licensee shall immediately report the incident to the Board.

(11) Audiology licensees may not consult with, contract with, or be employed by a business that dispenses hearing aids if the business holds itself out as having an audiologist on staff or providing audiology services unless audiology licensees provide audiological services as follows:

(a) The licensee, in combination with other audiology licensees or alone, performs audiology evaluations or hearing fitting services or both at each of the business locations that is advertised as having an audiologist on staff or providing audiology services;

(b) The licensee, or the licensee and other licensees, are physically present for at least 30 hours per month at each of the business locations that is advertised as having an audiologist on staff or providing audiology services; and

(c) The licensee keeps a record of the hours he or she spends at each of the business locations that is advertised as having an audiologist on staff or providing audiology services.

(12) Except as described in section 13 of this rule, a licensee shall not sign, or authorize anyone else to sign on the licensee's behalf, letters or reports purporting to describe the function or condition of any person unless the licensee has personally performed testing of the person.

(13) If support personnel or a student in supervised practicum provide services, the name of the assistant or the student and a description of duties performed must be clearly referenced in any formal documents (e.g. letters, treatment plans, reports) signed by the licensee.

Stat. Auth.: ORS 681
Stats. Implemented: ORS 681.330
Hist.: SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2004, f. & cert. ef. 2-6-04; SPA 2-2004, f. & cert. ef. 5-26-04; SPA 1-2005, f. & cert. ef. 9-13-05

**335-060-0010**
**Fees**

In accordance with the provisions of ORS 681.340 and 681.360, the following fees, where applicable, are payable to the Board/Health Division by check or money order:

(1) All Applicants except those listed in (1) (d):

(a) Application fee shall be $40, non-refundable.

(b) Delinquent fee shall be $50.

(c) The Board may provide for waiver of the license or certificate fee where the license or certificate is issued less than 45 days before the date on which it will expire.

(d) Speech-language pathologists applying for permission to supervise speech-language pathology assistants in schools shall pay an annual application fee of $60.

(2) Speech-Language Pathologists and Audiologists:

(a) Biennial license fee and renewal thereof shall be $160.

(b) Biennial inactive license fee and renewal thereof shall be $50.

(c) Conditional license fee and renewal thereof shall be $50.

(3) Speech-Language Pathology Assistants:

(a) Biennial certificate fee and renewal thereof shall be $50.

(b) Biennial inactive certificate fee and renewal thereof shall be $20.

Stat. Auth.: ORS 681.340, 681.360, 681.420 & 681.460
Stats. Implemented: ORS 681.340(1), 681.360(2)(b) & 681.360(3)(b)
Hist.: SPA 2-1993(Temp), f. 12-8-93, cert. ef. 12-10-93; SPA 1-1994, f. & cert. ef. 6-10-94; SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2002(Temp), f. 11-8-02, cert. ef. 12-1-02 thru 5-1-03; SPA 1-2003, f. & cert. ef. 5-7-03; SPA 1-2005, f. & cert. ef. 9-13-05

**335-060-0060**
**Use of Social Security Numbers as Identifiers**

(1) Applicants for licensure are required to provide Social Security Numbers as required by ORS 215.785, 305.385, 42 USC § 405(c)(2)(i), and 42 USC § 666(a)(13) for child support enforcement purposes and Department of Revenue purposes. If an applicant indicates voluntary consent to disclosure of their Social Security number on the application for licensure, the Social Security number will be provided to the Oregon Student Assistance Commission.

(2) The Board will not issue or renew a license or certificate unless an applicant provides his or her SSN on the application or renewal form. The applicant need not provide the SSN on the application for renewal, if the applicant's SSN has previously been provided to the Board and is in the record.

(3) If an applicant has not been issued a social security number by the United States Social Security Administration, the Board will accept a written statement from the applicant to fulfill the requirements of section (2). 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 US Social Security Administration

(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 $6250.

Stat. Auth.: ORS 681.420(5)
Stats. Implemented: ORS 215.785, 305.385, 42 USC § 405(c)(2)(i) & 42 USC § 666(a)(13)
Hist.: SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2005, f. & cert. ef. 9-13-05

**335-070-0040**
**Procedures for Approval of Professional Development Offerings**

Approval of professional development activities not specified above may be requested from the Board by an institution, organization, agency or individual licensee. Such requests may be submitted before or after the professional development activity takes place. If prior approval is required, requests must be received by the Board office no later than 60 days prior to the commencement of the activity. Requests for approval following an activity must be received by the Board office no later than 30 days after the professional development offering takes place. All requests must be submitted on a form provided by the board, stating the type of learning activity, the subject matter, the names and qualifications of the instructors and the number of professional development hours offered. An activity shall qualify for approval if the board determines that the activity:

(1) Is an organized program of learning; and

(2) Pertains to subject matter which integrally relates to the practice of speech-language pathology and/or audiology; and

(3) Contributes to the professional competency of the licensee; and

(4) Is conducted by individuals who have education, training or experience acceptable to the Board.

(5) Credit for the hours of a single presentation will be acceptable if the presenter submits the request for approval within the required timeframe and meets criteria (1) through (4) above.

(6) Credit will not be given for attending or participating in a particular activity more than once in a licensing period.

Stat. Auth.: ORS 681.420(5) & 681.460
Stats. Implemented: ORS 681.320(1)(a)
Hist.: SPA 2-1996, f. & cert. ef. 7-22-96; SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2005, f. & cert. ef. 9-13-05

**335-070-0060**
**New Licensees**

Professional development for new licensees will be required on the following scale:

(1) Licensed after July 30th of odd-numbered years — no report is required.

(2) Licensed from August 1st of even-numbered years to July 30th of odd-numbered years — report half of required number of hours.

(3) Licensed prior to July 30th of even-numbered years — report full number of required hours.

Stat. Auth.: ORS 681.420(5) & 681.460
Stats. Implemented: ORS 681.320(1)(a)
Hist.: SPA 2-1996, f. & cert. ef. 7-22-96; SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2003, f. & cert. ef. 5-7-03; SPA 1-2004, f. & cert. ef. 2-6-04; SPA 2-2004, f. & cert. ef. 5-26-04; SPA 1-2005, f. & cert. ef. 9-13-05

**335-070-0080**
**Inactive Status License**

Professional development requirements may be waived for a licensee on inactive status during the period they remain inactive. However, if at any time the inactive licensee applies to the board to return to active status, the licensee must submit proof of completion of forty (40) professional development hours within the twenty-four (24) month period immediately preceding the date on which the application is submitted.

Stat. Auth.: ORS 681.420(5) & 681.460
Stats. Implemented: ORS 681.320(1)(a)
Hist.: SPA 2-1996, f. & cert. ef. 7-22-96; SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2005, f. & cert. ef. 9-13-05

**335-070-0085**
**Expired Status**

Professional development requirements do not affect those licenses with expired status. However, if at any time within four years after the expiration date, the person whose license is in the expired status wishes to activate their license the applicant must submit proof of completion of forty (40) professional development hours within the twenty-four (24) month period immediately preceding the date on which the application is submitted.

Stat. Auth.: ORS 681.420(5) & 681.460
Stats. Implemented: ORS 681.320(1)(a)
Hist.: SPA 1-2001, f. & cert. ef. 3-12-01; SPA 1-2005, f. & cert. ef. 9-13-05

**335-095-0055**
**Permission for Supervisors of SLPAs in Schools**

A speech-language pathologist holding either a basic license in speech impaired or a standard license in speech impaired issued by the Teacher Standards and Practices Commission, may supervise a speech-language pathology assistant working in a school if the following conditions are met:

(1) The speech-language pathologist meets the requirements of OAR 335-095-0040.

(2) The speech-language pathologist agrees to supervise according to OAR 335-095-0050(2).

(3) The speech-language pathologist completes an application proscribed by the Board and pays the required application fee on an annual basis.

Stat. Auth.: ORS 681
Stats. Implemented: ORS 681.360
Hist.: SPA 1-2005, f. & cert. ef. 9-13-05

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**Board of Tax Practitioners**
**Chapter 800**

**Adm. Order No.:** BTP 3-2005
**Filed with Sec. of State:** 8-31-2005
**Certified to be Effective:** 9-1-05
**Notice Publication Date:** 7-1-05
**Rules Adopted:** 800-020-0022
**Rules Amended:** 800-001-0005, 800-010-0015, 800-010-0025, 800-015-0005, 800-015-0010, 800-020-0015, 800-020-0020, 800-020-0025, 800-020-0030, 800-025-0010, 800-025-0020, 800-025-0025, 800-025-0027, 800-025-0030, 800-025-0040, 800-025-0060, 800-030-0025, 800-030-0035
**Subject:** The *adoption* of OAR 800-020-0022 is to provide the Board of Tax Practitioners guidance and recourse when handling disciplinary actions pertaining to an applicant's conduct during an examination.

The *amendments* to the OARs are for general "housekeeping" & "maintenance" as well as to change language to better reflect the "norm" in industry standards and the practices of other state agencies.
**Rules Coordinator:** Monica J. Leisten—(503) 378-4034

**800-001-0005**
**Contested Cases**

The Board of Tax Practitioners adopts the current version of the Attorney General's Model Rules of Procedure under the Administrative Procedure Act. The Board may close a contested case hearing to members of the public to keep confidential personal financial information gathered by the Board pursuant to an investigation.

Stat. Auth.: ORS 183
Stats. Implemented:
Hist.: TSE 1, f. 2-19-74, ef. 4-20-76; TSE 7, f. & ef. 4-20-76; Renumbered from 852-010-0005; TSE 2-1978, f. & ef. 3-27-78; TSE 1-1980, f. & ef. 4-17-80; TSE 1-1982, f. & ef. 3-22-82; TSE 1-1985, f. & ef. 1-15-85; TSE 1-1986, f. & ef. 7-14-86; TSE 2-1988, f. & cert. ef. 8-26-88; TSE 15-1991, f. & cert. ef. 12-20-91; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-010-0015**
**Definitions**

As used in these rules, unless the context requires otherwise:

(1) "Board" means the State Board of Tax Practitioners.

(2) "Client" means a person for whom a licensee performs or agrees to perform professional services for a fee and the services are related directly or indirectly to the client's personal income taxes.

(3) "Confidential Information" means information furnished to a licensee for, or in connection with, the preparation of a client's income tax return.

(4) "Designated Consultant" means a consultant who is the responsible individual for the preparation of all personal income tax returns prepared for the public for each registered business.

(5) "Licensee" means a tax consultant, tax preparer, or any person, corporation, firm or partnership falling within the purview of ORS 673.605 to 673.735.

(6) "Resident Consultant" means the tax consultant who is physically present to conduct and carryout his/her duties in the principal or branch office.

(7) "Tax Consultant or Tax Preparer Practice" and a licensee's "professional practice" means any service performed or supervised by the licensee for a client, including any advice or recommendation made by the licensee to the client, when it is related directly or indirectly to the client's personal income tax return, if the licensee also prepares the client's personal income tax returns.

(8) "Tax Preparation Business" means a sole proprietorship, partnership, corporation or other entity that offers personal income tax preparation services to the public, for a fee, whether operated under an individual's own name or under an assumed business or corporate name, and including tax preparation businesses operated on a full- or part-time basis.

(9) "Valuable Consideration", as used in ORS 673.615 and OAR Chapter 800, means a benefit that accrues to a person as a result of preparing, advising or assisting in the preparation of personal tax returns for others, or offering to perform such services. Valuable consideration need not be translatable into dollars and cents.

Stat. Auth.: ORS 673
Stats. Implemented:
Hist.: TSE 6, f. & ef. 1-5-76; TSE 2-1982, f. & ef. 5-10-82; TSE 1-1985, f. & ef. 1-15-85; TSE 6-1986, f. & ef. 12-31-86; TSE 3-1987, f. & ef. 10-2-87; TSE 1-1990, f. & cert. ef. 1-25-90; TSE 4-1991, f. & cert. ef. 10-28-91; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-010-0025**
**Integrity and Objectivity**

(1) A licensee shall not knowingly misrepresent facts while preparing or advising in the preparation of income tax returns. A licensee may resolve doubt in favor of a client if there is reasonable support for the position.

(2) A licensee who finds that a client has made an error or omitted information or related material required on an income tax return shall promptly advise the client of such error or omission.

(3) A licensee shall not arrange for or permit a client's individual income tax refund check to be mailed to the licensee at any time, for any purpose.

(4) Commissions earned for the personal services of the licensee, such as real estate, insurance, investment and securities sales, may be earned if the licensee also holds any license, permit or registration required by law to perform the services. A licensee shall disclose in writing that s/he will be compensated for any personal services. The client will acknowledge receipt of the disclosure in writing.

(5) Fees in connection with preparation of tax returns must be stated separately from, and in addition to, any other professional services provided.

(6) A licensee shall, upon written request by a client, make available or return within a reasonable time to the client, personal papers or source material in the manner furnished to the licensee by the client;

(a) A licensee who has provided a tax return to a client shall, upon written request by the client, make available within a reasonable time to the client, copies of depreciation schedules that support the return;

(b) A licensee is not required to furnish records to a client more than once under this subsection.

(7) A licensee shall not engage in fraudulent, deceptive or dishonest conduct relating to the licensee's professional practice.

(8) A licensee shall not violate any position of trust, including positions of trust outside the licensee's professional practice.

Stat. Auth.: ORS 673.730(6)
Stats. Implemented:
Hist.: TSE 6, f. & ef. 1-5-76; TSE 3-1980, f. & ef. 8-22-80; TSE 1-1985, f. & ef. 1-15-85; TSE 4-1986, f. & ef. 8-15-86; TSE 3-1989, f. & cert. ef. 12-20-89; TSE 1-1992, f. 3-24-92, cert. ef. 6-1-92; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-015-0005**
**Basic Education**

(1) An accredited college/university, educational service district (ESD), or a private firm that has met or is exempt from the registration requirements of the Oregon Department of Education or a private firm offering classes only to its own employees and is exempt from the Oregon Department of Education requirements may act as a sponsor for the basic income tax course.

(2) Sponsors shall apply for course certification on a form provided by the Board.

(3) A basic course shall include:

(a) At least 80 classroom hours of basic tax preparation instruction. If the course is offered through correspondence, it must be the equivalent of 80 classroom hours of instruction;

(b) Instruction in each of the subject areas specified in the Preparer Examination Index maintained by the Board;

(c) Sufficient working problems to instruct in the use of appropriate forms and schedules; and

(d) A midterm and final examination.

(4) The Board may require that a sponsor applicant submit evidence that course materials and lesson plans comply with section (3) of this rule.

(5) Basic course sponsors shall employ only instructors to teach basic courses who are actively licensed or who fall within the exemptions of ORS 673.610(2)(4) and who prepared taxes for at least two (2) tax seasons immediately prior to teaching the course.

(a) The Board may grant a specific waiver to instructor qualifications when unusual or extenuating circumstances exist.

(b) Sponsors shall submit to the Board the names and qualifications of instructors teaching each basic course.

(c) Repeated low passage rates of an instructor's students on the tax preparers' examination is evidence that the instructor may not be qualified to teach a basic tax preparation course.

(d) The instructor's approval to teach Basic Tax Preparation courses may be revoked at the option of the Board.

(6) Evidence of successful course completion shall be furnished to students by course instructors on a Board-approved session attendance certification form. Forms may be reproduced by course sponsors. If a student misses a portion of the class sessions, the instructor may provide makeup work.

(7) Applications for course certification shall be submitted annually at least 60 days prior to the course starting. Certification shall be for the subsequent 12 months.

(8) The Board may refuse to issue or withdraw a course certification for failure to meet any of the course or instructor requirements contained in this rule.

Stat. Auth.: ORS 673.625(1)
Stats. Implemented:
Hist.: TSE 9, f. & ef. 6-28-76; TSE 1-1979, f. 6-14-79, ef. 6-15-79; TSE 2-1979, f. 9-28-79, ef. 10-1-79; TSE 3-1979, f. 11-28-79, ef. 11-30-79; Renumbered from OAR 800-020-0040 by TSE 2-1980, f. & ef. 5-30-80; TSE 3-1982, f. & ef. 11-19-82; TSE 1-1985, f. & ef. 1-15-85; TSE 3-1990, f. & cert. ef. 1-25-90; TSE 7-1992, f. & cert. ef. 12-22-92; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-015-0010**
**Continuing Education**

(1) Except for renewal of an initial license, a tax consultant or tax preparer renewing a license shall submit evidence of attending at least 30 hours of acceptable continuing education since the last renewal date.

(2) Continuing education credit will be accepted only for courses and seminars that comply with all Board rules regarding continuing education.

(3) The Board may verify continuing education information submitted by licensees.

(4) Education hours earned in excess of 30 hours annually cannot be carried over from one renewal period to the next, except extra hours earned during the month of renewal may be withheld by the licensee and submitted with the following year's renewal.

(5) Continuing education credit shall be granted only once during a license year for attendance at or instruction of duplicate seminars offered by the same sponsor.

(6) Continuing education credit for courses at accredited universities and colleges will be 15 hours for each semester hour credit and 10 hours for each quarter hour credit. For all other courses and seminars, one hour of continuing education credit will be allowed for each hour of classroom attendance.

(7) Continuing education credit may be accepted for instructors of basic or advanced courses or seminars. The credit allowed will be two hours for each hour of teaching, which includes preparation time. No more than 1/2 of total required continuing education credit can be in teaching.

(8) Correspondence study courses may be accepted if the program and sponsor comply with all Board rules regarding continuing education and:

(a) The sponsor requires evidence of satisfactory completion of workbooks or examinations before certificates are issued.

(b) The hours credited do not exceed the credit that would be allowed in a resident course covering the same material; and

(c) A course outline with accompanying workbooks or exams is submitted to the Board, prior to offering the material, for approval of course content and hours of credit claimed.

(9) "In-Company" instruction may be accepted if the course or seminar is presented to ten or more people and all other requirements for continuing education sponsors are met. Portions of such educational sessions devoted to administrative and firm matters shall not be accepted.

(10) If a licensee claims credit for a course or seminar in the reasonable belief the instruction qualifies as acceptable continuing education, but the Board finds all or part of the hours claimed to be unacceptable, the licensee may be granted an additional period of time, not to exceed 60 days, to make up the rejected hours.

(11) Consultants and Preparers who have extenuating circumstances and are unable to obtain all their continuing education by their license due dates shall, upon written request and approval of the Board, be allowed three additional months, at no extra cost, to obtain the remaining continuing education hours. Prepares will be allowed until December 31 and Consultants until August 31.

Stat. Auth.: ORS 673.645 - 673.667
Stats. Implemented: ORS 673.645 - 673.667
Hist.: TSE 9, f. & ef. 6-28-76; TSE 1-1979, f. 6-14-79, ef. 6-15-79; TSE 2-1979, f. 9-28-79, ef. 10-1-79; TSE 3-1979, f. 11-28-79, ef. 11-30-79; TSE 2-1980, f. & ef. 5-30-80, Renumbered from OAR 800-020-0045; TSE 3-1980, f. & ef. 8-22-80; TSE 2-1982, f. & ef. 5-10-82; TSE 3-1982, f. & ef. 11-19-82; TSE 1-1985, f. & ef. 1-15-85; TSE 3-1985, f. & ef. 12-5-85; TSE 9-1987, f. & ef. 12-21-87; TSE 1-1997, f. & cert. ef. 7-2-97; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-020-0015**
**Application for Examination**

(1) Application to take the examination for a tax preparer or tax consultant must be filed with the Board on forms prescribed and furnished by the Board, together with the examination fee. The application must be signed.

(2) The application and examination fee shall be filed with the Board no later than one month prior to the examination date, except when the Board sets tighter deadlines due to time constraints.

(3) Tax preparer applicants may file an application to take the examination before completing the basic tax course. Applicants who have completed a course of study which has not received prior approval of the Board shall furnish the Board a brief outline of courses completed, together with a transcript from the educational institution. If, in the judgment of the Board, the courses completed are comparable to those described in OAR 800-015-0005, the applicant shall be eligible to take the examination.

(4) Completed basic course certification forms as required under OAR 800-015-0005(6) shall be submitted to the Board by the student with the application for license. If the student has not completed the basic tax course prior to filing the examination application, the student may still submit the exam application.

(5) A tax consultant applicant who is a licensed tax preparer shall submit verification by the applicant's employer or employers, on forms prescribed and furnished by the Board, that the applicant has worked in the capacity of a tax preparer for not less than a cumulative total of 780 hours during at least two of the last five years.

(6) A tax consultant applicant who is claiming equivalent tax preparer experience shall submit on forms prescribed and furnished by the Board:

(a) Verification by the applicant's employer or employers that the applicant has worked in the capacity of a tax preparer for not less than a cumulative total of 780 hours during at least two of the last five years.

(A) The Board will accept employment as an income tax auditor or taxpayer service representative with the Internal Revenue Service or State Department of Revenue as being equivalent experience.

(B) For the purpose of meeting the work experience requirement for tax consultants, one hour of experience gained through volunteer tax preparation programs such as VITA and AARP-TCE will be accepted for each five hours spent preparing, advising or assisting in the preparation of tax returns through the volunteer program, up to a maximum of 150 hours credited. To qualify for the one to five hour experience credit, total hours worked in the volunteer program must be verified in writing by a supervisor.

(b) To claim experience under this section, the applicant must submit a petition signed under penalty of perjury that the work experience claimed is true, correct and complete.

(7) Applicants for the tax consultant examination must have completed, within a year prior to submitting application, a minimum of 15 hours of acceptable continuing education in personal income taxation to meet the requirements of OAR 800-015-0010 to 800-015-0030. This requirement is in addition to the required 780 hours of work experience earned during at least two of the last five years.

(8) A tax consultant applicant claiming tax consulting experience in another state shall:

(a) Submit, on a form prescribed and furnished by the Board, a petition signed under penalty of perjury, claiming self-employment as a tax consultant for no less than two of the last five years; and

(b) Furnish documented proof of self-employment as a tax consultant.

(9) A tax preparer or tax consultant applicant who has worked in the capacity of a tax preparer or tax consultant in another state or in an exempt status may request Board approval to substitute work experience for up to two-thirds of the classroom hours of basic income tax education otherwise required to qualify as a tax preparer or tax consultant. Approval may be granted to substitute experience for education only if:

(a) The applicant was actively engaged in a tax preparation business within two years prior to the date of application;

(b) The applicant has at least three years experience in a tax preparation business;

(c) In the opinion of the Board, the applicant has gained a competency level through work experience that is equal to those applicants who have successfully completed the basic income tax course; and

(d) The applicant submits verification by the applicant's employer(s) or evidence of self- employment regarding the work experience.

(10) The Board may accept education credit for courses completed by a tax consultant applicant to substitute for up to 260 hours of work experience at the rate of one classroom hour of education for five hours of experience if:

(a) The subject matter of the course was related to taxation;

(b) The applicant completed the course within one year of applying to become a tax consultant; and

(c) Credit for the course is not claimed to fulfill continuing education requirements.

(11) Information required of the applicant and on the application forms shall be completed before an applicant may be admitted to an examination.

Stat. Auth.: ORS 673.625
Stats. Implemented:
Hist.: TSE 8, f. & ef. 5-19-76; TSE 1-1979, f. 6-14-79, ef. 6-15-79; TSE 2-1979, f. 9-28-79, ef. 10-1-79; TSE 2-1980, f. & ef. 5-30-80; TSE 2-1982, f. & ef. 5-10-82; TSE 3-1982, f. & ef. 11-19-82; TSE 1-1985, f. & ef. 1-15-85; TSE 3-1985, f. & ef. 12-5-85; TSE 4-1988, f. & cert. ef. 11-2-88; TSE 5-1990, f. & cert. ef. 5-3-90; TSE 9-1992, f. & cert. ef. 12-22-92; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 1-2005, f. & cert. ef. 1-5-05; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-020-0020**
**Examinations**

(1) Licensing examinations shall be scheduled as the Board deems appropriate.

(2) Tax preparer and tax consultant applicant's examination shall be written. Questions shall be so constructed as to measure the applicant's knowledge of Oregon and federal personal income tax law, theory and practice; the provisions of ORS 673.605 to 673.735 and the Code of Professional Conduct. The tax consultant examination shall require a higher standard of knowledge.

(3) A tax preparer applicant must have at least a 75 percent grade or score on the entire examination to pass.

(4) A tax consultant applicant must have at least a 75 percent grade or score on the entire examination to pass.

(5) An agent holding a valid treasury card who is enrolled to practice before the Internal Revenue Service must have at least a 75 percent grade or score on the consultant's state-only portion of the examination to pass.

(6) Pass or fail results, including scores, of the examination shall be mailed to each examination candidate, in writing by regular US Postal Service. Results will not be given by any other means.

(7) No review of examination questions by the applicant will be granted.

(8) An applicant who fails to pass the examination shall be eligible for a succeeding examination upon making application and payment of the examination fee.

(9) An applicant who passes an examination must apply for licensing within 60 days from the examination date. If application for license is not made within 60 days, the applicant must be reexamined, unless there are verifiable circumstances beyond the reasonable control of the applicant, subject to the discretion of the Board.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 673
Stats. Implemented: ORS 673.605 - 673.740 & 673.990
Hist.: TSE 8, f. & ef. 5-19-76; TSE 10(Temp), f. & ef. 11-29-76 thru 3-28-77; TSE 11, f. & ef. 4-6-77; TSE 1-1979, f. 6-14-79, ef. 6-15-79; TSE 2-1980, f. & ef. 5-30-80; TSE 1-1981 (Temp), f. 1-2-81, ef. 1-5-81; TSE 2-1982, f. & ef. 5-10-82; TSE 1-1983, f. & ef. 3-10-83; TSE 1-1984(Temp), f. & ef. 12-20-84; TSE 1-1985, f. & ef. 1-15-85; TSE 2-1985(Temp), f. & ef. 6-11-85; TSE 2-1986, f. & ef. 7-14-86; TSE 4-1987, f. & ef. 10-2-87; TSE 1-1989, f. & cert. ef. 6-8-89; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 2-2004, f. 8-12-04 cert. ef. 8-31-04; BTP 2-2005, f. 7-28-05, cert. ef. 8-1-05; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-020-0022**
**Examination Conduct; Disqualification**

(1) Examination Conduct: Examinations shall be conducted in a designated area with restricted access. Approval notification of an applicant's eligibility to take the examination must be issued by the board office prior to scheduling an appointment for examination. Authorization must be provided by the board office or proctoring site before bringing any materials, electronic equipment or devices into the examination area. Applicants shall be required to provide photographic identification such as a driver's license before being allowed to take the examination.

(2) Examination Disqualification: A candidate may be immediately disqualified during or after the examination for conduct that interferes with the examination. Such conduct includes:

(a) Taking or attempting to take any unauthorized items, notes, materials or devices into the examination area;

(b) Giving or attempting to give assistance to others in answering questions during the examination;

(c) Receiving or attempting to receive assistance during the examination, including assistance from other individuals, notes, books or devices to answer questions;

(d) Removing or attempting to remove any secure examination-related information, notes, or materials from the examination site;

(e) Failing to follow directions relative to the conduct of the examination;

(f) Exhibiting behavior which impedes the normal progress of the examination; and

(g) Endangering the health or safety of a person involved in the examination.

(3) Disqualification will invalidate the examination and result in forfeiture of the examination and fees. The candidate will be required to reapply, submit additional examination fees, and request in writing via submission of a new application to schedule another examination. Reexamination can be scheduled upon receipt of an approval notification issued by the board office.

Stat. Auth.: ORS 673.605 - 673.740, 673.990
Stats. Implemented: ORS 673.605 - 673.740, 673.990
Hist.: BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-020-0025**
**Fees**

(1) The fee for application for examination for a tax preparer's license is $40.

(2) The fee for application for examination for a tax consultant's license is $70.

(3) The fee for issuance or renewal of a tax preparer's active license is $65.

(4) The fee for an initial Preparer license issued within 6 months of the renewal date will be one-half the annual fee.

(5) Except as provided in subsection (a) of this section, the fee for issuance of a tax consultant's active license is $75.

(a) If an applicant holds an active tax preparer's license which was renewed less than six months previously, the fee for issuance of a tax consultant's active license is offset by a credit equal to 50% of the preparer license fee.

(6) The fee for renewal of a tax consultant's active license is $75.

(7) The fee for issuance or renewal of a tax preparer's inactive license is $35.

(8) The fee for issuance or renewal of a tax consultant's inactive license is $50.

(9) The fee for reactivation of a tax preparer's inactive license is $65.

(10) The fee for reactivation of a tax consultant's inactive license is $75.

(11) The late fee for restoration of a tax preparer's or tax consultant's lapsed license is $25, plus payment of all unpaid renewal fees.

(12) The fee for a replacement or duplicate license is $10.

(13) The fee for a replacement tax consultant's certificate is $15.

(14) The fee for issuance or renewal of a tax preparation business registration is $95.

(15) As provided by subsection (a) and (b) of this section, the fee for issuance or renewal of a combination tax consultant's or tax preparer's license and tax preparation business registration is $120:

(a) For Consultants — If postmarked on or before June 15th.

(b) For Preparers — If postmarked on or before October 15th.

(16) The fee for issuance or renewal of a branch office registration is $5.

Stat. Auth.: ORS 673.730
Stats. Implemented: ORS 673.685
Hist.: TSE 4(Temp), f. & ef. 11-20-75 through 3-19-76; TSE 8, f. & ef. 5-19-76; TSE 14, f. 10-25-77, ef. 11-1-77; TSE 1-1979, f. 6-14-79, ef. 6-15-79; TSE 3-1979, f. 11-28-79, ef. 11-30-79; TSE 1-1985, f. & ef. 1-15-85; TSE 2-1986, f. & ef. 7-14-86; TSE 1-1987(Temp), f. 6-30-87, ef. 7-1-87; TSE 5-1987, f. & ef. 10-2-87; TSE 7-1987(Temp), f. & ef. 11-17-87; TSE 1-1988, f. & cert. ef. 2-19-88; TSE 4-1990, f. & cert. ef. 5-3-90; TSE 3-1991(Temp), f. 8-14-91, cert. ef. 9-29-91; TSE 5-1991, f. & cert. ef. 10-28-91; TSE 12-1991(Temp), f. & cert. ef. 11-25-91; TSE 3-1992, f. 5-15-92, cert. ef. 6-1-92; TSE 3-1997, f. & cert. ef. 9-4-97; BTSE 1-2001, f. & cert. ef. 4-19-01; BTSE 1-2002(Temp), f. & cert. ef. 8-6-02 thru 1-1-03; Administration correction 4-16-03; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-020-0030**
**Licenses — Renewals**

(1) Applicants who pass the required examination and meet all other requirements shall be issued a license upon request and payment of the license fee. The licensee shall be assigned a permanent license number.

(2) Tax preparers' licenses shall expire annually on September 30.

(3) Tax consultants' licenses shall expire annually on May 31.

(4) Renewal licenses shall be issued upon receipt of a signed renewal application

notice, proof of required continuing education, and the appropriate fee.

(5) If a tax preparer's or tax consultant's license is suspended or revoked, the individual's license and pocket identification card become the property of the Board and shall, on demand, be delivered by the holder to the Board of Tax Practitioners.

Stat. Auth.: ORS 673.730
Hist.: TSE 8, f. & ef. 5-19-76; TSE 1-1979, f. 6-14-79, ef. 6-15-79; TSE 2-1982, f. & ef. 5-10-82; TSE 1-1985, f. & ef. 1-15-85; TSE 2-1986, f. & ef. 7-14-86; TSE 2-1993, f. & cert. ef. 2-23-93; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0010**
**Firm Names**

(1) The name under which a tax preparation business offers and/or performs services must be in compliance with the laws and rules of the Oregon Corporation Division.

(2) The designation Licensed Tax Preparer or reference to the title Licensed Tax Preparer in any manner, including initials or acronyms shall not be included as part of a firm name.

Stat. Auth.: ORS 673.730(5)
Stats. Implemented:
Hist.: TSE 1-1985, f. & ef. 1-15-85; TSE 4-1992, f. & cert. ef. 5-15-92; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0020**
**Tax Preparation Business Registration**

(1) A tax preparation business shall not offer services to the public until the business has:

(a) Complied with applicable laws and rules of the Oregon Corporation Division;

(b) Registered with the Board, on a Board-approved application form, the business name, address and telephone number; the name(s) of the owner(s) of the business; and the name of the individual(s) responsible under OAR 800-025-0040 for the tax activities of the business; and

(c) Paid the tax business registration fee required under OAR 800-025-0025.

(2) Within ten days of a change of name or ownership, a tax preparation business must file a new registration with the Board and pay a new registration fee.

(3) A person who offers tax preparation services under more than one name must register each such name as a separate business.

Stat. Auth.: ORS 673.730(5)
Stats. Implemented:
Hist.: TSE 1-1985, f. & ef. 1-15-85; TSE 13-1991(Temp), f. & cert. ef. 11-25-91; TSE 14-1991, f. 11-25-91, cert. ef. 1-1-92; TSE 4-1992, f. & cert. ef. 5-15-92; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0025**
**Renewal of Tax Preparation Business Registration**

(1) Tax preparation business registrations shall expire annually on June 15, except that combination business registration/tax preparer licenses shall expire annually on October 15.

(2) At least 30 days before the registration expiration date each year, the Board shall mail a renewal notice to each registered tax preparation business.

(3) Renewal registrations shall be issued to qualifying businesses upon receipt of a completed registration renewal application and the fee for registering a tax preparation business specified in OAR 800-020-0025(14) or the fee for a combined tax consultant's or preparer's license and business registration specified in OAR 800-020-0025(15).

(4) A business whose registration has expired shall not perform tax preparation services for the public, for a fee, or offer such services, until the re-application process has been completed.

Stat. Auth.:
Stats. Implemented:
Hist.: TSE 8-1991, f. & cert. ef. 10-28-91; BTP 1-2004, f. 1-28-04, cert. ef. 2-1-04; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0027**
**Eligibility for Combined Business Registration and Tax Consultant/Preparer License**

(1) A tax preparation business is not eligible for a combined license and registration under OAR 800-020-0025(15) unless at least one of the owners of the business is a licensed tax consultant or licensed tax preparer. As used in this section, "owner" means an individual who owns at least ten percent of the business.

(2) A tax preparation business, including a business that must file a new registration due to a change of name or ownership, is not eligible for a combined license and registration under OAR 800-020-0025(15) unless the registration is submitted:

(a) If a new registration, at the time of application for the owner's tax consultant's or tax preparer's license;

(b) If a renewal registration, before the expiration date of the current registration.

(3) A licensee who owns more than one tax preparation business is eligible for a combined license and business registration under OAR 800-020-0025(15) for only one of the businesses and must pay the business registration fee specified in OAR 800-020-0025(14) for the second and additional businesses.

Stat. Auth.:
Stats. Implemented:
Hist.: TSE 9-1991, f. & cert. ef. 10-28-91; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0030**
**Branch Offices**

(1) "Branch Office" means an office or other place of business where clients would normally or usually contact a licensee.

(2) A tax preparation business shall not operate any branch office until:

(a) The business has complied with all laws and rules of the Board concerning tax business registration;

(b) The address and phone number of the branch office and the name and license number of the resident consultant for the branch office have been submitted to the Board; and

(c) The business has paid an annual branch office registration fee for that location as required under OAR 800-020-0025(16).

(3) Branch office registrations shall expire annually on the expiration date of the associated tax business registration.

(4) At least 30 days before the expiration of a branch office registration, the Board shall mail a renewal notice to the tax preparation business that operates the branch office.

(5) Renewal branch office registrations shall be issued to qualifying businesses upon receipt of the required annual registration fee.

(6) A tax preparation business operating branch offices shall notify the Board within 10 days of:

(a) Change of address or phone number of the branch office.

(b) Change in resident consultant of the branch office.

(c) Closing the branch office.

(7) Branch offices must be conducted under the same name as the principal office. This name shall be posted conspicuously in each branch office.

(8) The name of the Designated Consultant and the name of the Resident Consultant must be posted conspicuously in or on each branch office.

(9) The current registration issued by the Board for a branch office must be posted conspicuously in the branch office.

Stat. Auth.: ORS 673.730(5)
Stats. Implemented: ORS 673.730(5)
Hist.: TSE 1-1985, f. & ef. 1-15-85; TSE 10-1991, f. & cert. ef. 10-28-91; TSE 5-1992, f. 5-15-92, cert. ef. 7-1-92; TSE 2-1996, f. & cert. ef. 12-30-96; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0040**
**Designated Consultants**

(1) A tax preparation business shall not engage in the preparation of personal income tax returns for the public, or offer such services, until the business has designated a tax consultant or other authorized person ("Designated Consultant") as the responsible individual. A form prescribed by the Board shall be signed by the designated consultant and signed by the owner or authorized representative of the tax preparation business.

(2) The license number of the Designated Consultant shall be placed on all tax returns prepared by the tax preparation business.

(3) The Designated Consultant shall be responsible for all tax preparation activities of the business, and the Designated Consultant and the designating business shall each be responsible for the business's compliance with laws and rules of the Board.

(4) A Designated Consultant will cease to be responsible for a business's tax preparation services upon receipt by the Board of written notice from the consultant or business.

(5) A tax consultant may act as the Designated Consultant for only one tax preparation business except by application of the tax consultant and approval by the Board's Business Practices Committee. Disapproval of an application by the Business Practices Committee may be appealed to the Board.

(6) An application to serve as a Designated Consultant for more than one tax preparation business shall set forth the following:

(a) The name and address of the tax preparation business for which the tax consultant is presently serving as the Designated Consultant;

(b) The name and address of the additional tax preparation business for which the tax consultant is requesting approval to serve as the Designated Consultant;

(c) A detailed plan how each tax preparation business will be supervised in carrying out the duties as a Designated Consultant;

(d) The financial relationship of the proposed Designated Consultant and the tax preparation businesses;

(e) Unusual or extenuating circumstances why approval should be granted.

(7) In determining whether a tax consultant will be approved to act as a Designated Consultant for more than one tax preparation business, the Board:

(a) May approve an application only wherein the tax consultant has an ownership interest in the tax preparation businesses, or unusual or extenuating circumstances exist, such as the death of a Designated Consultant, resulting in undue hardship. The Board may limit the tax consultant designation period; and

(b) Shall consider the tax consultant's past record of compliance with ORS 673.605 to 673.735, rules of the Board, statutes of the State of Oregon together with information set forth in the application, particularly the feasibility of the plan in supervising the corporation, firm or partnership.

(8) A tax preparation business shall notify the Board within ten days of any change in status of its Designated Consultant.

Stat. Auth.: ORS 673.730(5)
Stats. Implemented:
Hist.: TSE 8, f. & ef. 5-19-76; TSE 3-1980, f. & ef. 8-22-80; TSE 2-1982, f. & ef. 5-10-82; TSE 3-1982, f. & ef. 11-19-82; TSE 1-1985, f. & ef. 1-15-85; Renumbered from 800-020-0050; TSE 4-1989, f. & cert. ef. 12-20-89; TSE 11-1991, f. & cert. ef. 10-28-91; TSE 10-1992, f. & cert. ef. 12-22-92; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-025-0060**
**Consultant in Residence**

(1) A licensed tax consultant shall be in residence at each principal and branch office. "Tax consultant in residence" means that a tax consultant is physically present to conduct and carry out his/her duties in the principal or branch office for at least fifty (50) percent of the time an office is open to the public for tax preparation, assistance & advice during each week from January 15 to April 15 or during each month for the remainder of the year.

(2) The Board may waive the licensed tax consultant in residence requirement of subsection (1) upon written application which details how the management and supervision of principal and branch offices will effectively be accomplished. The Board shall grant a waiver only where at least one of the following circumstances exist:

(a) Sickness or death of a tax consultant.

(a) Unforeseen or unusual circumstances.

(3) In granting or denying a written application for waiver, the Board shall evaluate each case on an individual basis, considering the following factors:

(a) Distance between offices supervised by a tax consultant.

(b) Past compliance of waiver applicants with ORS 673.605 to 673.735 and rules of the Board.

(c) Whether the policies and procedures described in the application will result in effective management and supervision of preparers in the absence of a resident consultant.

(4) Applicants shall apply annually for waiver of the resident consultant rule. The application shall provide all of the information described in guidelines established by the Board for applying for waivers. Except in emergency circumstances, such as incapacitation, death or resignation of a resident tax consultant, waiver applications will not be accepted after January 31 for branch offices intended to operate at any time during the period January 1 to April 15 of the same calendar year. Approved waivers shall expire on the expiration date of the associated tax business registration or a date established by the Board.

(5) All applications must be acted upon by a Business Practices Committee consisting of three Board members appointed by the Board chair. Disapproval of an application by the Business Practices Committee may be appealed to the Board.

(6) The supervising tax consultant of an office for which a waiver has been approved shall meet in person with preparers in the office at least twice weekly to review the work of each preparer and respond to questions.

Stat. Auth.: ORS 673.730(5)
Stats. Implemented: ORS 673.615(2)4
Hist.: TSE 1-1985, f. & ef. 1-15-85; TSE 5-1986, f. & ef. 10-6-86; TSE 6-1987, f. & ef. 10-2-87; TSE 3-1988, f. & cert. ef. 8-26-88; TSE 5-1995, f. & cert. ef. 5-5-95; TSE 2-1996, f. & cert. ef. 12-30-96; BTSE 1-2001, f. & cert. ef. 4-19-01; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-030-0025**
**Civil Penalties**

(1) Civil Penalty Ranges. Pursuant to ORS 673.735, a civil penalty in the following range shall be assessed for each violation of the following statutes and rules: [Table not included. See ED. NOTE.]

(2) Civil Penalty Factors. Pursuant to ORS 673.735, the following factors shall be considered in determining the amount of civil penalty to assess for each violation above the minimum established under paragraph (1) of this rule or for violations not specified in paragraph (1):

(a) The previous record of the person in complying, or failing to comply, with ORS 673.605 to 673.740, or any rule or order adopted there under.

(b) The harm to the consumer as a result of the violation.

(c) The person's knowledge of the statute, rule, or order violated. An intentional, reckless, or willful violation warrants a high civil penalty per violation.

(d) The person's lack of cooperation with the Board.

(e) The seriousness of the violations committed.

(3) Daily Civil Penalty. Pursuant to ORS 673.735, the Board may impose civil penalties of not more than $5,000 for each violation of ORS 673.605 to 673.740, or any rule adopted there under. In the case of violations of ORS 673.615, 673.643, or 673.705(5), or OAR 800-010-0025(7) or 800-010-0042, the Board may consider each business day a person continues in violation following Board notification to be a separate violation.

(4) Civil Penalty Adjustment. The civil penalty amount to be imposed under this rule shall be lowered to an appropriate amount when the Board determines that the total civil penalties to be assessed against a person are grossly disproportionate to the seriousness of the violations committed.

(5) Payment of Civil Penalties. Unless otherwise ordered by the Board, payment of any civil penalty imposed by the Board must be made within 60 days of the date a final order assessing the penalty is issued. If the civil penalty is not paid within that time, in addition to any other action allowed by law or Board rules, proceedings may be instituted to suspend, revoke or refuse to renew the tax consultant's or tax preparer's license of the person against whom the penalty is assessed.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 673.730
Stats. Implemented: ORS 673.735
Hist.: TSE 1-1985, f. & ef. 1-15-85; BTSE 1-1998, f. & cert ef 9-3-98; BTSE 1-2002(Temp), f. & cert. ef. 8-6-02 thru 1-1-03; Administrative correction 4-16-03; BTP 1-2003, f. & cert. ef. 9-23-03; BTP 1-2004, f. 1-28-04, cert. ef. 2-1-04; BTP 3-2004, f. 10-11-04 cert. ef. 11-1-04; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

**800-030-0035**
**Board Meeting — Rules of Procedure**

(1) Board procedure shall be governed by **Sturgis Standard Code of Parliamentary Procedure** and rules adopted by the Board.

(2) There shall be an annual election of Chair and Vice-chair.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 673
Stats. Implemented:
Hist.: TSE 8, f. & ef. 5-19-76; TSE 1-1985, f. & ef. 1-15-85; Renumbered from 800-020-0085; BTP 3-2005, f. 8-31-05, cert. ef. 9-1-05

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## Bureau of Labor and Industries
## Chapter 839

**Adm. Order No.:** BLI 16-2005(Temp)
**Filed with Sec. of State:** 8-23-2005
**Certified to be Effective:** 8-23-05 thru 2-19-06
**Notice Publication Date:**
**Rules Amended:** 839-011-0084
**Subject:** Amends requirements for approval of new local joint apprenticeship committees and clearly states prerequisites for approval by the Oregon State Apprenticeship and Training Council. Establishes timelines for objections to applications for new committees. Formally establishes a probation period of three year after approval for new committees.
**Rules Coordinator:** Marcia Ohlemiller—(971) 673-0784

**839-011-0084**
**Approval of New Committees and Standards**

(1) Any additional committees or standards in an area already served by a committee in the same trade, craft or occupation shall be established in the same manner as any other joint committee.

(2) All employers and their apprenticeable employees shall be afforded the opportunity to participate, on a non-discriminatory basis, in existing programs.

(3) The Council will approve the creation of a new local joint committee or new standards for an existing committee only if the applicant for the new program or new standards can first demonstrate to the Oregon State Apprenticeship and Training Council, by a preponderance of evidence, that the application is in conformity with the following requirements:

(a) The applicant shall submit documentation showing apprenticeship committee composition pursuant to ORS 660.135, .145.

(b) The applicant shall submit apprenticeship standards in a format approved by the Council that meet or exceed any existing statewide guideline standards (ORS 660.137(1), .226, .155) for the occupation. Where no state guideline standards exist, proposed standards shall meet or exceed national guideline standards approved by the United States Department of Labor. Where no state or national guideline standards exist, standards will be approved at the discretion of the Council when the proposed occupation is clearly identified and commonly recognized throughout an industry.

(c) The applicant shall submit an administration plan that includes:

(A) Written designation of the program administrator; and

(B) Documented assurances that the committee will be adequately funded to support its administration and the presentation of related instruction, along with detailed statements of direct costs to apprentices (including instruction, books, tuition) and assurances that training agents and prospective training agents will be provided with a written statement of costs for program participation.

(d) The applicant must demonstrate the ability to track required apprenticeship, educational and affirmative action information (i.e., work progress reports, apprentice rotation system, employer's apprentice evaluation forms, grading sheets, applicant logs) and provide the Council with copies of the forms and documents that will be used to track such information.

(e) The applicant shall submit a plan detailing how the committee will ensure that participating employers will provide work in all areas covered by the program standards (ORS 660.137(5)), including:

(A) Training in all counties listed in proposed geographical area;

(B) Training in all work processes set forth in the standards;

(C) Committee expectations of supervising journey workers and a plan for the supervision of apprentices in the ratio set forth in the standards (ORS 660.126(1)(c), (f));

(D) Training agent qualifications and duties (ORS 660.137(5)); and

(E) A plan for training participating employers on their duties and responsibilities.

(f) The applicant shall submit a complete related training curriculum, including instructor qualifications, class outlines and expected competencies, grading procedures and completion criteria. This submission shall include:

(A) An explanation of the curriculum delivery method and a description of the related training facilities;

(B) Certification of the curriculum and instructional delivery plan by either a state education certifying authority or nationally recognized industry association (ORS 660.137(2)(c), .126(1)(j), .157); and

(C) Assurances that classroom and related instruction can be delivered throughout the geographic area. The applicant must submit a contract or other documentation demonstrating that actual instructional resources are in place. The committee's geographic area must be one that can be reasonably served by the committee with respect to employers and the location of the related training services (ORS 660.126(1)(a)).

(g) The applicant must submit operating policies and procedures and assurances that the program will be operated in accordance with the same;

(h) The applicant shall submit a plan to recruit, evaluate and select apprenticeship applicants, including an application form that meets Council requirements.

(4) All objections to the approval of a new committee or new standards shall be submitted to the Council in writing at the meeting where the application is being considered for approval, specifically detailing any objections to the application. Council may rule on the application and objections thereto at that time or grant the applicants 30 days after the Council meeting to submit a written rebuttal to the objections to the Director. Council shall direct the Director to investigate and evaluate the objections and rebuttal and provide a report to Council within 45 days of receipt of the rebuttal statement. At the next Council meeting after the initial submission, Council shall either approve or deny the application and provide a specific written explanation for its actions.

(5) All new programs shall serve a probationary period of three years after approval by Council. Failure to clearly demonstrate the ability to operate a satisfactory program during the probationary period, based upon periodic program reviews conducted by the Division, shall result in cancella-

tion of the program by Council.

Stat. Auth.: ORS 660
Stats. Implemented: ORS 660.135(1)
Hist.: BL 6-1985, f. & ef. 10-15-85; BL 1-1991, f. & cert. ef. 1-23-91; BLI 2-1999, f. & cert. ef. 4-2-99; BLI 16-2005(Temp), f. & cert. ef. 8-23-05 thru 2-19-06

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**Adm. Order No.:** BLI 17-2005
**Filed with Sec. of State:** 8-26-2005
**Certified to be Effective:** 8-29-05
**Notice Publication Date:**
**Rules Amended:** 839-025-0750
**Subject:** The rule adopts prevailing rates of wage as determined by the Commission of the Bureau of Labor and Industries for specified residential projects for the dates specified.
**Rules Coordinator:** Marcia Ohlemiller—(971) 673-0784

**839-025-0750**
**Residential Prevailing Wage Rate Determinations**

(1) Pursuant to ORS 279C.815, the Commissioner of the Bureau of Labor and Industries has determined that the wage rates stated in the following residential rate determinations are the prevailing rates of wage for workers upon said public works projects for the periods of time specified:

(a) *Special Prevailing Wage Rate Determination for Residential Project, Student Housing, Phase Four, Project #2005-01*, dated April 14, 2005, for the period of April 18, 2005 through September 30, 2005.

(b) *Special Prevailing Wage Rate Determination for Residential Project, "Civic Redevelopment," Project #2005-03*, dated May 26, 2005, for the period of June 1, 2005 through June 30, 2006.

(c) *Special Prevailing Wage Rate Determination for Residential Project, Prairie House, Project #2005-04*, dated May 26 2005, for the period of June 1, 2005 through June 30, 2006.

(d) *Special Prevailing Wage Rate Determination for Residential Project, Ariel South, Project #2005-05*, dated June 20, 2005, for the period of June 21, 2005 through June 30, 2006.

(e) *Special Prevailing Wage Rate Determination Extension for Residential Project, Headwaters Apartments, Project #2004-06*, dated October 14, 2004. Rate extension dated June 20, 2005, for the period of July 1, 2005 through June 30, 2006.

(f) *Special Prevailing Wage Rate Determination Extension for Residential Project, Madrone Street Affordable Housing, Project #2004-01*, dated April 22, 2004. Rate extension dated June 29, 2005 for the period of July 1, 2005 through December 31, 2005.

(g) *Special Prevailing Wage Rate Determination for Residential Project, Tri-Harbor Landing Apartments, Project #2005-06*, dated July 18, 2005, for the period of July 21, 2005 through June 30, 2006.

(h) *Special Prevailing Wage Rate Determination for Residential Project, Sunflower Park Apartments, Project #2005-07*, dated July 18, 2005, for the period of July 21, 2005 through June 30, 2006.

(i) *Amended Special Prevailing Wage Rate Determination for Residential Project, Prairie House, Project #2005-04*, dated July 20, 2005, for the period of July 22, 2005 through June 30, 2006.

(j) *Special Prevailing Wage Rate Determination for Residential Project, Quail Run Apartments Project #2005-08*, dated for August 9, 2005, for the period of August 10, 2005 through June 30, 2006.

(k) *Special Prevailing Wage Rate Determination for Residential Project, Hazedel Seniors Limited Partnership, Project #2005-09*, dated for August 26, 2005 for the period of August 29, 2005 through June 30, 2006.

(2) Copies of the rates referenced in section (1) of this rule are available from any office of the Wage and Hour Division of the Bureau of Labor and Industries. The offices are located in Eugene, Medford, Portland and Salem and listed in the blue pages of the phone book. Copies may also be obtained from the Prevailing Wage Rate Coordinator, Prevailing Wage Rate Unit, Wage and Hour Division, Bureau of Labor and Industries, 800 NE Oregon Street #1045, Portland, Oregon 97232; (971) 673-0839.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 279C.815
Stats. Implemented: ORS 279C.815
Hist.: BLI 5-1999, f. 6-30-99, cert. ef. 7-1-99; BLI 7-1999, f. 8-26-99, cert. ef. 9-15-99; BLI 8-1999, f. & cert. ef. 9-8-99; BLI 10-1999, f. 9-14-99, cert. ef. 9-17-99; BLI 11-1999, f. 9-22-99, cert. ef. 9-27-99; BLI 6-2000, f. 2-14-00, cert. ef. 2-15-00; BLI 12-2000, f. 5-24-00, cert. ef. 7-1-00; BLI 18-2000, f. & cert. ef. 9-1-00; BLI 21-2000, f. 9-15-00, cert. ef. 9-22-00; BLI 23-2000, f. & cert. ef. 9-25-00; BLI 24-2000, f. 10-30-00, cert. ef. 11-1-00; BLI 2-2001, f. & cert. ef. 1-24-01; BLI 6-2001, f. 6-21-01, cert. ef. 7-1-01; BLI 7-2001, f. 7-20-01, cert. ef. 7-24-01; BLI 9-2001, f. 7-31-01, cert. ef. 8-1-01; BLI 10-2001, f. 8-14-01, cert. ef. 8-15-01; BLI 11-2001, f. & cert. ef. 8-22-01; BLI 13-2001, f. 9-26-01, cert. ef. 10-1-01; BLI 6-2002, f. 3-14-02, cert. ef. 3-15-02; BLI 7-2002, f. 3-22-02, cert. ef. 3-25-02; BLI 11-2002, f. & cert. ef. 5-23-02; BLI 13-2002, f. 6-26-02 cert. ef. 7-1-02; BLI 14-2002, f. 8-23-02, cert. ef. 10-1-02; BLI 2-2003, f. & cert. ef. 3-28-03; BLI 2-2004, f. 4-23-04, cert. ef. 5-1-04; BLI 3-2004, f. 5-18-04, cert. ef. 5-19-04; BLI 4-2004, f. & cert. ef. 5-24-04; BLI 5-2004, f. 6-23-04, cert. ef. 6-24-04; BLI 7-2004, f. 7-14-04, cert. ef. 7-15-04; BLI 13-2004, f. & cert. ef. 10-19-04; BLI 14-2004, f. 10-29-04 cert. ef. 11-1-04; BLI 16-2004, f. 11-8-04, cert. ef. 11-10-04; Renumbered from 839-016-0750, BLI 7-2005, f. 2-25-05, cert. ef. 3-1-05; BLI 9-2005, f. 4-15-05, cert. ef. 4-18-05; BLI 10-2005, f. & cert. ef. 5-2-05; BLI 11-2005, f. 5-31-05, cert. ef. 6-1-05; BLI 12-2005, f. & cert. ef. 6-21-05; BLI 13-2005, f. 6-30-05, cert. ef. 7-1-05; BLI 14-2005, f. & cert. ef. 7-22-05; BLI 15-2005, f. 8-9-05, cert. ef. 8-10-05; BLI 17-2005, f. 8-26-05, cert. ef. 8-29-05

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**Construction Contractors Board**
**Chapter 812**

**Adm. Order No.:** CCB 3-2005
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 8-24-05
**Notice Publication Date:** 8-1-05
**Rules Adopted:** 812-002-0001, 812-002-0275
**Rules Amended:** 812-001-0015, 812-002-0450, 812-002-0580, 812-002-0620, 812-003-0100, 812-003-0250, 812-003-0260, 812-004-0120, 812-004-0250, 812-004-0520, 812-004-0535, 812-004-0540, 812-004-0590, 812-006-0011, 812-006-0030
**Subject:** 812-002-0001 is adopted to define "applicant."

812-002-0275 is adopted to define "family members."

OAR 812-001-0015, 812-002-0450, 812-002-0580, 812-002-0620, 812-003-0100, 812-003-0250, 812-003-0260, 812-004-0120, and 812-006-0011, are amended to add and clarify limited partnerships and joint ventures and for general housekeeping amendments.

812-004-0250 is amends the cite reference to reflect amendments to 812-004-0540.

812-004-0520 is amended to add language allowing the agency, at its discretion, to hold an on-site meeting on a claim that has been filed in court, if the agency finds that the meeting is likely to assist the parties to resolve the dispute.

812-004-0535 is amended to a cite reference to reflect amendments to 812-004-0540.

812-004-0540 is amended allow the agency to issue a proposed order in the amount of the claim processing fee if respondent pays all of the damages due to the claimant after the fee is paid, but before the agency issues its order, this payment does not apply to payments by a respondent under a settlement agreement, and requires agency to notify respondent before issuing an order to reimburse the processing fee and to allow respondent 30 days to reimburse the fee.

812-004-0590 is amended to correct the site reference.

812-006-0030 is amended to change the way CCB tracks test passing rates for purposes of education provider evaluation. Tracking only first time passing rates should provide more statistically valid data. The Training Education Advisory Committee (TEAC) recommended these proposed rule changes to correct problems with the current system of statistical reporting on education providers.
**Rules Coordinator:** Catherine Dixon—(503) 378-4621, ext. 4077

**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 numbers.

(c) The business names used by the entity of record with the agency.

(d) Type of business entity.

(e) Personal names of owners, partners, joint venturers, members, corporate officers, or trustees.

(f) Last known address.

(g) Category of license.

(h) Class of independent contractor license status.

(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 must 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 numbers.

(b) Name of licensed entity and any assumed business names on file with the agency.

(c) Type of business entity.

(d) Category of license.

(e) Class of independent contractor license status.

(f) Personal names of owner, partners, joint venturers, members, corporate officers, or trustees.

(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 dispute resolution information relating to a specific licensee, the agency will provide by mail a brief explanation of the dispute resolution 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 must 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) 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; CCB 7-2004, f. 8-26-04, cert. ef. 9-1-04; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-002-0001**
**Applicant**

"Applicant" has the same meaning as licensee.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701
Hist.: CCB 3-2005, f. & cert. ef. 8-24-05

**812-002-0275**
**Family Members**

"Family members" mean members of the same family and are parents, spouses, sisters, brothers, daughters, sons, daughters-in-law, sons-in-law, or grandchildren.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701
Hist.: CCB 3-2005, f. & cert. ef. 8-24-05

**812-002-0450**
**Licensee**

"Licensee" shall include the:

(1) Sole proprietor that makes application to license or subsequently operate the sole proprietorship;

(2) Partnership or limited liability partnership and the partners who make application to license or subsequently operate the partnership or limited liability partnership;

(3) Joint venture and the joint venturers who make application to license or subsequently operate the joint venture;

(4) Limited partnership and the general partners who make application to license or subsequently operate the limited partnership;

(5) Limited liability company and the members who make application to license or subsequently operate the limited liability company;

(6) Corporation and the corporate officers who make application to license or subsequently operate the corporation; or

(7) Trust and the trustees who make application to license or subsequently operate the trust.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701
Hist.: CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 3-2005, f. & cert. ef. 8-24-05

**812-002-0580**
**Person**

"Person" means a self-employed individual, a partnership, joint venture, limited liability partnership, limited partnership, corporation, trust, limited liability company, or other entity.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 87.005, 87.093, 445.080, 656.021, 656.029 & 701
Hist.: CCB 4-1998, f. & cert. ef. 4-30-98; CCB 6-1998, f. 8-31-98, cert. ef. 9-1-98; CCB 3-2005, f. & cert. ef. 8-24-05

**812-002-0620**
**Registrant**

"Registrant" has the same meaning as licensee.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701
Hist.: CCB 4-1998, f. & cert. ef. 4-30-98; CCB 6-1998, f. 8-31-98, cert. ef. 9-1-98; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 3-2005, f. & cert. ef. 8-24-05

**812-003-0100**
**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) Entities shall include but not be limited to the following:

(a) Sole proprietorship;

(b) Partnership, limited liability partnership or joint venture;

(c) Limited partnership;

(d) Corporation;

(e) Limited liability company; or

(f) Trust. For purposes of licensing, a trust will be treated the same as a corporation.

(3) All partners or joint venturers listed in subsection (2)(b) of this rule shall be on record with the agency.

(4) All general partners listed in subsection (2)(c) of this rule shall be on record with the agency. The agency shall not maintain a record of limited partners.

(5) If an entity listed in section (2) of this rule seeks to change to another entity, the former license may be terminated. The new entity must license anew.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 701.055
Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-003-0250**
**Exempt and Nonexempt Class of Independent Contractor Licenses**

Contractors shall license as either nonexempt or exempt as provided in ORS 701.035.

(1) The nonexempt class is composed of the following entities:

(a) Sole proprietorships with one or more employees;

(b) Partnerships or limited liability partnerships with one or more employees;

(c) Partnerships or limited liability partnerships with more than two partners if any of the partners are not family members;

(d) Joint ventures with one or more employees;

(e) Joint ventures with more than two joint venturers if any of the joint venturers are not family members;

(f) Limited partnerships with one or more employees;

(g) Limited partnerships with more than two general partners if any of the general partners are not family members;

(h) Corporations with one or more employees;

(i) Corporations with more than two corporate officers if any of the corporate officers are not family members;

(j) Trusts with one or more employees; or

(k) Trusts with more than two trustees if any of the trustees are not family members.

(2) The exempt class is composed of sole proprietors, partnerships, joint ventures, limited liability partnerships, limited partnerships, corporations, trusts, and limited liability companies that do not qualify as nonexempt.

(3) An exempt contractor may work with the assistance of individuals who are employees of a nonexempt contractor as long as the nonexempt contractor:

(a) Is in compliance with ORS Chapters 316, 656, and 657 and is providing the employees with workers' compensation insurance; and

(b) Does the payroll and pays all its employees, including those employees who assist an exempt contractor.

(4) Except as provided in section (5) of this rule, entities shall supply the following employer account numbers as required under ORS 701.075:

(a) Workers' Compensation Division 7-digit compliance number or workers' compensation insurance carrier name and policy or binder number;

(b) Oregon Employment Department and Oregon Department of Revenue combined business identification number; and

(c) Internal Revenue Service employer identification number or federal identification number.

(5) Exempt entities are not required to supply employer account numbers under section (4) of this rule except as follows:

(a) Partnerships, joint ventures, limited liability partnerships, and limited partnerships that have no employees and are not directly involved in construction work may be classed as exempt when the entity certifies that all partners or joint venturers qualify as nonsubject workers under ORS 656.027. Such partnerships or joint ventures must supply the Internal Revenue Service employer identification number or federal identification number.

(b) Corporations qualifying as exempt under ORS 656.027(10) must supply the Oregon Employment Department and Oregon Department of Revenue combined business identification number unless the corporation certifies that corporate officers receive no compensation (salary or profit) from the corporation.

(c) Corporations qualifying as exempt must supply the Internal Revenue Service employer identification number or federal identification number.

(d) Limited liability companies must supply the Internal Revenue Service employer identification number or federal identification number unless the limited liability company has only one member and has no employees.

(6) Out-of-state applicants with no Oregon subject workers as provided in ORS 656.126 and OAR 436-050-0055 must supply their home state account numbers, and need not supply an Oregon workers' compensation account number.

Stat. Auth.: ORS 183.310 - 183.500, 670.310, 701.235, 701.280 & 701.992
Stats. Implemented: ORS 701.035 & 701.135
Hist.: CCB 1-1989, f. & cert. ef. 11-1-89; CCB 3-1991, f. 9-26-91, cert. ef. 9-29-91; CCB 5-1992, f. 7-31-92, cert. ef. 8-1-92; CCB 7-1992, f. & cert. ef. 12-4-92; CCB 4-1993, f. 8-17-93, cert. ef. 8-18-93; CCB 1-1994, f. 6-23-94, cert. ef. 7-1-94; CCB 3-1995, f. 9-7-95, cert. ef. 9-9-95; CCB 2-1997, f. 7-7-97, cert. ef. 7-8-97; CCB 4-1998, f. & cert. ef. 4-30-98; CCB 6-1998, f. 8-31-98, cert. ef. 9-1-98; CCB 4-1999, f. & cert. ef. 6-29-99; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 9-2004, f. & cert. ef. 12-10-04, Renumbered from 812-003-0002; CCB 3-2005, f. & cert. ef. 8-24-05

**812-003-0260**
**Application for New License**

(1) Each entity shall complete an application form prescribed by the agency. Information provided on the form shall include, but not be limited to:

(a) Name of business entity, all additional business names, including assumed business names, under which business as a contractor is conducted, and Corporation Division registry numbers (if applicable);

(b) Mailing and location address of the business entity;

(c) Names, social security number, date of birth and driver license number of all:

(A) Owners of a sole proprietorship;

(B) Partners of a general partnership or limited liability partnership;

(C) Joint venturers of a joint venture;

(D) General partners of a limited partnership;

(E) Corporate officers of a corporation;

(F) Trustees of a trust; or

(G) Members of a limited liability company, and if one or more of the members is a partnership, limited liability partnership, joint venture, limited partnership, corporation, trust or limited liability company, the general partners, venturers, corporate officers, trustees or members of the entity that is a member of the limited liability company that is the subject of this paragraph.

(d) Class of independent contractor license and employer account numbers as required under OAR 812-003-0250;

(e) Category of license requested as required under OAR 812-003-0130;

(f) Name and identification number of the responsible managing individual who has completed the education required under ORS 701.280 and passed the examination required under ORS 701.075 or is otherwise exempt under Division 6 of these rules;

(g) The Standard Industrial Classification (SIC) numbers of the main construction activities of the entity;

(h) Names and certification numbers of all certified home inspectors if the entity will do work as a home inspector under ORS 701.350;

(i) Litigation, claim, and licensing history;

(j) Criminal background;

(k) Independent contractor certification statement and 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; and

(l) Signature of owner, partner, joint venturer, corporate officer, member or trustee, signifying that the information provided in the application is true and correct.

(2) A complete license application includes but is not limited to:

(a) A completed application form as provided in section (1) of this rule;

(b) The new application license fee as required under OAR 812-003-0140;

(c) A properly executed bond as required under OAR 812-003-0150; and

(d) The certification of insurance coverage as required under OAR 812-003-0200.

(3) The agency may return an incomplete license application to the applicant with an explanation of the deficiencies.

(4) All entities listed in section (1) of this rule that are otherwise required to be registered with the Oregon Corporation Division must be registered with the Oregon Corporation Division and be active and in good standing. All assumed business names used by persons or entities listed in section (1) of this rule must be registered with the Oregon Corporation Division as the assumed business name of the person or entity using that name.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 25.270, 25.785, 25.990, 701.035, 701.075, 701.085, 701.105, 701.125 & 701.280
Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-004-0120**
**Liability of Licensee**

A licensee, as defined in OAR 812-002-0620, participating in a corporation wholly-owned by the licensee, or a limited liability partnership, limited liability company, joint venture, limited partnership or partnership, may be held individually liable for claim actions brought under ORS 701.139 to 701.180, whether or not the corporation, limited liability partnership, limited liability company, joint venture, limited partnership, or partnership was licensed as required by ORS Chapter 701.

Stat. Auth.: ORS 183.310 - 183.500, 670.310 & 701.235
Stats. Implemented: ORS 701.102, 701.139, 701.140 & 701.145
Hist.: CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; 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 3-2005, f. & cert. ef. 8-24-05

**812-004-0250**
**Award of Claim-Processing Fee, 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 judgment, award or decision by a court, arbitrator or other entity 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 damages not directly related to negligent or improper work under the contract or breach of the contract that is the basis of the claim.

(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 or issued under OAR 812-004-0540(6) 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, arbitrator or other entity that are related to the portion of the order or award of the court, arbitrator or other entity that is within the jurisdiction of the board if the order or award of the court, arbitrator 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 183.415, 183.460, 701.145 & 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; CCB 8-2004, f. & cert. ef. 10-1-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-004-0520**
**Processing of Claim Submitted to Court, Arbitrator or Other Entity**

(1) "Court, arbitrator or other entity" has the meaning given that phrase in division 2 of this chapter.

(2) The agency may suspend processing a claim if:

(a) Respondent submits a complaint against claimant to a court, arbitrator or other entity that relates to same facts and issues contained in the claim filed against respondent, including but not limited to a breach of contract claim or a suit to foreclose a lien involving the same contract at issue in the claim;

(b) Claimant submits a complaint against respondent to a court, arbitrator or other entity that relates to same facts and issues contained in the claim filed against respondent; or

(c) The agency requires the claimant to submit the claim to a court because the agency determined that a court is the appropriate forum for the adjudication of the claim because of the nature or complexity of the claim.

(3) If the agency suspends processing a claim under section (2) of this rule, the agency shall notify the claimant on the date it suspends processing the claim that processing has been suspended. The following provisions apply to the agency and the claimant if processing is suspended:

(a) The notice of suspension of processing shall include notification of the requirements contained in subsections (3)(b) and (d) of this rule and shall comply with the requirements of OAR 812-004-0260.

(b) Beginning six months after the date that the agency suspends processing the claim and no less frequently than every sixth month thereafter, the claimant shall deliver to the agency a written report describing the current status of the action before the court, arbitrator or other entity.

(c) The agency may, at any time, demand from the claimant a written report describing the current status of the action before the court, arbitrator or other entity. The demand shall be in writing and shall comply with the requirements of OAR 812-004-0260. The claimant shall deliver a written response to the agency within 30 days of the date the demand letter is mailed by the agency.

(d) Within 30 days of the date of final action by the court, arbitrator or other entity, the claimant shall deliver to the agency a certified copy of the final judgment; a copy of the arbitration award or decision by another entity and a copy of the complaint or other pleadings on which the judgment, award or decision is based.

(e) If claimant complies with subsections (3)(b), (c) and (d) of this rule, the agency may resume processing the claim. If the claimant fails to comply with subsections (3)(b), (c) or (d) of this rule, the agency may close the claim under OAR 812-004-0260.

(4) If the agency suspends processing a claim under subsection (2)(a) of this rule, the following provisions apply in addition to the provisions in section (3) of this rule:

(a) The agency shall notify the claimant that the claimant must file the claim as a counter-suit, complaint or counter-claim in the court, arbitration or other proceedings and submit evidence, including a copy of the counter-suit, complaint or counter-claim, to the agency that the claimant has done so within 30 days of notification. The notice shall comply with the requirements of OAR 812-004-0260.

(b) If the claimant fails to submit the evidence as required under subsection (4)(a) of this rule, the agency may close the claim under OAR 812-004-0260.

(5) If the agency suspends processing a claim under subsection (2)(c) of this rule, the following provisions apply in addition to the provisions in section (3) of this rule:

(a) The agency shall notify the claimant, in a notice that complies with the requirements of OAR 812-004-0260, that agency has suspended processing the claim and that the claimant must:

(A) File the claim as a complaint in a court of competent jurisdiction within 90 days of notification that the agency has suspended processing the claim; and

(B) Submit evidence, including a copy of the complaint, to the agency that the claimant complied with paragraph (5)(a)(A) of this rule within 21 days of filing the complaint.

(b) If the claimant fails to submit the evidence as required under subsection (5)(a) of this rule, the agency may close the claim under OAR 812-004-0260.

(6) If the agency resumes processing a claim under section (3) of this rule:

(a) The agency shall accept a final judgment, award or decision of the court, arbitrator or other entity as the final determination of the merits of the claim.

(b) Based on the judgment, award or decision, the agency shall issue a proposed default order to pay damages or to dismiss or refer the claim to the Office of Administrative Hearings for arbitration or a contested case hearing. The following apply to proceedings under subsection (6)(a) of this rule:

(A) The provisions of OAR 812-004-0560 and 812-004-0590 apply to a proposed default order or a referral to the Office of Administrative Hearings.

(B) A proposed default order to pay damages issued under section (6) of this rule must include a statement of the portion of the final judgment, award or decision of the court, arbitrator or other entity that the agency finds is within the jurisdiction of the agency.

(C) If the agency refers the claim to the Office of Administrative Hearings for arbitration or a contested case hearing, the arbitrator or administrative law judge shall determine the portion of the final judgment, award or decision, if any, that is within the jurisdiction of the agency.

(7) At its discretion and with the agreement of claimant and respondent, the agency may hold an on-site meeting under OAR 812-004-0450 before suspending claim processing under section (2) of this rule if the agency finds that an on-site meeting may help the parties to resolve the claim.

Stat. Auth.: ORS 670.310 & 701.235
Stats. Implemented: ORS 183.415, 183.460, 701.145, 701.146 & 701.147
Hist.: CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 2-2001, f. & cert. ef. 4-6-01; 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 8-2004, f. & cert. ef. 10-1-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-004-0535**
**Elements of Claim that Must Be Proved**

The following provisions apply to OAR 812-004-0540(5) and (6), 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; CCB 3-2005, f. & cert. ef. 8-24-05

**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) of this rule 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 subsections (5)(a) or (6)(a) of this rule only if the record of the claim contains evidence that persuades the agency of the existence of facts necessary to support the order.

(6)(a) If the record of a claim supports an award of damages to claimant under OAR 812-004-0535 and respondent pays claimant the amount of those damages after claimant submits the claim processing fee required under OAR 812-004-0110 to the agency, the agency may issue a proposed default order proposing that respondent reimburse claimant for the amount of the processing fee paid.

(b) Subsection (6)(a) of this rule does not apply if the respondent paid damages to the claimant to satisfy a written settlement agreement that claimant signed.

(c) Before issuing a proposed order under subsection (6)(a) of this rule, the agency shall notify respondent of the agency's intent to issue the proposed order and allow respondent 30 days to submit written evidence that respondent reimbursed the claim processing fee to claimant.

(7) 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; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-004-0590**
**Referral of Claim to Arbitration or Contested Case Hearing or Removal to Court**

(1) If a hearing on a claim is conducted by the Office of Administrative Hearings:

(a) The hearing shall be held as an arbitration under the rules in division 10 of this chapter, unless a party requests that the hearing be held as a contested case hearing under subsection (1)(b) of this rule or files the dispute in court under section (2) of this rule.

(b) Except as provided in sections (2) and (6) of this rule, the hearing shall be held as a contested case hearing under OAR 137-003-0501 to 137-003-0700 and the rules in division 9 of this chapter if:

(A) A party to the claim makes a timely written request under section (4) of this rule that the claim be heard as a contested case; or

(B) The agency requests under sections (4) and (7) of this rule that the claim be heard as a contested case.

(2) Subject to section (3) of this rule, a claim shall be decided in court if:

(a) The claimant files a complaint in court that alleges the elements of the claim in the complaint; or

(b) The respondent files a complaint in court for damages, a complaint for declaratory judgment or other complaint that arises from the contract or work that is the subject of the claim and that allows the claimant to file a response alleging the elements of the claim.

(3) A copy of a complaint filed under section (2) of this rule must be received by the agency or the Office of Administrative Hearings no later than 30 days after the Office of Administrative Hearings sends the first notice that an arbitration or contested case hearing is scheduled. Failure to deliver the copy of the complaint within the time limitation in this rule constitutes waiver of the right to have the claim decided in court and consent to the hearing being held as binding arbitration or a contested case hearing under section (1) of this rule. Delivery shall be either to the agency or the Office of Administrative Hearings as required by OAR 137-003-0520 or 812-010-0085, whichever is applicable.

(4) A request that a claim be heard as a contested case filed under subsection (1)(b) of this rule is subject to the following:

(a) The request by a party or the agency must be in writing and received by the agency or the Office of Administrative Hearings no later than 30 days after the Office of Administrative Hearings sends the first notice that an arbitration is scheduled. Delivery shall be either to the agency or the Office of Administrative Hearings as required by OAR 137-003-0520 or 812-010-0085, whichever is applicable.

(b) A referral of a claim to the Office of Administrative Hearings by the agency for a contested case hearing shall be deemed a request that the claim be heard as a contested case under subsection (1)(b) of this rule.

(c) A party or the agency may not withdraw a request made under this section without the written consent of the agency and all parties to the claim.

(5) Failure to deliver a timely written request for a contested case hearing under subsection (1)(b) and section (4) of this rule or a copy of a filed complaint under sections (2) and (3) of this rule constitutes consent to the hearing on the claim being held as binding arbitration under subsection (1)(a) of this rule.

(6) Except as provided in paragraph (1)(b)(B) and section (7) of this rule, if the claimant in a claim does not seek $1,000 or more, a hearing on the claim may not be conducted as a contested case hearing.

(7) Notwithstanding section (6) of this rule, the agency may request under paragraph (1)(b)(B) of this rule that a hearing be held as a contested case hearing if:

(a) The agency's jurisdiction to decide the claim under ORS 701.139 to 701.180 is at issue; or

(b) The agency determines that the agency has an interest in interpreting the rules and statutes that apply to the claim.

(8) The amendments to this rule that became effective on or after July 1, 2002 apply to a claim that is referred to the Office of Administrative Hearings after July 1, 2002.

Stat. Auth.: ORS 670.310, 701.145 & 701.235
Stats. Implemented: ORS 701.145 & 701.147
Hist.: CCB 5-1999, f. & cert. ef. 9-10-99; 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 6-2002 f. 6-10-02 cert. ef. 7-1-02; CCB 8-2002, f. & cert. ef. 9-3-02; CCB 7-2003, f. & cert. ef. 8-8-03; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 3-2005, f. & cert. ef. 8-24-05

**812-006-0011**
**Responsible Managing Individual**

(1) Upon initial license application, a license applicant shall:

(a) Designate one individual as the applicant's responsible managing individual. Unless otherwise exempt, the responsible managing individual shall be responsible for completing any education required by ORS 701.280 and passing any test required by ORS 701.075. The responsible managing individual must be:

(A) The owner, if the applicant is a sole proprietorship;

(B) A partner, if the applicant is a partnership or limited liability partnership;

(C) A joint venturer if the applicant is a joint venture;

(D) A general partner if the applicant is a limited partnership;

(E) A member, if the applicant is a limited liability company;

(F) A corporate officer, if the applicant is a corporation;

(G) A trustee if the applicant is a trust; or

(H) A designated full-time permanent employee, if an applicant has documented that no owner, partner, joint venturer, member, corporate officer, or trustee of the applicant is directly involved in construction in Oregon, and that the employee is the supervisor of the Oregon construction operations of the applicant.

(b) Provide evidence that the licensee's responsible managing individual has completed the prescribed 16 hours of education, as provided by these rules; and

(c) Provide evidence that the licensee's responsible managing individual has passed the prescribed test on the 16 hours of education, as provided by these rules; or

(d) Document an exemption to the education and testing requirements to the Agency's satisfaction under OAR 812-006-0020.

(2) An individual who is not an owner, partner, joint venturer, member, corporate officer, or trustee may not be designated as the responsible managing individual of more than one licensee.

(3) When a responsible managing individual leaves a business, the business shall:

(a) Immediately appoint another responsible managing individual; and

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

(4) A responsible managing individual appointed under section (3) of this rule must:

(a) Document completion of the education and testing requirements under ORS 701.075 and section (1) of this rule; or

(b) Document an exemption to the education and testing requirements to the Agency's satisfaction under OAR 812-006-0020.

Stat. Auth.: ORS 670.310, 701.235 & 701.280
Stats. Implemented: ORS 701.075 & 701.280
Hist.: CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 3-2005, f. & cert. ef. 8-24-05

**812-006-0030**
**Education Provider Approval**

(1) No education shall meet the requirements of ORS 701.280 unless it is offered by a provider approved by the agency.

(2) To receive agency approval, individuals and organizations shall make application and sign an agreement with the agency prior to offering the 16 hours of education.

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

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

(B) Demonstrating that all its instructors have at least two years total experience either teaching adults or working in the instructor's subject area or a combination of the two, including the submission of instructor resumes or work history summaries.

(b) No provider may instruct any part of the 16-hour course until there is a fully executed agreement.

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

(A) The provider will provide 16-hours of instruction which will exclude registration and breaks.

(B) The provider will verify that each student taking the 16-hour course has a current agency-approved manual.

(C) The provider will instruct using all the approved curriculum and the approved course manual.

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

(E) The provider will communicate law changes and program procedural changes sent to them in writing from the agency to the provider's instructors and will implement these changes within 30 business days.

(F) The provider will only use approved instructors who have at least two years total experience either teaching adults or working in the instructor's subject area or a combination of the two.

(G) The provider will request and receive in writing agency approval of all instructors at least 10 business days before instructor is scheduled to teach.

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

(I) The provider will give all students information about how to contact instructors and hours of availability before the end of the 16-hour course.

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

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

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

(a) Meet all requirements of the agreement; and

(b) Comply with administrative rules in 812-006-0030.

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

(a) Whose students do not pass the agency test on their first attempt at least 70 percent of the time after the provider has provided classes for three months; and

(b) That fails to maintain the 70 percent first attempt test passing rate during the remaining period of the agreement.

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

Stat. Auth.: ORS 701.075 & 701.280
Stats. Implemented: ORS 701.075 & 701.280
Hist.: CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 5-2002, f. 5-28-02, cert. ef. 6-1-02; CCB 4-2003, f. & cert. ef. 6-3-03; CCB 1-2005(Temp), f. & cert. ef. 1-5-05 thru 7-1-05; CCB 2-2005, f. 6-29-05, cert. ef. 7-1-05; CCB 3-2005, f. & cert. ef. 8-24-05

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**Adm. Order No.:** CCB 4-2005
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 8-1-05
**Rules Amended:** 812-003-0140
**Subject:** 812-003-0140 is amended to reduce the license fee from $295 to $260 effective October 1, 2005.
**Rules Coordinator:** Catherine Dixon—(503) 378-4621, ext. 4077

**812-003-0140**
**License, Renewal, and Reissue Fees**

(1) The fee for all categories for new license, renewal, or reissue applications is:

(a) $260 for two years; or

(b) $520 for four years.

(2) Fees will not be prorated.

(3) Except as provided in sections (4) and (5) of this rule, licensing, renewal, or reissue fees are non-refundable and nontransferable.

(4) When an applicant withdraws their application for a new license or renewal prior to issuance or fails to complete the licensing or renewal

process, the agency may refund the licensing fee, but will retain a processing fee of $40.

(5) 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.

Stat. Auth.: ORS 670.310, 701.130 & 701.235
Stats. Implemented: ORS 701.115, 701.125 & 701.130
Hist.: CCB 9-2004, f. & cert. ef. 12-10-04; CCB 4-2005, f. 8-24-05, cert. ef. 10-1-05

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**Adm. Order No.:** CCB 5-2005
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 1-1-06
**Notice Publication Date:** 8-1-05
**Rules Amended:** 812-005-0005
**Rules Ren. & Amended:** 812-008-0080 to 812-008-0200, 812-008-0080 to 812-008-0201, 812-008-0080 to 812-008-0202, 812-008-0080 to 812-008-0203, 812-008-0080 to 812-008-0204, 812-008-0080 to 812-008-0205, 812-008-0080 to 812-008-0206, 812-008-0080 to 812-008-0207, 812-008-0080 to 812-008-0208, 812-008-0080 to 812-008-0209, 812-008-0080 to 812-008-0210, 812-008-0080 to 812-008-0211, 812-008-0080 to 812-008-0212, 812-008-0080 to 812-008-0213, 812-008-0080 to 812-008-0214
**Subject:** 812-005-0005 is amended to correct the cite references. 812-008-0080 is amended and renumbered to simplify and clarify language, correct cite references, combine some sections to streamline, and adds a new requirements in 812-008-0202. These changes were recommended by the Home Inspector Advisory Committee (HIAC) and are filed under the authority of HB 2075 (Chapter 114, Oregon Laws 2005).
**Rules Coordinator:** Catherine Dixon—(503) 378-4621, ext. 4077

**812-005-0005**
**Schedule of Penalties**

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

(1) $600 for advertising or submitting a bid to do work as a contractor in violation of ORS 701.055(1) and OAR 812-003-0120, which may be reduced to $200 if the respondent becomes licensed or to $50 if the advertisement or bid is withdrawn immediately upon notification from the agency that a violation has occurred and no work was accepted as a result of the advertisement or bid; and

(2) $700 per offense without possibility of reduction for advertising or submitting a bid to do work as a contractor in violation of ORS 701.055(1) and OAR 812-003-0120, when one or more previous violations have occurred, or when an inactive, lapsed, invalid, or misleading license number has been used; and

(3) $1,000 per offense for performing work as a contractor in violation of ORS 701.055(1) when the Board has no evidence that the person has worked previously without having a license and no consumer has suffered damages from the work, which may be reduced to $700 if the respondent becomes licensed within a specified time; and

(4) $5,000 per offense for performing work as a contractor in violation of ORS 701.055(1), when an owner has filed a complaint for damages caused by performance of that work, which may be reduced to $700 if the contractor becomes licensed within a specified time and settles or makes reasonable attempts to settle with the owner; and

(5) $5,000 per offense for performing work as a contractor in violation of ORS 701.055(1), when one or more violations have occurred, or when an inactive, lapsed, invalid, or misleading license number has been used; and

(6) $500 per offense for failure to respond to the agency's request for the list of subcontractors required in ORS 701.055(11); and

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

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

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

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

(11) Failure to use a written contract as required by ORS 701.055(14), $200; when a claim has been filed, $400; second and subsequent offenses, $1,000.

(12) Violation of ORS 701.055 (13), failure to provide a Consumer Notification form; $100 first offense; $500 second offense; $1,000 third offense; and $5,000 for subsequent offenses. Civil penalties shall not be reduced unless the agency determines from clear and convincing evidence that compelling circumstances require a suspension of a portion of the penalty in the interest of justice. In no event shall a civil penalty for this offense be reduced below $100.

(13) Failure to conform to information provided on the application in violation of ORS 701.075(2), issuance of a $1,000 civil penalty, and suspension of the license until the contractor provides the agency with proof of conformance with the application.

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

(b) If the violator is a licensed developer working in violation of the conditions established pursuant to ORS 701.005(7), the licensee shall be permanently barred from licensure in the Licensed Developer category.

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

(15) Failure to comply with any part of ORS Chapters 316, 656, or 657, ORS 701.035 or 701.075, as authorized by ORS 701.100, $1,000 and suspension of the license until the contractor provides the agency with proof of compliance with the statute.

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

(17) Working without a construction permit in violation of ORS 701.135, $1,000 for the first offense; $2,000 and suspension of CCB license for three (3) months for the second offense; $5,000 and permanent revocation of CCB license for the third and subsequent offenses.

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

(19) Violation of ORS 701.135(1)(L) by engaging in conduct as a contractor that is dishonest or fraudulent and injurious to the welfare of the public: first offense, $1,000, suspension of the license or both; second and subsequent offenses, $5,000, per violation, revocation or suspension of the license until the fraudulent conduct is mitigated in a manner satisfactory to the agency or both.

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

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

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

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

(d) Failing to comply with the payroll certification requirements of ORS 279.354; or

(e) Failing to comply with the posting requirements of ORS 279.350: $1,000 and suspension of the license until the money required as wages for employees is paid in full and the contractor is in compliance with the appropriate state and federal laws.

(21) Violation of ORS 701.135(1)(L) by engaging in conduct as a contractor that is dishonest or fraudulent and injurious to the welfare of the public, as described in subparagraphs (19) or (20), where more than two violations have occurred: $5,000 and revocation of the license.

(22) When, as set forth in ORS 701.135(1)(h), the number of licensed contractors working together on the same task on the same job site, where one of the contractors is licensed exempt under ORS 701.035(2)(b), exceeded two sole proprietors, one partnership, or one limited liability company, penalties shall be imposed on each of the persons to whom the contract is awarded and each of the persons who award the contract, as follows: $1,000 for the first offense, $2,000 for the second offense, six month suspension of the license for the third offense, and three-year revocation of license for a fourth offense.

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

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

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

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

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

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

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

(30) Violation of ORS 279.323:

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

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

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

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

(31) Violation of ORS 701.175, inclusion of provisions in a contract that preclude a homeowner from filing a claim with the Board: $1,000 for the first offense, $2,000 for the second offense, and $5,000 for the third and subsequent offenses.

Stat. Auth.: ORS 183.310 - 183.500, 670.310, 701.235, 701.280 & 701.992
Stats. Implemented: ORS 279C.590, 701.135, 701.175, 701.227 & 701.992
Hist.: 1BB 4-1982, f. & ef. 10-7-82; 1BB 1-1983, f. & ef. 3-1-83; Renumbered from 812-011-0080(13); 1BB 3-1983, f. 10-5-83, ef. 10-15-83; 1BB 3-1984, f. & ef. 5-11-84; 1BB 3-1985, f.& ef. 4-25-85; BB 1-1987, f. & ef. 3-5-87, BB 1-1988(Temp), f. & cert. ef. 1-26-88; BB 2-1988, f. & cert. ef. 6-6-88; CCB 1-1989, f. & cert. ef. 11-1-89; CCB 2-1990, f. 5-17-90, cert. ef. 6-1-90; CCB 3-1990(Temp), f. & cert. ef. 7-27-90; CCB 4-1990, f. 10-30-90, cert. ef. 11-1-90; CCB 3-1991, f. 9-26-91, cert. ef. 9-29-91; CCB 1-1992, f. 1-27-92, cert. ef. 2-1-92; CCB 2-1992, f. & cert. ef. 4-15-92; CCB 4-1992, f. & cert. ef. 6-1-92; CCB 5-1993, f. 12-7-93, cert. ef. 12-8-93; CCB 2-1994, f. 12-29-94, cert. ef. 1-1-95; CCB 3-1995, f. 9-7-95, cert. ef. 9-9-95; CCB 4-1995, f. & cert. ef. 10-5-95; CCB 3-1996, f. & cert. ef. 8-13-96; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98 ; CCB 7-1999(Temp), f. & cert. ef. 11-1-99 thru 4-29-00; CCB 4-2000, f. & cert. ef. 5-2-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 13-2000(Temp), f. & cert. ef 11-13-00 thru 5-11-01; CCB 2-2001 f. & cert. ef. 4-6-01; CCB 8-2001, f. 12-12-01, cert. ef. 1-1-02; CCB 1-2002(Temp), f. & cert. ef. 3-1-02 thru 8-26-02; CCB 2-2002, f. & cert. ef. 3-1-02; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; CCB 8-2002, f. & cert. ef. 9-3-02; CCB 11-2003, f. 12-5-03, cert. ef. 1-1-04; CCB 6-2004, f. 6-25-04, cert. ef. 9-1-04; CCB 9-2004, f. & cert. ef. 12-10-04; CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0200**
**Standards of Behavior and Standards of Practice**

OAR 812-008-0201 sets forth the standards of behavior of Oregon certified home inspectors. OAR 812-008-0202 through 812-008-0214 of this rule set forth the minimum standards of practice required by Oregon certified home inspector.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0201**
**Standards of Behavior**

(1) An Oregon certified home inspector shall not engage in dishonest or fraudulent conduct or undertake activities that are injurious to the welfare of the public, which result in injury or damage to another person.

(2) Opinions expressed by Oregon certified home inspectors shall only be based on their education, experience, and physical evidence observed by the inspector.

(3) An Oregon certified home inspector shall not disclose any information about the results of an inspection without the approval of the client for whom the inspection was undertaken.

(4) No Oregon certified home inspector shall accept compensation or any other consideration from more than one interested party for the same service without the consent of all interested parties.

(5) No Oregon certified home inspector shall give any gift, rebate, kickback, or any thing of value, including but not limited to any payment of money, to any person for the purposes of obtaining an engagement, referral or preference selection to perform a home inspection. However, section (5) of this rule shall not apply to items of nominal value given as part of an advertising promotion of general distribution.

(6) No Oregon certified home inspector shall express, within the context of an inspection, an appraisal or opinion of the market value of the inspected property.

(7) Before the execution of a contract to undertake a home inspection, an Oregon certified home inspector shall disclose to the client any interest in a business that may affect the client. No Oregon certified home inspector shall allow his or her interest in any business to affect the quality or results of inspection work that the Oregon certified home inspector may be called upon to undertake.

(8) An Oregon certified home inspector shall not engage in false or misleading advertising or otherwise misrepresent any matters to the public.

Stat. Auth.: ORS 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0202**
**Purpose and Scope**

(1) Home inspections undertaken according to division 8 shall be based solely on the property conditions, as observed at the time of the home inspection.

(2) Oregon certified home inspectors shall:

(a) Provide a written inspection contract, signed by both the Oregon certified home inspector and client, prior to completing a home inspection that shall:

(A) State that the home inspection is in accordance with standards and practices set forth in division 8 of OAR chapter 812;

(B) Describe the services provided and their cost;

(C) State where the planned inspection differs from the standard home inspection categories as set forth in OAR 812-008-0205 through 812-008-0214; and

(D) Conspicuously state whether the home inspection includes a wood destroying organism inspection and if such inspection is available for a fee.

(E) For the purpose of this rule, a home inspection shall be deemed completed when the initial written inspection report is delivered.

(b) Observe readily visible and accessible installed systems and components listed as part of a home inspection as defined by these rules unless excluded pursuant to these rules in OAR 812-008-0200 through 812-008-0214; and

(c) Submit a written report to the client that shall:

(A) Describe those systems and components as set forth in OAR 812-008-0205 through 812-008-0214;

(B) Record in the report each item listed in OAR 812-008-0205 through 812-008-0214 and indicate whether or not the property inspected was satisfactory with regard to each item of inspection; it will not be sufficient to satisfy subsection (2)(c) of this rule that the certified home inspector prepare a report listing only deficiencies;

(C) State whether any inspected systems or components do not function as intended, allowing for normal wear and tear; and how, if at all, the habitability of the dwelling is affected.

(D) State the inspector's recommendation to monitor, evaluate, repair, replace or other appropriate action.

(E) State the Construction Contractors Board license number of the business and the name, certification number and signature of the person undertaking the inspection.

(d) Submit to each customer at the time the contract is signed a copy of Summary of Oregon Home Inspector Certification Law (ORS 701) or Summary of Oregon Home Inspector Certification Law (ORS 701) and Standards of Practice for Home Inspectors.

(3) Division 8 does not limit Oregon certified home inspectors from reporting observations and conditions or rendering opinions of items in addition to those required in division 8.

(4) All written reports, bids, contracts, and an individual's business cards shall include the Oregon certified home inspector's certification number.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0203**
**General Limitations**

(1) Inspections undertaken in accordance with division 8 are visual and are not technically exhaustive.

(2) "Residential structures" and "appurtenances" thereto are defined in ORS Chapter 701.005 and OAR chapter 812-008-0020.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0204**
**General Exclusions**

(1) Oregon certified home inspectors are not required to report on:

(a) Life expectancy of any component or system;

(b) The causes of the need for a repair;

(c) The methods, materials, and costs of corrections;

(d) The suitability of the property for any specialized use;

(e) Compliance or non-compliance with codes, ordinances, statutes, regulatory requirements or restrictions;

(f) The advisability or inadvisability of purchase of the property;

(g) The presence or absence of pests such as wood damaging organisms, rodents, or insects;

(h) Cosmetic items, underground items, or items not permanently installed; or

(i) Detached structures.

(2) Oregon certified home inspectors are not required to:

(a) Offer or undertake any act or service contrary to law;

(b) Offer warranties or guarantees of any kind;

(c) Offer to undertake engineering, architectural, plumbing, electrical or any other job function requiring an occupational license in the jurisdiction where the inspection is taking place, unless the Oregon certified home inspector holds a valid occupational license, in which case the Oregon certified home inspector may inform the client that the home inspector is so certified, and is therefore qualified to go beyond division 8 and undertake additional inspections beyond those within the scope of the basic inspection;

(d) Calculate the strength, adequacy, or efficiency of any system or component;

(e) Enter any area, undertake any procedure that may damage the property or its components, or be dangerous to the Oregon certified home inspector or other persons;

(f) Operate any system or component that is shut down or otherwise inoperable;

(g) Operate any system or component that does not respond to normal operating controls;

(h) Disturb insulation, move personal items, panels, furniture, equipment, plant life, soil, snow, ice, or debris that obstructs access or visibility;

(i) Determine the presence or absence of any suspected adverse environmental condition or hazardous substance, including but not limited to toxins, carcinogens, noise or contaminants in the building or soil, water, and air;

(j) Determine the effectiveness of any system installed to control or remove suspected hazardous substances;

(k) Predict future condition, including but not limited to failure of components;

(l) Project operating costs of components;

(m) Evaluate acoustical characteristics of any system or component;

(n) Observe special equipment or accessories that are not listed as components to be observed in division 8; or

(o) Identify presence of odors or their source.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0205**
**Structural Components**

(1) The Oregon certified home inspector shall observe and describe visible structural components including:

(a) Foundation;

(b) Floors and floor structure;

(c) Walls and wall structure;

(d) Columns or piers;

(e) Ceilings and ceiling structure; and

(f) Roofs and roof structure.

(2) The Oregon certified home inspector shall:

(a) Probe or sound structural components where deterioration is suspected, except where probing would damage any finished surface;

(b) Enter underfloor crawl spaces, basements, and attic spaces except when access is obstructed or restricted, when entry could damage any property, or when dangerous or adverse situations are suspected;

(c) Report the methods used to observed underfloor crawl spaces and attics; report inaccessible areas; and

(d) Report signs of abnormal or harmful water penetration into the building or signs of abnormal or harmful condensation on building components.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0206**
**Exterior and Site**

(1) The Oregon certified home inspector shall observe and describe:

(a) Wall cladding, flashings, and trim;

(b) Entryway doors and all windows;

(c) Garage door operators;

(d) Attached decks, balconies, stoops, steps, areaways, porches, and applicable railings;

(e) Eaves, soffits, and fascias; and

(f) Vegetation, grading, drainage, driveways, patios, walkways, and retaining walls with respect to their effect on the condition of the building that adversely affect the structure.

(2) The Oregon certified home inspector shall:

(a) Operate all entryway doors and a representative number of windows;

(b) Operate garage doors manually or by using permanently installed controls for any garage door opener; and

(c) Report whether or not any garage door opener will automatically reverse or stop when meeting reasonable resistance during closing, or reverse with appropriately installed optical sensor system.

(3) The Oregon certified home inspector is not required to observe:

(a) Storm windows, storm doors, screening, shutters, and awnings;

(b) Garage door operator remote control transmitters;

(c) Soil or geological conditions, site engineering, property boundaries, encroachments, or easements;

(d) Recreational facilities (including spas, saunas, steambaths, swimming pools, decorative water features, tennis courts, playground equipment, and other exercise, entertainment, or athletic facilities); or

(e) Detached buildings or structures;

(f) Fences or privacy walls;

(g) Ownership fencing, privacy walls, retaining walls; or

(h) Condition of trees, shrubs, or vegetation.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0207**
**Roofing**

(1) The Oregon certified home inspector shall observe and describe:

(a) Roof coverings;

(b) Roof drainage systems;

(c) Flashings;

(d) Skylights, chimneys, and roof penetrations; and

(e) Signs of leaks or abnormal condensation on building components.

(2) The Oregon certified home inspector shall report the method used to observe the roofing and components.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355

Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0208**
**Plumbing**

(1) The Oregon certified home inspector shall observe:

(a) Interior water supply and distribution system, including piping materials, supports, and insulation, fixtures and faucets, functional flow, leaks, and cross connections;

(b) Interior drain, waste, and vent system, including traps, drain, waste, and vent piping, piping supports and pipe insulation, leaks, and functional drainage;

(c) Hot water systems including water heating equipment, normal operating controls, automatic safety controls, and chimneys, flues, and vents;

(d) Above ground oil storage and distribution systems including interior oil storage equipment, supply piping, venting, and supports; leaks; and

(e) Sump pumps and sewage ejection pumps.

(2) The Oregon certified home inspector shall describe:

(a) Water supply and distribution piping materials;

(b) Drain, waste, and vent piping materials; and

(c) Water heating equipment.

(3) The Oregon certified home inspector shall operate all plumbing fixtures, including their faucets and all exterior faucets attached to the house except where the flow end of the faucet is connected to an appliance or interior faucets not serviced by a drain.

(4) The Oregon certified home inspector is not required to:

(a) State the effectiveness of anti-siphon devices and anti-backflow valves;

(b) Determine whether water supply and waste disposal systems are public or private;

(c) Operate automatic safety controls;

(d) Operate any valve except toilet flush valves, fixture faucets, and hose faucets;

(e) Observe:

(A) Water conditioning systems;

(B) Fire and lawn sprinkler systems;

(C) On-site water supply quantity and quality;

(D) On-site waste disposal systems;

(E) Foundation irrigation systems;

(F) Whirlpool tubs, except as to functional flow and functional drainage;

(G) Swimming pools and spas; or

(H) Solar water heating equipment.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0209**
**Electrical**

(1) The Oregon certified home inspector shall observe:

(a) Service entrance conductors;

(b) Service equipment, grounding equipment, main overcurrent device, and distribution panels;

(c) Amperage and voltage ratings of the service;

(d) Branch circuit conductors, their overcurrent devices, and the compatibility of their amperages and voltages;

(e) The operation of a representative number of installed ceiling fans, lighting fixtures, switches, and receptacles located inside the house, garage, and on the dwelling's exterior walls;

(f) The polarity and grounding of all receptacles within six feet of interior plumbing fixtures, and all receptacles in the garage or carport, and on the exterior of inspected structures;

(g) The operation of ground fault or arc fault circuit interrupters; and

(h) Smoke alarms.

(2) The Oregon certified home inspector shall describe:

(a) Service amperage and voltage;

(b) Service entry conductor materials; and

(c) Service type as being overhead or underground;

(3) The Oregon certified home inspector shall report:

(a) Any observed 110 volt aluminum branch circuit wiring; and

(b) The presence or absence of smoke alarms, and operate their test function, if accessible, except when detectors are part of a central security system.

(4) The Oregon certified home inspector is not required to:

(a) Insert any tool, probe, or testing device inside the panels;

(b) Test or operate any overcurrent device or safety device in the electrical service panel or elsewhere that may adversely affect the personal property of the resident;

(c) Dismantle any electrical device or control other than to remove the covers of the main or auxiliary distribution panels;

(d) Observe:

(A) Low-voltage systems except to report the presence of solenoid-type lighting systems;

(B) Security system devices, heat detectors, or carbon monoxide detectors;

(C) Telephone, security, TV, intercoms, lightening arrestors or other ancillary wiring that is not a part of the primary electrical distribution system; or

(D) Built-in vacuum equipment.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0210**
**Heating**

(1) The Oregon certified home inspector shall observe permanently installed heating systems including:

(a) Heating equipment;

(b) Normal operating controls;

(c) Automatic safety controls;

(d) Chimneys, flues, and vents, where readily visible;

(e) Solid fuel heating devices;

(f) Heat distribution systems including fans, pumps, ducts, and piping, with supports, insulation, air filters, registers, radiators, fan coil units, convectors; and

(g) The presence of installed heat source in each room.

(2) The Oregon certified home inspector shall describe:

(a) Energy source; and

(b) Heating equipment and distribution type.

(3) The Oregon certified home inspector shall operate the systems using normal operating controls.

(4) The Oregon certified home inspector shall open readily accessible panels provided by the manufacturer or installer for routine homeowner maintenance.

(5) The Oregon certified home inspector is not required to:

(a) Operate automatic safety controls;

(b) Ignite or extinguish solid fuel fires;

(c) Observe:

(A) The interior of flues;

(B) Fireplace insert flue connections;

(C) Humidifiers; or

(D) The uniformity or adequacy of heat supply to the various rooms.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0211**
**Central Air Conditioning**

(1) The Oregon certified home inspector shall observe:

(a) Central air conditioning systems including cooling and air handling equipment and normal operating controls.

(b) Distribution systems including fans, pumps, ducts and piping, with associated supports, dampers, insulation, air filters, registers, and fan-coil units.

(2) The Oregon certified home inspector shall describe:

(a) Energy sources; and

(b) Cooling equipment type.

(3) The Oregon certified home inspector shall operate the systems using normal operating controls.

(4) The Oregon certified home inspector shall open readily openable panels provided by the manufacturer or installer for routine homeowner maintenance.

(5) The Oregon certified home inspector is not required to:

(a) Operate cooling systems when weather conditions or other circumstances may cause equipment damage;

(b) Observe non-central air conditioners; or

(c) Observe the uniformity or adequacy of cool-air supply to the various rooms.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0212**
**Interiors**

(1) The Oregon certified home inspector shall observe and describe:

(a) Walls, ceiling, and floors;

(b) Steps, stairways, balconies, and railings;

(c) Counters and cabinets; and

(d) Doors and windows.

(2) The Oregon certified home inspector shall:

(a) Operate a representative number of windows and interior doors; and

(b) Report signs of abnormal or harmful water penetration or damage in the building or components or signs of abnormal or harmful condensation on building components.

(3) The Oregon certified home inspector is not required to:

(a) Operate a representative number of cabinets and drawers;

(b) Observe paint, wallpaper, and other finish treatments on the interior walls, ceilings, and floors; or

(c) Observe draperies, blinds, or other window treatments.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0213**
**Insulation and Ventilation**

(1) The Oregon certified home inspector shall observe and describe:

(a) Insulation and vapor retarders/barriers in unfinished spaces;

(b) Ventilation of attics and foundation areas;

(c) Kitchen, bathroom, and laundry venting systems; and

(d) The operation of any readily accessible attic ventilation fan, and when the temperature permits, the operation of any readily accessible thermostatic control.

(e) Absence of insulation in unfinished space adjacent to heated living areas.

(2) The Oregon certified home inspector is not required to report on:

(a) Concealed insulation and vapor retarders;

(b) Venting equipment that is integral with household appliances; or

(c) Thermal efficiency ratings.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

**812-008-0214**
**Built-in Kitchen Appliances**

(1) The Oregon certified home inspector shall observe and operate the basic functions of the following kitchen appliances:

(a) Installed dishwasher, through its normal cycle;

(b) Range, cook top, and installed oven;

(c) Trash compactor;

(d) Garbage disposal;

(e) Ventilation equipment or range hood;

(f) Installed microwave oven; and

(g) Built-in refrigerators.

(2) The Oregon certified home inspector is not required to observe:

(a) Clocks, timers, self-cleaning oven function, or thermostats for calibration or automatic operation;

(b) Non built-in appliances;

(c) Refrigeration units that are not installed; or

(d) Microwave leakage.

(3) The Oregon certified home inspector is not required to operate:

(a) Appliances in use; or

(b) Any appliance that is shut down or otherwise inoperable.

Stat. Auth.: ORS 670.310, 701.235, 701.350 & 701.355
Stats. Implemented: ORS 701.350 & 701.355
Hist.: CCB 1-1998, f. & cert. ef. 2-6-98; CCB 8-1998, f. 10-29-98, cert. ef. 11-1-98; CCB 2-2000, f. 2-25-00, cert. ef. 3-1-00; CCB 7-2000, f. 6-29-00, cert. ef. 7-1-00; CCB 9-2000, f. & cert. ef. 8-24-00; CCB 6-2001, f. & cert. ef. 9-27-01; CCB 7-2002, f. 6-26-02 cert. ef. 7-1-02; Renumbered from 812-008-0080, CCB 5-2005, f. 8-24-05, cert. ef. 1-1-06

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## Department of Administrative Services
## Chapter 125

**Adm. Order No.:** DAS 10-2005(Temp)
**Filed with Sec. of State:** 8-31-2005
**Certified to be Effective:** 9-21-05 thru 3-18-06
**Notice Publication Date:**
**Rules Adopted:** 125-600-0005
**Subject:** The Department of Administrative Services is directed by ORS 84.064 to make determinations and adopt standards for state agencies to implement UETA. This rule addresses the electronic signature provisions of the act.
**Rules Coordinator:** Kristin Keith—(503) 378-2349, ext. 325

**125-600-0005**
**Guidelines for Use of Electronic Signatures by State Agencies**

(1) The purpose of this rule is to implement the electronic signature provisions of the Uniform Electronic Signatures Act (UETA). The rule is not intended to apply to the other provisions of the act.

(2) This rule applies prospectively to new software applications with electronic transactions requiring signatures that are implemented after the effective date of this rule.

(3) Agencies shall follow the Information Resources Management Division policy which adopts the federal E-authentication process. The IRMD policy requires that agencies using electronic signatures:

(a) Determine the level of assurance the agency needs that the party signing an electronic transaction is authentic.

(b) Use only those tools and software applications approved by NIST and the Department of Administrative Services, Information Resources Management Services Division to mitigate the risks identified and provide the level of authentication needed.

(4) Agencies may request an exemption from these rules from the Department of Administrative Services.

Stat. Auth.: ORS 184.305, 291.038, 84, 84.049, 84.052, 84.055 & 84.064
Stats. Implemented: Portions of 2001 HB 2112
Hist.: DAS 10-2005(Temp), f. 8-31-05, cert. ef. 9-21-05 thru 3-18-06

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## Department of Administrative Services, Public Employees' Benefit Board
## Chapter 101

**Adm. Order No.:** PEBB 3-2005
**Filed with Sec. of State:** 8-31-2005
**Certified to be Effective:** 9-1-05
**Notice Publication Date:** 8-1-05
**Rules Amended:** 101-002-0015, 101-010-0005, 101-015-0005, 101-020-0005, 101-020-0010, 101-020-0040, 101-020-0045, 101-030-0022, 101-030-0040, 101-040-0005, 101-040-0010, 101-040-0020, 101-040-0030, 101-040-0035, 101-040-0040, 101-040-0045, 101-040-0050, 101-040-0055, 101-040-0080, 101-050-0005, 101-050-0025
**Subject:** This rulemaking amends current rules governing the eligibility of benefits and procedures of the Public Employees' Benefit Board and are made a part of OAR chapter 101 generally. Experience in using the rules, changes and clarification of federal regulations governing Internal Revenue Service Code Section 125, federal and state statutes and the ongoing development of the agency-specific PEBB administrative manual has identified the need for clarification of existing rules.
**Rules Coordinator:** Kristin Keith—(503) 378-2349, ext. 325

**101-002-0015**
**Public Employees' Benefit Board Appeal Procedure and Delegation**

(1) **Appeal of Administrative and Eligibility Issues to PEBB**. The following procedure will be used by individuals to request review with respect to administrative or eligibility issues:

(a) **To a Benefits Analyst**. If an individual requesting insurance coverage through PEBB receives what the individual considers an incorrect or

unfair denial from the employing agency or insurance carrier, the individual may seek consideration by a Benefits Analyst. The request for consideration may be in writing or by telephone. The Benefits Analyst will review the request and make a determination within 45 days of the date of receipt of the request. If a determination cannot be made within 45 days, the individual will be notified.

(b) **To Benefits Manager**. If an individual receives a written denial of a request for consideration from the PEBB Benefits Analyst and the individual is dissatisfied with the denial, the individual may seek reconsideration of the denial by the PEBB Benefits Manager. The request for reconsideration must be made in writing and received by the Benefits Manager within 45 days of the date of the determination letter. Upon receipt of the request for reconsideration, the Benefits Manager will review the request and determine whether to deny or grant the request. The Benefits Manager will send a written notice and explanation to the individual of the Benefits Manager's decision within 30 days after receipt by the Benefits Manager of the request for reconsideration.

(c) **To Administrator or Designee**.

(A) The Benefits Manager may forward, with the consent of the Administrator or designee, a request for reconsideration from the individual to the Administrator or designee for a determination. If a request for reconsideration is forwarded from the Benefits Manager, the Administrator or designee will send a written notice and explanation to the individual of the decision within 30 days after receipt by the Benefits Manager of the request for reconsideration.

(B) If the individual is dissatisfied with the determination of the Benefits Manager, the individual may request further reconsideration by the PEBB Administrator or designee. A request for reconsideration must be made in writing and received within 60 days of the date of the determination letter by the Benefits Manager. If PEBB receives a timely written request for reconsideration of a prior determination by the Benefits Manager, the Administrator or designee will review the request and determine whether to deny or grant the request. The Administrator or designee will send a written notice and explanation to the individual of the decision within 30 days after receipt of the request for reconsideration from the individual.

(d) **To Operations Subcommittee**. The Administrator or designee may forward a request for reconsideration from the individual or the Benefits Manager to the PEBB Operations Subcommittee or the Board for review and determination. If the individual is dissatisfied with a determination of the Administrator or designee, the individual may request further reconsideration by the PEBB Operations Subcommittee. A request for reconsideration must be made in writing and received by the Operations Subcommittee within 30 days of the date of the determination letter by the Administrator or designee. If a request is forwarded to the Operations Subcommittee, or the Operations Subcommittee receives a timely request for reconsideration, the Subcommittee will review the request and determine whether to deny or grant the request. The Subcommittee will send a written notice and explanation to the individual of the Subcommittee's determination within 30 days after the next regularly scheduled meeting of the Subcommittee.

(e) **To the Board**. If an individual is dissatisfied with a determination of the Operations Subcommittee, the individual may request further reconsideration by the Board. A request for reconsideration must be made in writing and received by the Board within 30 days of the date of the determination letter by the Operations Subcommittee. A request for reconsideration may be forwarded, with the consent of the Board, by the Operations Subcommittee to the Board for review and a determination. If a request is forwarded to the Board by the Administrator or the Subcommittee, or the Board receives a timely request for reconsideration, the Board will review the request and determine whether to deny or grant the request. The Board will send a written notice and explanation to the individual of the Board's determination within 30 days after the next regularly scheduled meeting of the Board.

(f) An individual may appeal the Board's decision as provided under the Oregon Administrative Procedures Act, ORS Chapter 183.

(g) An individual will be notified of the status of his or her request for reconsideration within 15 days of receipt of the request for reconsideration by the applicable reviewing entity.

(2) **Delegation to Administrator and Staff**.

(a) The Administrator is hereby authorized to take all action necessary, desirable or convenient to administer the benefit plans of the Public Employees' Benefit Board, including but not limited to:

(A) Acting on any applications for insurance coverage or for refund of premiums.

(B) Reviewing, granting or denying requests for benefit plan coverage or other requests related to providing the benefit plans through PEBB.

(b) The Administrator may, in his or her discretion, refer for a final determination any matter to the Board or to the Operations Subcommittee.

(c) The Administrator is authorized to delegate to subordinates the authority to take any action on the Administrator's behalf.

(3) **Appeal of Contract Coverage Issues To the Insurance Carrier**. The following procedure will be used to request review of an action or determination by an insurance carrier with respect to the insurance coverage provided by the insurance carrier:

(a) If an eligible individual receives a claim denial from an insurance carrier, the eligible individual may appeal directly to the insurance carrier as described in OAR 101-002-0020. The procedure to appeal to the insurance carrier is outlined in the benefit plan's member handbook; or

(b) If the eligible individual receives a claim denial from an insurance carrier, the eligible individual may seek assistance from PEBB with his or her appeal to the insurance carrier. Upon request from the eligible individual, PEBB will verify that the insurance carrier is acting within the scope of the insurance contract. This may require that the eligible individual's request be reviewed through the insurance carrier's internal review process. Within 45 days after receipt of the request for assistance by PEBB, or such later date as may be allowed by any contractual provisions set forth between PEBB and the applicable insurance carrier, the insurance carrier will issue its determination to the Benefits Manager. The Benefits Manager will notify the eligible individual of the insurance carrier's decision within 15 days of receipt of the determination by the Benefits Manager.

(c) The Benefits Manager will review the insurance carrier's determination with the Administrator.

(d) If PEBB agrees with the insurance carrier's determination and so notifies the eligible individual, the eligible individual may appeal the insurance carrier's determination through mediation or binding arbitration.

(e) Information about mediation or binding arbitration can be obtained from the Public Employees' Benefit Board.

Stat. Auth.: ORS 243.061 - 243.302, 659A.060 - 659A.069 & 743.600 - 743.602
Stats. Implemented: ORS 183.310-550, 243.061-302, 192.660 & 292.051
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-010-0005**
**Definitions**

Unless the context indicates otherwise, as used in OAR chapter 101, divisions 1 through 60, the following definitions will apply:

(1) "Actively at Work" means:

(a) For medical and dental insurance coverage, an Eligible Employee at work, in Paid Regular status, scheduled for work during the month for which insurance coverage is requested, or using accrued leave on the effective date of coverage. In accordance with the Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) enacted on August 21, 1996, an employee may not be denied eligibility for health insurance coverage based on health status or disability.

(b) For life, disability and accidental death and dismemberment insurance coverage, an Eligible Employee who is physically on the job and receiving pay for the first scheduled day of work and performing the material duties of the employee's own occupation at the employer's usual place of business. If an Eligible Employee is incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of his or her insurance coverage or increase in insurance coverage, the insurance coverage or increase in insurance coverage will not become effective until the day after the Eligible Employee completes one full day of active work.

(2) "Administrator" means the individual who administers the benefit plans on behalf of the Board.

(3) "Affidavit of Dependency" means a written document in which an Eligible Employee attests that the dependent meets the criteria set forth in OAR 101-010-0005(7) on the date the document is signed by the Eligible Employee.

(4) "Affidavit of Domestic Partnership" means a written document in which an Eligible Employee and another individual attest that they meet the criteria set forth in OAR 101-010-0005(8) on the date the document is signed by the Eligible Employee and the individual.

(5) "Board" means the Public Employees' Benefit Board established under ORS 243.061.

(6) "Decline Benefits" means the Eligible Employee waives his or her right to the employer contribution and enrollment in any of the insurance plans available through PEBB, including flexible spending accounts and all voluntary insurance plans.

(7) "Dependent Child" means any child who meets the criteria in (a) and at least one criterion in (b) of the following:

(a) The Dependent Child: Is unmarried and without a Domestic Partner; and

(A) Is under the age of 19 at the end of the calendar year; or

(B) Is at least age 19 and under the age of 24 and continues to qualify as a student or meets the gross income test set forth and provided to taxpayers annually by the Internal Revenue Service; and

(C) Meets the criteria for a "Dependent Child" of an Eligible Employee, or the Eligible Employee's spouse or Domestic Partner under Section 152 of the Internal Revenue Code, whether or not the Eligible Employee, or the Eligible Employee's spouse or Domestic Partner actually claims or receives a dependent exemption from federal income tax for the child. Not all individuals listed in Section 152 of the Internal Revenue Code are eligible — Refer OAR 101-010-0005(13).

(b) The Dependent Child:

(A) Is a biological or adopted child or a child placed for adoption with the Eligible Employee or the Eligible Employee's spouse or Domestic Partner;

(B) Is a child living in the home of the Eligible Employee, or the Eligible Employee's spouse or Domestic Partner, who is a legal ward by court decree; a dependent by Affidavit of Dependency; or is under the legal guardianship of the Eligible Employee, or the Eligible Employee's spouse or Domestic Partner;

(C) Is a child aged 24 or older who is incapable of self-sustaining employment by reason of mental retardation or physical handicap. The child must have been covered by the insurance plan at the time of his or her 24th birthday and the physical handicap or mental retardation must have existed prior to the child attaining age 24.

(c) The Dependent Child of a Domestic Partner is entitled to the same benefit plans under these rules as the Dependent Child of an Eligible Employee or his or her spouse.

(8) "Domestic Partner" means an individual who, together with an Eligible Employee, meets all the criteria listed below. The individual and Eligible Employee:

(a) Are both at least 18 years of age;

(b) Share a close personal relationship and are responsible for each other's welfare;

(c) Are each other's sole Domestic Partners;

(d) Are not married to anyone and have not had a spouse or another Domestic Partner within the prior six months;

(e) Are not related by blood closer than would bar marriage in the State of Oregon;

(f) Have jointly shared the same regular and permanent residence for at least six months.

(g) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household.

(h) If previously married, would commence the six-month period on the final date of divorce.

(9) "Eligible Employee" means an employee of a PEBB participating organization, including state officials, in exempt, unclassified, classified and management service positions who are expected to work at least 90 days; and who work at least Half Time or are in a position classified as job share.

(10) "Family Member" means:

(a) A legally married spouse of an Eligible Employee; or

(b) A Dependent Child.

(11) "Group Medical Plan" for purposes of Opting Out of medical coverage means:

(a) Any medical plan offered or contributed to by an employer or a former employer;

(b) Medical coverage provided by a federal government or other governmental entity as an insurance plan sponsor, employer or former employer such as Federal Employee Health Benefits or TriCare; and other group medical insurance coverage as approved by PEBB. Reference OAR 101-020-0015 regarding Opting Out of medical insurance coverage.

(12) "Half Time" means an employee who works less than fulltime but at least:

(a) Eighty (80) Paid Regular hours per month; or

(b) .5 FTE for OUS employees; or

(c) As defined by collective bargaining.

(13) "Ineligible Dependent" means a dependent who does not meet the definition of spouse, "Domestic Partner," or "Dependent Child" as set forth in 101-010-0005. The following individuals are not eligible:

(a) Children under age 19 who are other than biological or adopted children or a child placed for adoption with the Eligible Employee or the Eligible Employee's spouse or Domestic Partner and for whom the Eligible Employee, spouse, or Domestic Partner has no financial or medical responsibility.

(b) Children between the ages of 19 and 24 who are other than biological or adopted children, or a child placed for adoption with the Eligible Employee or the Eligible Employee's spouse or Domestic Partner and for whom the Eligible Employee, spouse, or Domestic Partner has no financial or medical responsibility or who do not meet the test for student status or gross income as set forth and provided to taxpayers annually by the Internal Revenue Service.

(c) Members of the Eligible Employee's household who may be eligible dependents under Internal Revenue Service guidelines but are not eligible for enrollment in the PEBB benefit plans such as the Eligible Employee's brother, sister, half-brother, half-sister, stepbrother, stepsister, parent, grandparent, great grandparent or other direct ancestor, stepfather, stepmother, brother or sister of the Eligible Employee's father or mother, a son or daughter of the Eligible Employee's brother or sister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, foster parent, or foreign students. The exception is when the Eligible Employee has financial and medical responsibility for a child who is under the age of 19 and who qualifies under 101-010-0005(7).

(14) "Open Enrollment Period" means a period designated by the Board during which Eligible Employees are permitted to make changes to their insurance coverage and other benefit plan choices for the next Plan Year.

(15) "Opt Out" means to elect a form of benefit that may include a cash payment, to be determined by the Board, in lieu of receiving medical insurance coverage through PEBB.

(16) "Paid Regular" means paid work time that includes vacation, sick, personal leave and compensatory time.

(17) "PEBB" means the Public Employees' Benefit Board and the system of benefit plans administered under the PEBB program established under ORS 243.061.

(18) "Pebb.benefits" means the Web-based automated benefit management application sponsored by PEBB allowing the Eligible Employee to electronically convey and update demographic information, beneficiary, dependent and benefit plan selections.

(19) "PEBB Participating Organization" means participating state agency, officer, Board, commission, department or other entity of state government.

(20) "Plan Year" means a period of 12 consecutive months, currently designated by the Board as the calendar year of January through December.

(21) "Pre-existing Condition" means:

(a) For medical and dental insurance coverage, a physical or mental condition which was diagnosed or treated or for which medication was prescribed or taken in the six months before coverage begins. A condition is diagnosed whenever a physician tells a person that he or she has that condition or makes an entry to that effect in the person's medical records. This applies even if the physician is examining or treating the person for a different condition.

(b) For life and disability insurance coverage, a mental or physical condition for which an individual has consulted a physician, received medical treatment or services or taken prescribed drugs or medication six months prior to the effective date of insurance coverage.

(22) "Qualified Status Change" (QSC) means any of the following:

(a) Events that change the legal marital status of an Eligible Employee including marriage, death of spouse, divorce, legal separation, or annulment;

(b) Events that change the status of a Domestic Partner relationship, including a Domestic Partner initially meeting qualifying criteria, death of the Domestic Partner or termination of the Domestic Partnership;

(c) Events that change the number of an Eligible Employee's or Domestic Partner's Dependent Children including birth, adoption, placement for adoption or death of a Dependent Child;

(d) A termination or commencement of employment by the Eligible Employee, spouse, or Domestic Partner;

(e) A reduction or increase in hours of employment by the Eligible Employee, spouse, or Domestic Partner that affects eligibility, including a change between Half Time and full-time, or commencement or return from an unpaid leave of absence, or commencement or return from a federal Family and Medical Leave Act (FMLA) leave whether the FMLA leave is paid or unpaid or as otherwise permitted by the (FMLA) and the Oregon Family Leave Act (OFLA);

(f) An event that causes an Eligible Employee's or Domestic Partner's Dependent Child to satisfy or cease to satisfy the eligibility requirements for benefit plan coverage due to age, student status or any similar circumstance;

(g) An increase in Eligible Employee, spouse or Domestic Partner's out-of-pocket premium amount resulting from decisions of the employer or employee;

(h) An involuntary loss of other group medical or dental insurance coverage, HIPAA Special Enrollment because:

(A) An Eligible Employee's spouse or Domestic Partner exhausts COBRA through previous employer;

(B) An Eligible Employee's spouse, Domestic Partner or Dependent Child ceases to be eligible for other group medical or dental insurance coverage (i.e., coverage discontinued by employer); or

(C) Employer contributions toward other group medical or dental insurance coverage from the employer of an Eligible Employee's spouse or Domestic Partner cease.

(i) In compliance with a final judgment, decree or order resulting from a divorce, legal separation, annulment or change in custody proceedings including issuance of a National Medical Support Notice (NMSN) or Qualified Medical Child Support Order (QMCSO) requiring enrollment of a Dependent Child on the existing medical and dental insurance plan(s);

(j) An Eligible Employee or an Eligible Employee's spouse or Domestic Partner moves out of the insurance plan service area, and thus loses eligibility for that insurance plan;

(k) Gain or loss of Medicare or a Medicaid insurance plan;

(l) In the Dependent Care Flexible Spending Account (FSA), the dependent care contribution changes only if:

(A) A cost change is imposed by a dependent care provider who is not a relative of the employee as defined by IRC 152(a)(1)-(8); or

(B) A change of dependent care provider, relative or not, results in a change in the cost of day care; or

(C) A Dependent Child attains age 13; or

(D) There is a qualified change in employment; or

(E) There is a change in the number of Family Members.

(F) Other Qualified Status Changes are considered except no changes are allowed with HIPAA Special Enrollment Rights, a judgment, decree or order, a change in residence or gain or loss of Medicare or Medicaid.

(m) In the Healthcare Flexible Spending Account (FSA), the healthcare contribution changes only if:

(A) There is a qualified change in employment; or

(B) There is a change in the number of Family Members.

(C) Other Qualified Status Changes are considered except no changes are allowed with HIPAA Special Enrollment Rights, a change in residence or a change in care cost.

(n) A change or cessation of coverage, such as an overall reduction in coverage, addition or elimination of benefit plan options, or changes in the Dependent Child's, spouses' or Domestic Partner's insurance coverage through the employer.

(23) "Reinstatement" or "Reinstated" means to reactivate all previous medical, dental, life, and disability insurance policies, if available, on a guaranteed basis when returning from a leave or termination of employment.

(24) "State Contribution" means the amount of money paid by the State of Oregon on behalf of Eligible Employees for the purchase of the benefit plans provided through PEBB.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-015-0005**
**Eligible Individuals**

The following individuals may receive insurance coverage under the benefit plans provided through PEBB:

(1) An Eligible Employee.

(2) Family Members of an Eligible Employee, provided the Eligible Employee lists the Family Members on his or her applicable form(s) or the pebb.benefits electronic equivalent.

(3) A Domestic Partner of an Eligible Employee and the Domestic Partner's Dependent Child(ren), provided the Eligible Employee lists the Domestic Partner and Dependent Child(ren) on his or her applicable form(s) or the pebb.benefits electronic equivalent.

(4) Appointed and elected officials, beginning on the first day of the month following the date the official takes the oath of office. Eligibility for benefit plan coverage terminates on the last day of the month for which the last payroll deduction is taken for the official's office.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-066, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-020-0005**
**Medical and Dental Insurance Enrollment — New Employees**

(1) A newly hired employee may receive medical and dental insurance coverage effective on the first of the month following the Eligible Employee's hire date and receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency if the applicable premium payment is made and the Eligible Employee is Actively at Work on the effective date of insurance coverage.

(2) A newly hired employee hired on a full-time basis, or a newly hired employee hired on at least a Half-Time or job-share basis and who is expected to work at least 90 days, is eligible for benefits. Medical and dental insurance coverage will be effective on the first of the month following the Eligible Employee's hire date and receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency regardless of the number of hours worked in the month in which the Eligible Employee began work.

(3) A newly hired employee must enroll within 60 days following his or her hire date. Coverage will be effective on the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency. An Eligible Employee who does not enroll within the initial 60 days following his or her hire date may apply for late enrollment by following late enrollment procedures set forth in OAR 101-020-0040.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 183.310-550, 192.660, 292.051, 659A.060-069, 659A.150-186, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-020-0010**
**Medical and Dental Insurance Plan Enrollment — Current Employee**

(1) An Eligible Employee must work at least Half Time during the immediately preceding month to be eligible for benefits for the next month.

(2) Except as provided in subsection (3) below, an Eligible Employee may make changes to his or her benefit plans only during the Open Enrollment Period. If an Eligible Employee wishes to change benefit plans or coverage, the Eligible Employee must submit the completed applicable form(s) or the pebb.benefits electronic equivalent, as instructed, during the Open Enrollment Period.

(3) An Eligible Employee may make changes to his or her benefit plans outside of the Open Enrollment Period as a result of and consistent with a Qualified Status Change event. The change must be requested within 60 days of the Qualified Status Change event date. Insurance coverage will be effective the first of the month following either the date the agency received the completed applicable form(s) or the Qualified Status Change event date, whichever is later.

(4) It is the responsibility of the Eligible Employee to maintain a valid enrollment.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 183.310-550, 192.660, 292.051, 659A.060-069, 659A.150-186, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-020-0040**
**Late Enrollment**

(1) Late enrollment occurs when a newly hired or newly Eligible Employee fails to enroll in benefit plans within 60 days following the date of hire or date of eligibility. Late enrollment also occurs when a current Eligible Employee fails to enroll a newly eligible individual within 60 days of gaining the eligibility or fails to enroll a new spouse who was most recently enrolled as a Domestic Partner within 60 days of the marriage date. All late enrollment requests must be reviewed by PEBB.

(a) A newly hired or newly Eligible Employee who does not submit the completed applicable form(s) or the pebb.benefits electronic equivalent, during the enrollment time frame required under OAR 101-020-0005 and

who submits late form(s) may obtain only medical, dental and basic life insurance coverage.

(b) PEBB will allow the newly hired or newly Eligible Employee to enroll in an available PEBB medical and dental insurance plan of choice. The effective date of medical and dental insurance coverage will be the first of the month following the agency's receipt of the completed applicable form(s).

(2) A current Eligible Employee failing to add a newly eligible individual to his or her existing insurance coverage within the time frames required under OAR 101-020-0020 must complete the applicable form(s) and appeal to PEBB for late enrollment. PEBB will ask the Eligible Employee to document, by explanation, with sufficient supporting data that the late enrollment was due to circumstances beyond the member's control or due to a reasonable misunderstanding of the enrollment requirements. If sufficient documentation is received to substantiate the late enrollment, PEBB will allow enrollment of the eligible individual effective the first of the month following the agency's receipt of the completed applicable form(s). If sufficient documentation is not received, PEBB will deny this request to enroll the newly eligible individual.

(3) A current Eligible Employee failing to enroll his or her biological newborn Dependent Child within 60 days of birth will be allowed to add the biological newborn Dependent Child to his or her existing insurance coverage during the first twelve months of life, retroactive to the date of birth, following receipt of the completed applicable form(s) by the agency.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 183.310-550, 192.660, 292.051, 659A.060-069, 659A.150-186, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-020-0045**
**Eligibility Upon Return to Work for Medical, Dental, Life, and Disability Insurance Plans**

(1) Loss of Eligible Employee Status. Leave Without Pay:

(a) An employee returning to work from leave without pay status is required to work at least Half Time in a month to be eligible for medical, dental, life, and disability insurance coverage for the following month. The previous active employment enrollment will be Reinstated in accordance with OAR 101-040-0010 for the Eligible Employee's medical, dental, life, and disability insurance plans unless the Eligible Employee submits the completed applicable form(s) requesting an enrollment change that is due to and consistent with a Qualified Status Change event.

(b) When an employee returns to work from leave without pay status due to an on-the-job injury or illness during the period in which the employer is responsible for premium payment under the Continuation of Benefits for Injured Workers (CBIW), ORS 659A.060–659A.069 provisions, and the employee does not meet eligibility for medical and dental insurance coverage, the employer will continue premium payments for medical and dental insurance coverage under the provisions of CBIW until the employee becomes eligible for the insurance coverage, or until the employer has met its obligations under ORS 659A.060–659A.069.

(c) An employee returning to work from leave without pay at the end of a qualified federal Family Medical Leave, qualified state Family Leave, and CBIW will be reinstated in the medical, dental, life, and disability insurance plans that were in effect the day before the leave began. If the employee returns to work the first day immediately following the end of the leave, the medical, dental, life, and disability insurance coverage will be effective retroactive to the first of the month in which the employee returned.

(d) An employee returning to work from leave due to active military duty will be Reinstated in the medical, dental, life, and disability insurance plans that were in effect the day before the leave began. If the employee returns to work following the end of the military leave, under ORS 408.240, the medical, dental, life, and disability insurance coverage will be effective retroactive to the first of the month in which the employee returned.

(2) Seasonal and Intermittent Employees.

(a) A first time seasonal and intermittent employee is eligible for benefits if he or she is expected to work at least a 90-day period and will work at least Half Time or will be in a position classified as job share. Insurance coverage will be effective on the first of the month following the Eligible Employee's hire date and receipt of the completed applicable form(s) or the pebb.benefit electronic equivalent by the agency.

(b) A returning seasonal or intermittent employee not expected to initially work a 90-day period is eligible for benefits when the employee has accumulated a total of 60 calendar days of employment (which need not be consecutive) within the current or immediately previous Plan Year. Insurance coverage is effective the first of the month following eligibility for benefits and receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency.

(c) Once a seasonal employee qualifies for insurance coverage in the current or immediately preceding Plan Year, the Eligible Employee will be Reinstated for benefit plans under OAR 101-040-0010 with insurance coverage effective the first of the month following re-employment.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 183.310-550, 192.660, 292.051, 659A.060-069, 659A.150-186, 743.600-602 & 743.707
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-030-0022**
**Continuation of Insurance Coverage for Employees on Active Military Leave**

(1) An Eligible Employee who would otherwise lose PEBB medical and dental insurance coverage due to active military leave will receive paid continuation of the medical and dental insurance coverage. The continued insurance coverage will be the same insurance coverage as was in place the day before active duty began. The paid insurance coverage will continue for an Eligible Employee on active military duty for the length of the leave or up to, but not to exceed, 12 months. An Eligible Employee who leaves a position to enter or reenter active military duty on or after January 1, 2006, will have paid insurance coverage continue for the length of the leave or up to, but not to exceed, 24 months.

(a) An Eligible Employee on military leave who is eligible for paid medical and dental insurance coverage may change insurance plans and add or delete eligible individuals during an Open Enrollment Period or as a result of and consistent with a Qualified Status Change event.

(b) An Eligible Employee covered under State of Oregon paid medical and dental insurance coverage due to active military leave that exhausts his or her maximum paid insurance coverage period under OAR 101-030-0022(1), and is still in active duty status, and has not returned to work, will experience a COBRA qualifying event and will be allowed all COBRA rights of continuation.

(2) For a period up to but not to exceed his or her maximum paid insurance coverage period under OAR 101-030-0022(1), an Eligible Employee enrolled in PEBB-sponsored Life, Accidental Death and Dismemberment (AD&D) and Long Term Care insurance coverage may elect to continue these benefit plans under active military leave by self-paying the premiums to his or her payroll department.

(3) An Eligible Employee enrolled in PEBB-sponsored Short Term Disability or Long Term Disability insurance coverage is not eligible to continue these benefit plans under active military leave.

(4) If an Eligible Employee, on active military leave, returns to work immediately following the end of the military leave, under ORS 408.240, retroactive Reinstatement will occur in accordance with OAR 101-020-0045(1).

(5) An Eligible Employee on unpaid active military leave is not eligible to contribute to and is not covered by the Dependent Care FSA. Upon return to work and paid status, the Eligible Employee must re-enroll in Dependent Care FSA.

(6) An Eligible Employee contributing to a Healthcare FSA and possessing a positive balance at the time he or she commences unpaid active military leave will be afforded COBRA rights of continuation. Upon return to work and paid status, the Eligible Employee must re-enroll in the Healthcare FSA.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 243.302
Hist.: PEBB 1-2003, f. & cert. ef 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-030-0040**
**Life, Accidental Death and Dismemberment (AD&D), and Disability Insurance Coverage**

An Eligible Employee covered through PEBB under Life, Accidental Death and Dismemberment (AD&D) and Disability insurance plans may continue under the insurance plans after an event that results in a loss of eligibility as described in this rule. Except for the portability and conversion options described in subsections (A) and (B) below, the applicable insurance premium payment must be paid by the Eligible Employee each month to the agency.

(1) Life Insurance Coverage.

(a) Medical and Non-Medical Leaves. An Eligible Employee whose employment is interrupted by a leave without pay may continue optional life insurance coverage for up to 12 months from the date active employee life insurance coverage ends by paying the insurance premium payment in full each month to the agency.

(b) Involuntary Temporary Reduction of Hours. An Eligible Employee who, at the agency's request, loses benefit eligible status due to a temporary reduction in hours of not more than 90 days may continue optional life insurance coverage for up to three months from the date of the loss of benefit eligible status by paying the insurance premium payment in full each month to the agency.

(c) Active Military Leave. An Eligible Employee whose employment is interrupted by active military duty may continue optional life insurance coverage for up to his or her maximum paid insurance coverage period under OAR 101-030-0022(1), from the date active employee life insurance coverage ends by paying the insurance premium payment in full each month to the agency.

(d) Lay Off or Termination of Employment. An Eligible Employee may not continue any life insurance coverage through self payment of insurance premium after lay off or termination of employment by a PEBB participating organization. Optional Employee, Spouse and Domestic Partner Life insurance plans may be purchased through the portability provision set forth below in subsection (A).

(e) Retirement or Termination of Employment Due to Disability. Optional Employee, Spouse, Domestic Partner, Basic and Dependent Life insurance coverage may be converted to individual whole life insurance policies through the life insurance carrier upon the retirement or termination of employment due to disability of the covered Eligible Employee.

(f) Retiree Life Insurance Coverage Option. An Eligible Employee whose life insurance coverage ends due to retirement has the option to purchase the Retiree Life Insurance Option without submitting evidence of insurability. Application to the insurance carrier must be submitted within 60 days of the date active employee life insurance coverage ends.

(g) Death of an Eligible Employee. Optional Spouse, Domestic Partner and Dependent Life insurance coverage may be converted to individual whole life insurance policies or continued via the portability option through the insurance carrier upon the death of the Eligible Employee through whom insurance coverage was obtained.

(A) Continuation of Life Insurance Coverage through Portability. An Eligible Employee may continue the amount of optional life insurance coverage in effect on the date employment ends at the group rate, plus billing fees. Portability is not available for Basic Life or Dependent Life insurance coverage. The policy remains a term life insurance policy. Application must be made directly to the insurance carrier within 60 days of the date active employee life insurance coverage ends.

(i) Lay off or Termination of Employment. Optional Employee, Spouse and Domestic Partner Life insurance coverage is eligible for continuation through portability if the Eligible Employee experiences a lay off or is terminated from employment.

(ii) Retirement or Disability. Optional life insurance coverage may not be continued through portability upon retirement, or if terminating employment due to disability.

(B) Continuation of Life Insurance Coverage through Conversion. An Eligible Employee who loses benefit eligible status due to any reason may convert any life insurance coverage to individual whole life insurance policies. Application must be made directly to the insurance carrier within 60 days of the date active employee life insurance coverage ends. An Eligible Employee may continue life insurance coverage under this subsection if the Eligible Employee loses benefit eligible status.

(2) Accidental Death & Dismemberment (AD&D) Insurance Coverage.

(a) Medical and Non-Medical Leaves. An Eligible Employee whose employment is interrupted by a leave without pay may continue AD&D insurance coverage for up to 12 months from the date active employee insurance coverage ends by paying the insurance premium payment in full each month to the agency.

(b) Involuntary Temporary Reduction of Hours. An Eligible Employee who, at the agency's request, loses benefit eligible status due to a temporary reduction in hours of not more than 90 days may continue AD&D insurance coverage for up to three months from the date of the loss of benefit eligible status by paying the insurance premium payment in full each month to the agency.

(c) Active Military Leave. An Eligible Employee whose employment is interrupted by active military duty may continue AD&D insurance coverage for up to his or her maximum paid insurance coverage period under OAR 101-030-0022, from the date active employee AD&D insurance coverage ends by paying the insurance premium payment in full each month to the agency. A contract exclusion is applied for loss resulting from war or act of war.

(d)(A) Lay Off, Termination of Employment or Retirement. An Eligible Employee who experiences a lay off, termination of employment, or retirement by a PEBB participating organization cannot continue AD&D insurance coverage through self-payment of insurance premium.

(B) Continuation of AD&D Insurance Coverage through Portability or Conversion. There are no portability or conversion rights for AD&D insurance coverage.

(3) Short Term or Long Term Disability Insurance Coverage.

(a) Medical Leave. An Eligible Employee whose employment is interrupted by a paid or unpaid medical leave is required to pay the insurance premium payments in full each month to the agency to maintain continuous Short Term and Long Term Disability insurance coverage if no disability claim is pending. When a disability claim is pending, an Eligible Employee is not required to pay the insurance premium payments in full each month to the agency during the Benefit Waiting Period. If a disability claim is denied insurance premium payments in full must be paid retroactively and continually to the agency at time of claim denial to maintain continuous Short Term and Long Term Disability insurance coverage.

(b) Non-Medical Leave. An Eligible Employee whose employment is interrupted by a non-medical leave without pay cannot continue Short or Long Term Disability insurance coverage through self-payment of insurance premiums.

(c) Involuntary Temporary Reduction of Hours. An Eligible Employee who, at the agency's request, loses benefit eligible status due to a temporary reduction in hours of not more than 90 days may continue Short and Long Term Disability insurance coverage for up to three months from the date of the loss of benefit eligible status by paying the insurance premium payment in full each month to the agency.

(d) Active Military Leave. An Eligible Employee whose employment is interrupted by active military duty cannot continue Short or Long Term Disability insurance coverage through self-payment of insurance premiums.

(e) Termination of Employment Due to Disability. An Eligible Employee terminating employment due to a disability is not required to self-pay disability insurance premiums during the Benefit Waiting Period defined in the applicable policy in order to receive the disability insurance benefit.

(f) Continuation of Short Term and Long Term Disability Insurance Coverage through Portability or Conversion. There are no portability or conversion rights for the Short Term or Long Term Disability insurance coverage.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707, 743.752-760 & PL 104-191
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0005**
**Benefit Election Changes**

(1) Benefit election changes may be made during the Open Enrollment Period by completing and submitting the applicable form(s) or the pebb.benefits electronic equivalent.

(2) A benefit election change request due to a Qualified Status Change event must be submitted within 60 days of the Qualified Status Change event date. The requested benefit election change must be consistent with the type of Qualified Status Change event experienced. The benefit election change will be effective the first of the month following either the date the agency receives the completed applicable form(s) or the Qualified Status Change event date, whichever is later.

(3) An employee who has been rehired and returns to work 31 or more days after the date of termination of employment may make benefit election changes without experiencing a Qualified Status Change event. The requested benefit election change must be submitted within 60 days of the Eligible Employee's rehire date. The benefit election change will be effective the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0010**
**Returning to Benefit Eligible Status**

An employee is eligible for benefits if he or she is expected to work at least 90 days and works at least Half Time or is in a position classified as job share.

(1) Following Leave Without Pay and Reduction of Hours. An employee who returns to benefit eligible status following a period of ineligibility due to a leave without pay or a reduction of hours must work at least Half Time in the month he or she returns to be eligible for benefits the following month.

(2) Following Lay Off, Termination of Employment, Family and Medical Leave, Continuation of Benefits for Injured Workers and Active Military Duty.

(a) An employee who returns to benefit eligible status following a period of ineligibility due to lay off, termination of employment, or following active military duty is not required to work at least Half Time in the month he or she returns to be eligible for benefits the following month.

(b) An employee who returns to benefit eligible status immediately following Family and Medical Leave or Continuation of Benefits for Injured Workers is not required to work at least Half Time in the month he or she returns to be eligible for benefits the following month.

(c) A returning employee who is not enrolled in any insurance program at the time of lay off or termination of employment is treated as a newly hired employee.

(3) Returning Within 12 Months. A previously Eligible Employee who returns to Paid Regular status within 12 months of the insurance coverage end date because of any cause has automatic Reinstatement of the insurance coverage options he or she had in effect prior to losing benefit eligibility. Exceptions to Reinstatement are Dependent Care Flexible Spending Account, Healthcare Flexible Spending Account and Long Term Care Insurance coverage. An Eligible Employee may make benefit election changes when he or she returns to benefit eligible status. Benefit election changes can also be made as a result of and consistent with a separate and distinct Qualified Status Change event. An Eligible Employee returning to benefit eligible status before current insurance coverage ends must experience a separate and distinct Qualified Status Change event to be eligible to make benefit election changes. The requested benefit election change must be consistent with the Qualified Status Change event.

(a) Deductibles. An eligible individual receives credit only for deductibles incurred within the Plan Year when the Eligible Employee left employment or went on leave.

(b) Retroactive Effective Date. If an Eligible Employee returns to Paid Regular status following a military leave, under ORS 408.240, or on the day immediately following a leave under FMLA or OFLA, insurance coverage options in effect previously are Reinstated retroactive to the first of the month in which the Eligible Employee returns.

(c) Open Enrollment Rights. An Eligible Employee returning to Paid Regular status within 12 months of the insurance coverage end date but who was not on Paid Regular status during the Open Enrollment Period for the Plan Year during which he or she returns will also have open enrollment rights.

(d) Life Insurance Coverage. An Eligible Employee whose life insurance coverage ends may have the amount of life insurance coverage previously in effect Reinstated without a medical history statement as long as he or she returns to Paid Regular status within 12 months of the insurance coverage end date and did not convert the policy. If an Eligible Employee converted to an individual insurance policy, the Eligible Employee must provide a medical history statement to become insured again under the group policy.

(e) Disability. An Eligible Employee who returns to Paid Regular status within 12 months of the insurance coverage end date may Reinstate the amount of disability insurance coverage previously in effect. Credit will be given for Pre-existing Conditions as if there had been no break in disability insurance coverage in the following instances:

(A) If the Eligible Employee becomes insured under the disability insurance plan again within 90 days.

(B) If the Eligible Employee's disability insurance coverage ended due to an occupational disability leave.

(C) If the Eligible Employee's disability insurance coverage ended because the Eligible Employee received Long Term Disability insurance benefits under the group disability insurance policy.

(D) Returning Beyond 90 Days (Disability Insurance Coverage only). An Eligible Employee enrolled in a disability insurance plan prior to leaving Paid Regular status will not receive credit for time served toward the Pre-existing Condition limitation if the employee returns to benefit eligible status beyond 90 days. This provision applies consistently to an employee who returns to Paid Regular status within the same Plan Year or in a subsequent Plan Year. An exception is made for an employee returning to Paid Regular status from a medical leave of absence and who received insurance benefits under the Short or Long Term Disability insurance plans during the leave.

(4) Returning Beyond 12 Months. No Reinstatement of previous benefit plan levels exists for an employee returning to active or Paid Regular status after 12 months from the insurance coverage end date. An employee will receive newly hired employee rights. The Eligible Employee may enroll in any benefit plan available by submitting the completed applicable form(s) or the pebb.benefits electronic equivalent within 60 days of returning to Paid Regular status. Guarantee issue options are available for the employee returning to Paid Regular status beyond 12 months from the insurance coverage end date, except as restricted in (b) (c) of this section.

(a) Medical and Dental Insurance Coverage. An employee who returns to Paid Regular status after 12 months from the insurance coverage end date due to a leave without pay, layoff or termination of employment will be treated as a newly hired employee and must enroll in medical and dental insurance coverage.

(b) Life Insurance Coverage. An employee who returns to benefit eligible status is not eligible for guarantee issue of life insurance coverage if previous life insurance coverage has been ported.

(c) Long Term Care Insurance. An employee who returns to benefit eligible status is not eligible for guarantee issue of long term care insurance coverage a second time because the Eligible Employee had an initial guarantee enrollment and the opportunity to continue, at the same premium rates, the long term care insurance coverage following the termination of previous employment.

(5) Pre-existing Conditions. An eligible individual will be given credit for continuous insurance coverage under a previous medical benefit plan if the previous medical benefit plan coverage was continuous to a date not more than 63 days prior to the effective date of the new PEBB medical benefit plan. Pre-existing Condition limitations do not apply to pregnancy or to a newborn or adopted child younger than age 18 who was covered within 60 days of becoming an eligible individual.

(6) Returning From Military Leave. A previously Eligible Employee who returns to Paid Regular status, under ORS 408.240, has automatic Reinstatement of the insurance coverage options he or she had in effect prior to losing benefit eligibility. Exceptions to Reinstatement are Dependent Care Flexible Spending Account, Healthcare Flexible Spending Account and Long Term Care Insurance coverage. An Eligible Employee may make benefit election changes when he or she returns to benefit eligible status. Benefit election changes can also be made as a result of and consistent with a separate and distinct Qualified Status Change event. An Eligible Employee returning to benefit eligible status before current insurance coverage ends must experience a separate and distinct Qualified Status Change event to be eligible to make benefit election changes. The requested benefit election change must be consistent with the Qualified Status Change event.

(a) Deductibles. An eligible individual receives credit only for those amounts eligible to be credited toward meeting the deductibles incurred within the period of participation in the Plan Year when the Eligible Employee went on leave.

(b) Retroactive Effective Date. If an Eligible Employee returns to Paid Regular status, under ORS 408.240, insurance coverage options in effect previously are Reinstated retroactive to the first of the month in which the Eligible Employee returns.

(c) Open Enrollment Rights. An Eligible Employee returning to Paid Regular status, under ORS 408.240, but who was not on Paid Regular status during the Open Enrollment Period for the Plan Year during which he or she returns will also have open enrollment rights.

(d) Life Insurance Coverage. An Eligible Employee returning to Paid Regular status, under ORS 408.240, whose life insurance coverage ended during his or her active military leave may have the amount of life insurance coverage previously in effect Reinstated without a medical history statement as long as he or she returns to Paid Regular status and did not convert the policy. If an Eligible Employee returning to Paid Regular status converted to an individual insurance policy during his or her active military leave, the Eligible Employee must provide a medical history statement to become insured again under the group policy.

(e) Disability Insurance Coverage. An Eligible Employee who returns to Paid Regular status, under ORS 408.240, may Reinstate the amount of disability insurance coverage previously in effect. Credit will be given for

Pre-existing Conditions as if there had been no break in disability insurance coverage in the following

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0020**
**PEBB Participating Organization Transfer**

(1) When an Eligible Employee transfers to another PEBB participating organization, the organization the Eligible Employee is leaving pays the state contribution for the month following the transfer regardless of hours worked in the month of transfer.

(2) The Eligible Employee must continue to meet eligibility requirements as defined in OAR 101-010-0005(9) to be eligible for PEBB benefit plans beyond the month following the month of transfer.

(3) All PEBB benefit plan elections must be transferred from the losing PEBB participating organization to the gaining PEBB participating organization with no lapse in insurance coverage.

(4) An Eligible Employee transferring from Oregon University System (OUS) to Oregon State Payroll System (OSPS) or vice versa must complete new applicable form(s) or the pebb.benefits electronic equivalent.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-066, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0030**
**Life Insurance Coverage**

(1) Enrollment. An Eligible Employee may enroll in optional life insurance plans within 60 days of the new hire date, during the Open Enrollment Period, or within 60 days following a Qualified Status Change event provided he or she shows satisfactory evidence of insurability to the insurance carrier, if applicable. Life insurance coverage is effective as follows and is subject to the Actively at Work requirements as defined in OAR 101-010-0005(1)(b):

(a) A Newly Hired Employee. For life insurance coverage not subject to medical underwriting, insurance coverage is effective the first of the month following the date the completed applicable form(s) or the pebb.benefits electronic equivalent is received by the agency if submitted within 60 days of new hire date. For life insurance coverage subject to approval of the Medical History Statement, insurance coverage is effective the first of the month following the date of approval.

(b) Open Enrollment. All life insurance coverage amounts are subject to medical underwriting. For life insurance coverage subject to approval of the Medical History Statement, insurance coverage is effective the latter of either the first of the month following the date of approval, or the first day of the new Plan Year.

(c) Qualified Status Change Event. For life insurance coverage not subject to medical underwriting, insurance coverage is effective the first of the month following the date the completed applicable form is received by the agency if submitted within 60 days following the Qualified Status Change event date. For life insurance coverage subject to approval of the Medical History Statement, insurance coverage is effective the first of the month following the date of approval. The effective date cannot precede the Qualified Status Change event date.

(2) Termination of Coverage. Coverage for life insurance plans ends on the last of the month for which a premium payment was made.

(a) Portability. An Eligible Employee terminating employment (for reasons other than disability or retirement) may continue their Optional Employee, Spouse and Domestic Partner Life insurance coverage at the same age-graded premium rates. Application must be made within 60 days following termination of insurance coverage. A billing fee will be charged by the insurance carrier for administration of this continuation option.

(b) Conversion Rights. An Eligible Employee terminating employment for any reason, or whose hours are reduced below 80 Paid Regular hours in the month, will have the right to apply for individual life insurance plans. Application must be made within 60 days following termination of insurance coverage. The individual non-group plan will be issued without regard to the health of any person for whom application is made.

(c) Rollover of Optional Employee Life Insurance. When two Eligible Employees are married or in a Domestic Partnership and both are state employees, the Eligible Employee or the spouse or Domestic Partner terminating employment for any reason can roll over his or her optional life insurance coverage to the other's life insurance coverage upon termination of employment. The Eligible Employee terminating employment must submit the completed applicable form(s) or the pebb.benefits electronic equivalent to his or her agency within 60 days of the termination of employment date. Other Qualified Status Change events that allow movement of optional life insurance coverage from one Eligible Employee to another include commencing an active military leave, divorce, retirement and termination of employment.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0035**
**Accidental Death and Dismemberment Insurance Coverage**

(1) Enrollment. An Eligible Employee may enroll in the Accidental Death and Dismemberment (AD&D) insurance plan within 60 days of the new hire date, during the Open Enrollment Period, or within 60 days following a Qualified Status Change event. AD&D insurance coverage is effective as follows and is subject to the Actively at Work requirements as defined in OAR 101-010-0005(1)(b):

(a) A Newly Hired Employee and Qualified Status Change Event. For a newly hired employee, or enrollment changes due to a Qualified Status Change event, the effective date is the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency if submitted within 60 days of the new hire date or within 60 days following the Qualified Status Change event date.

(b) Open Enrollment. For open enrollment changes, the effective date is the first day of the new Plan Year.

(2) Termination of AD&D Insurance Coverage. Coverage for the AD&D insurance plan ends on the last of the month for which a premium payment was made.

(3) Continuation. There are no portability, conversion or rollover continuation options for Accidental Death and Dismemberment insurance coverage.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0040**
**Long Term Disability Insurance Coverage**

(1) Enrollment. An Eligible Employee may enroll in a Long Term Disability insurance plan within 60 days of the new hire date, during the Open Enrollment Period, or within 60 days following a Qualified Status Change event. Eligible Employee claims will be subject to a Pre-existing Condition limitation and Actively at Work requirements as specified in the insurance plan documents. Long Term Disability insurance coverage is effective as follows and is subject to the Actively at Work requirements as defined in OAR 101-010-0005(1)(b):

(a) A Newly Hired Employee and Qualified Status Change Event. For a newly hired employee, or enrollment changes due to a Qualified Status Change event, the effective date is the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency if submitted within 60 days of the new hire date or within 60 days following the Qualified Status Change event date.

(b) Open Enrollment. For open enrollment changes, the effective date is the first of the new Plan Year. For purposes of disability insurance coverage, an employee is Actively at Work if he or she is on the job and receiving pay for the first scheduled day of work and performing the material duties of his or her own occupation at the employer's usual place of business. If an employee is incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of insurance coverage or increase in insurance coverage, the insurance coverage or increase will not become effective until the day after the employee completes one full day of active work.

(2) Termination of Long Term Disability Insurance Coverage. Coverage for the Long Term Disability insurance plan ends on the last of the month for which a premium payment was made.

(3) Continuation. There are no portability, conversion or rollover continuation options for Long Term Disability insurance coverage.

(4) Reinstatement Following a Compensable On-the-Job Injury or Illness. An Eligible Employee may be Reinstated in his or her Long Term Disability insurance coverage following a compensable on-the-job injury or

illness. Insurance coverage is effective the first of the month following the date the employee returns to work, provided the Eligible Employee is Actively at Work as specified in insurance plan documents on that effective day.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0045**
**Short Term Disability Insurance Coverage**

(1) Enrollment. An Eligible Employee may enroll in the Short Term Disability insurance plan within 60 days of the new hire date, during the Open Enrollment Period, or within 60 days following a Qualified Status Change event. Eligible Employee claims will be subject to a Pre-existing Condition limitation and Actively at Work requirements as specified in insurance plan documents. Insurance coverage is effective as follows and is subject to the Actively at Work requirements as defined in OAR 101-010-0005(1)(b):

(a) For a newly hired employee or enrollment changes due to a Qualified Status Change event, the effective date is the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency if submitted within 60 days of the new hire date or within 60 days following the Qualified Status Change event date.

(b) For open enrollment changes, the effective date is the first day of the new Plan Year. For purposes of disability insurance coverage, an employee is Actively at Work if he or she is on the job and receiving pay for the first scheduled day of work and performing the material duties of his or her own occupation at the employer's usual place of business. If an employee is incapable of active work because of sickness, injury or pregnancy on the day before the scheduled effective date of insurance coverage or increase in insurance coverage, the insurance coverage or increase will not become effective until the day after the employee completes one full day of active work.

(2) Termination of Short Term Disability Insurance Coverage. Coverage for the Short Term Disability insurance plan ends on the last of the month for which a premium payment was made.

(3) Continuation. There are no portability, conversion or rollover continuation options for Short Term Disability insurance coverage.

(4) Reinstatement Following a Compensable On-the-Job Injury or Illness. An Eligible Employee may be Reinstated in his or her Short Term Disability insurance coverage following a compensable on-the-job injury or illness. Insurance coverage is effective the first of the month following the date the Eligible Employee returns to work, provided the employee is Actively at Work as specified in insurance plan documents on that effective day.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2000, f. 11-15-00, cert. ef. 1-1-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0050**
**Dependent Care Flexible Spending Account Program**

(1) Enrollment.

(a) An Eligible Employee is one whose expenses qualify for reimbursement under IRS provisions and who is:

(A) Single; or

(B) Married, and the expenses are necessary for both the Eligible Employee and the spouse to work; or

(C) Married, and the spouse is either disabled, actively seeking employment, or a full-time student for some part of each of five months during the year.

(b) An Eligible Employee may enroll in the pretax Dependent Care Flexible Spending Account within 60 days of the new hire date, during the Open Enrollment Period, or within 60 days following and consistent with a Qualified Status Change event. Coverage is effective as follows:

(A) For a newly hired employee, enrollment in the pretax Dependent Care Flexible Spending Account will be effective the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency.

(B) Enrollment elections made during the Open Enrollment Period, to be effective the first of the following new Plan Year, will cease at the end of that Plan Year if the Eligible Employee fails to renew the participation annually by completing applicable form(s) or the pebb.benefits electronic equivalent during subsequent Open Enrollment Periods.

(C) Change in Family Status. A midyear enrollment election to the pretax Dependent Care Flexible Spending Account must be consistent with the Qualified Status Change event. A midyear enrollment election request must be made within 60 days of the Qualified Status Change event date. A midyear enrollment election following a Qualified Status Change event will be effective the first of the month following receipt of the completed applicable form(s) by the agency.

(c) In no event may the maximum amount allocated by an Eligible Employee to any pretax Dependent Care Flexible Spending Account exceed $5,000 per Plan Year, or $2,500 per Plan Year for a married participant who files a separate income tax return.

(2) According to federal tax regulations, once an Eligible Employee commences enrollment in a pretax Dependent Care Flexible Spending Account, he or she cannot change the amount of money deposited in the account, or stop the payroll deductions until the next Open Enrollment Period unless they experience a Qualified Status Change event.

(3) An Eligible Employee terminating employment (including retiring) may request, by submission of the completed applicable form(s), to stop the pretax Dependent Care Flexible Spending Account deduction in coordination with his or her last work day and final paycheck. The request must be made before the payroll deduction is processed.

(4) An Eligible Employee whose employment is terminated and who is rehired within the same or a subsequent Plan Year cannot be automatically Reinstated in the pretax Dependent Care Flexible Spending Account. A rehired employee may enroll in the pretax Dependent Care Flexible Spending Account within 60 days of the new hire date. The enrollment will become effective the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the employing agency.

(5) Use It or Lose It Rule. The pretax Dependent Care Flexible Spending Account is subject to the Internal Revenue Service "Use It or Lose It" rule. This means that an Eligible Employee must incur all expenses to be reimbursed by the account from the date of participation and prior to March 15 following the Plan Year (January 1–December 31). Any funds remaining in the account beyond March 31 following the Plan Year will be forfeited.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0055**
**Healthcare Flexible Spending Account Program**

(1) An Eligible Employee may enroll in the pretax Healthcare Flexible Spending Account within 60 days of the new hire date, during the Open Enrollment Period, or within 60 days following and consistent with a Qualified Status Change event.

(a) For a newly hired employee enrollment in the pretax Healthcare Flexible Spending Account will be effective the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the agency.

(b) Enrollment elections made during the Open Enrollment Period, to be effective the first of the following Plan Year, will cease at the end of that Plan Year if the Eligible Employee fails to renew the participation annually by completing applicable form(s) or the pebb.benefits electronic equivalent during subsequent Open Enrollment Periods.

(c) A midyear enrollment election to the pretax Healthcare Flexible Spending Account must be consistent with the Qualified Status Change event. A midyear enrollment election request must be made within 60 days of the Qualifying Status Change event date. A midyear enrollment election following a Qualified Status Change event will be effective the first of the month following receipt of the completed applicable form(s) by the agency or following the Qualified Status Change event date, whichever is later.

(d) Annual maximum contribution amounts and allowable covered expenses will be determined by the Board. Allowable covered expenses are expenses incurred by the Eligible Employee to treat or cure a medical condition.

(2) According to federal tax regulations, once an Eligible Employee commences enrollment in a pretax Healthcare Flexible Spending Account, he or she cannot change the amount of money deposited in the account, or

stop the payroll deductions until the next Open Enrollment Period unless they experience a Qualified Status Change event.

(3) An Eligible Employee terminating employment (including retiring) may request, by submission of the completed applicable form(s), to stop the pretax Healthcare Flexible Spending Account deduction in coordination with his or her last work day and final paycheck. The request must be made before the payroll deduction is processed. Upon termination of employment, the Eligible Employee's right to participate in the Healthcare Flexible Spending Account terminates, except as specifically stated in the benefit plan or pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). An Eligible Employee entitled to COBRA continuation and one who has a positive balance in his or her Healthcare Flexible Spending Account shall be given the opportunity to continue, on a self-pay basis, the same benefit coverage the Eligible Employee had under the benefit plan the day before the Qualified Status Change event for the periods prescribed by COBRA. Contributions for such benefit plan coverage are paid on an after-tax basis for a period of up to but not beyond the current Plan Year.

(4) An Eligible Employee whose employment is terminated and who is rehired within the same or a subsequent Plan Year cannot be automatically Reinstated in the pretax Healthcare Flexible Spending Account. A rehired employee may enroll in the pretax Healthcare Flexible Spending Account within 60 days of the new hire date. The enrollment will become effective the first of the month following receipt of the completed applicable form(s) or the pebb.benefits electronic equivalent by the employing agency.

(5) The pretax Healthcare Flexible Spending Account is subject to the Internal Revenue Service "Use It or Lose It" rule. This means that an Eligible Employee must incur all expenses to be reimbursed by the account from the date of participation and prior to March 15 following the Plan Year (January 1–December 31). Any funds remaining in the account beyond March 31 following the Plan Year will be forfeited.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 279
Hist.: PEBB 2-2004(Temp), f. 7-13-04, cert. ef. 8-31-04 thru 2-27-05; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-040-0080**
**Correcting Enrollment Errors**

These provisions cover enrollment errors and omissions on forms that may occur when an Eligible Employee elects benefit plan coverage or elects to make benefit plan changes and when agencies process those elections. If an Eligible Employee becomes aware of an enrollment error at the time he or she receives the first paycheck stub following the election, the plan identification card, the confirmation statement, or denied claim, it is the Eligible Employee's responsibility to bring the error to PEBB's attention through the appeal process.

(1) Eligible Employee Errors in Completing or Submitting the Form(s) or the pebb.benefits Electronic Equivalent.

(a) Enrollment errors and omissions on forms may occur when an Eligible Employee submits the PEBB enrollment form(s) or the pebb.benefits electronic equivalent as a newly hired employee, submits the update form(s) to make midyear enrollment changes or fails to act as a result of and following a midyear Qualified Status Change event.

(b) If an Eligible Employee recognizes he or she made an enrollment error and it is prior to payroll implementation, the error can be corrected by the agency representative. Implementation means the benefit plan election has been entered into the payroll and pebb.benefit systems and submitted to the carriers.

(c) Within 60 Days of the New Hire Date or the Qualified Status Change Event Date.

(A) If the Eligible Employee recognizes he or she made an enrollment error after implementation, but within 60 days of the new hire date or Qualified Status Change event date, the requested correction must be reviewed by PEBB through the appeal process.

(B) The Eligible Employee must clearly document that the enrollment does not accurately reflect their intent.

(C) If documentation is received confirming the enrollment error PEBB will correct the error retroactive to the first of the month following the date the enrollment form(s), pebb.benefits electronic equivalent, or update form(s) containing the enrollment error was first received by the agency. If documentation confirming the enrollment error is not received within 60 days of the request date for correction, PEBB will deny the request to correct the error.

(d) After 60 Days of the New Hire Date or the Qualified Status Change Event Date.

(A) If the Eligible Employee recognizes he or she made an enrollment error after 60 days of the new hire date or the Qualified Status Change event date the requested correction must be reviewed by PEBB through the appeal process.

(B) The Eligible Employee must clearly document that the enrollment does not accurately reflect their intent.

(C) If documentation is received confirming the enrollment error PEBB will correct the error effective the first of the month following the receipt of the request to correct the enrollment error. Effective date exception made only for Short or Long Term Disability insurance plans where a retroactive effective date would circumvent a pre-existing condition clause. If documentation confirming the enrollment error is not received within 60 days of the request date for correction, PEBB will deny the request to correct the error.

(e) After 120 Days of the New Hire Date or the Qualified Status Change Event Date. If the Eligible Employee recognizes he or she made an enrollment error and it is beyond 120 days of the new hire date or the Qualified Status Change event date, the request to correct the error will be denied.

(2) Eligible Employee Errors during Open Enrollment. An Eligible Employee may miss the open enrollment timeline, make enrollment errors or realize omissions on enrollment forms during the annual Open Enrollment Period. PEBB authorizes agency representatives to accept the late completed applicable form(s) and process changes or corrections to enrollment elections without PEBB approval for 30 days following the Open Enrollment Period.

(a) Within 60 Days of the New Plan Year.

(A) If an Eligible Employee recognizes he or she made an open enrollment error or neglected to submit the applicable open enrollment form(s) or the pebb.benefits electronic equivalent within 60 days of the new Plan Year, the requested correction must be reviewed by PEBB through the appeal process.

(B) The Eligible Employee must clearly document that the enrollment does not accurately reflect their intent.

(C) If documentation is received confirming the open enrollment error PEBB will correct the error retroactive to the first of the month of the new Plan Year. If documentation confirming the open enrollment error is not received within 60 days of the request date for correction PEBB will deny the request to correct the error.

(b) After 60 Days of the New Plan Year.

(A) If an Eligible Employee recognizes he or she made an open enrollment error after 60 days of the new Plan Year, the requested correction must be reviewed by PEBB through the appeal process.

(B) The Eligible Employee must clearly document that the enrollment does not accurately reflect their intent.

(C) If documentation is received confirming the open enrollment error PEBB will correct the error effective the first of the month following the receipt of the request to correct the open enrollment error. If documentation confirming the open enrollment error is not received within 60 days of the request date for correction, PEBB will deny the request to correct the open enrollment error.

(c) After 120 Days of the New Plan Year. If the Eligible Employee recognizes he or she made an open enrollment error and it is beyond 120 days of the new Plan Year, the request to correct the error will be denied.

(3) Enrollment Errors That Occur When Processing the Applicable Form(s) or pebb.benefits electronic equivalent for Open Enrollment, a Qualified Status Change Event or a Newly Hired Employee. Data entry errors or omissions may occur when benefit plan elections are processed in the state's payroll and benefit systems, when an Eligible Employee receives wrong information, or when an Eligible Employee does not receive enrollment information or materials in a timely manner.

(a) Within 60 Days of Open Enrollment, a Qualified Status Change Event or a New Hire Date. If it is determined that a data entry error or omission was made, incorrect information has been provided to the employee or transmission of information from the agency to the employee has been delayed and it is identified within the first 60 days of the agency's receipt of the completed applicable form(s) or pebb.benefits electronic equivalent the agency will correct the error in the payroll and benefit systems retroactive to the first of the month following the date the enrollment or update form(s) or pebb.benefits electronic equivalent was first received by the agency or the first day of the new Plan Year for open enrollment activity and the payroll system will automatically reconcile any overcharges or undercharges. Where information or materials were not received by a newly hired employee within 30 days of the hire date, benefit plan elections

will be effective retroactive to the first of the month following the Eligible Employee's hire date.

(b) After 60 Days of Open Enrollment, a Qualified Status Change Event or a New Hire Date.

(A) If it is determined that a data entry error or omission was made, incorrect information has been provided to the employee or transmission of information from the agency to the employee has been delayed, and it is identified after 60 days of open enrollment, a qualified status change event or the new hire date, PEBB must review any requested corrections through the appeal process.

(B) During PEBB's review, if the agency confirms and provides documentation of the entry error, or omission, PEBB will approve correction of the enrollment error retroactive to the first of the month following the date the completed applicable form(s) or pebb.benefits electronic equivalent was first received by the agency but no earlier than the first of the previous Plan Year, or in the case of open enrollment processing, first of current Plan Year. Where information or materials were not received by a newly hired employee within 30 days of the hire date benefit plan elections will be effective retroactive to the first of the month following the Eligible Employee's hire date.

(4) Overcharges and Undercharges of Insurance Premium. When enrollment errors or omissions are corrected overcharges and undercharges of insurance premium payments may result. Data entry errors or omissions also create insurance premium discrepancies that need to be rectified. Data entry errors or omissions resulting in insurance premium discrepancies may be corrected as described in (3) Enrollment Errors That Occur When Processing the Applicable Form(s) or pebb.benefits electronic equivalent for Open Enrollment, a Qualified Status Change Event or a Newly Hired Employee. Eligible Employee errors that result in insurance premium discrepancies will be reviewed as follows:

(a) Within 60 Days of the First Payroll Deduction Reflecting the Discrepancy. PEBB will review requests to correct the error with an insurance premium refund or charge for an Eligible Employee occurring upon approval. If notified within the 60 days, PEBB will approve the correction and insurance premium reconciliation retroactive to the date the discrepancy first occurred.

(b) More Than 60 Days of the First Payroll Deduction. If the Eligible Employee or the agency representative contacts PEBB more than 60 days from the first payroll deduction, PEBB will correct the error the first of the month following notification of the error. In instances where premiums were paid in error, no premium refund will occur. Exceptions to this rule include:

(A) Eligible Employee voluntary insurance premium deductions.

(B) Self-paid insurance premium amount.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 243.302
Hist.: PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 1-2005, f. & cert. ef. 4-14-05; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-050-0005**
**Eligibility for Medical and Dental Insurance Coverage upon Retirement**

A retiring Eligible Employee and his or her eligible individuals, not eligible for Medicare coverage, except for Medicare eligibility as a result of end-stage renal disease, who are enrolled in PEBB medical or dental insurance plans or both for active employees immediately prior to retirement will be eligible to continue participation in any PEBB retiree medical or dental insurance plan when the Eligible Employee retires and enrolls in a PEBB retiree insurance plan within 60 days of loss of active employee insurance coverage and continues to self-pay the insurance premium.

(1) A retired Eligible Employee must be:

(a) Receiving a service or disability retirement allowance under the Public Employees Retirement System or be receiving a service or disability retirement allowance or pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees; or

(b) Eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS Chapter 238; or

(c) Eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have attained earliest retirement age under the plan or system.

(2) A retired Eligible Employee may elect insurance coverage as the retiree, and elect insurance coverage for a spouse, Domestic Partner, eligible Dependent Child(ren) and the Domestic Partner's eligible Dependent Child(ren) under the PEBB retiree medical or dental insurance plans or both within 60 days of the date active employee insurance coverage ends. A retired Eligible Employee may select medical only, dental only, or medical and dental insurance coverage. Application for enrollment in PEBB retiree medical or dental insurance plans must be made by submitting the completed applicable form(s) within 60 days of loss of PEBB active employee insurance coverage.

(3) Medical or dental insurance coverage under all PEBB sponsored medical and dental insurance plans must be continuous. Enrollment in the PEBB retiree medical or dental insurance plans or both must be continuous from active employee insurance coverage until Medicare eligibility. Insurance premium payments and adjustments must occur in whole month increments.

(4) A retired Eligible Employee electing to continue PEBB medical or dental insurance plans or both under COBRA continuation of active employee insurance coverage will have the right to transfer the insurance coverage in place to the PEBB retiree medical or dental insurance plans or both at any time during or immediately following the COBRA continuation period.

(5) A former Eligible Employee who elects COBRA continuation following separation from state service and subsequently becomes eligible as a retired Eligible Employee while on COBRA continuation will have the right to transfer the medical or dental insurance coverage in place to the PEBB retiree medical or dental insurance plans at any time during or immediately following the COBRA continuation period. Insurance coverage under the PEBB active, COBRA continuation, and retiree medical or dental insurance plans or both must be continuous.

(6) A retired Eligible Employee may continue PEBB medical or dental insurance plans or both under the PEBB retiree medical and dental insurance plans as long as the premium is paid and PEBB continues to offer retiree insurance plan coverage.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061-302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

**101-050-0025**
**Retirees Eligible for Medicare Coverage**

(1) A PEBB retiree not eligible for Medicare coverage may enroll in PEBB non-Medicare retiree insurance plans according to provisions of OAR 101-050-0005.

(2) The retiree and eligible individuals enrolled in the PEBB retiree insurance plans who become eligible for Medicare coverage, except for Medicare eligibility as a result of end-stage renal disease, are no longer eligible to continue a PEBB retiree insurance plan. The insurance coverage will be terminated the first of the month following 60 days from the date the ineligible insurance coverage is discovered.

(3) When a retiree becomes eligible for Medicare coverage, except for Medicare eligibility as a result of end-stage renal disease, he or she is no longer eligible for participation in PEBB retiree insurance plans. If a retiree becomes eligible for Medicare coverage but the spouse or Domestic Partner and Dependent Child(ren) are not, these eligible individuals may continue PEBB insurance coverage as long as they are currently enrolled in the retiree's insurance plan when the retiree became eligible for Medicare coverage.

Stat. Auth.: ORS 243.061 - 243.302
Stats. Implemented: ORS 243.061 - 243.302, 659A.060-069, 659A.150-186, 743.600-602, 743.707 & 743.752-760
Hist.: PEBB 1-1999, f. 12-8-99, cert. ef. 1-1-00; PEBB 1-2001, f. & cert. ef. 9-6-01; PEBB 1-2002, f. 7-30-02, cert. ef. 8-1-02; PEBB 1-2003, f. & cert. ef. 12-4-03; PEBB 1-2004, f. & cert. ef. 7-2-04; PEBB 3-2004, f. & cert. ef. 10-7-04; PEBB 3-2005, f. 8-31-05, cert. ef. 9-1-05

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**Department of Agriculture,**
**Oregon Sweet Cherry Commission**
**Chapter 669**

**Adm. Order No.:** OSCC 2-2005
**Filed with Sec. of State:** 8-23-2005
**Certified to be Effective:** 8-26-05
**Notice Publication Date:** 6-1-05
**Rules Amended:** 669-010-0025, 669-010-0030
**Subject:** This amendment will revise the due date for Fresh Market cherries to allow for estimated payments of at least 75% of the amount due for the crop year on the due date with the balance due

within one month to avoid late penalties and interest and corrects a typographical error.
**Rules Coordinator:** Dana Branson—(541) 386-5761

**669-010-0025**
**Reports and Payment of Assessment Moneys**

(1) First purchasers and handlers must submit completed and signed assessment reports on commission approved forms. Assessment reports will include all purchases or deliveries to a first purchaser or handler of sweet cherries (net paid weight). The assessments will be reported as follows:

(a) Cherries destined for fresh market that were purchased or delivered to the first purchaser before August 1st, the assessment report is due in the commission office postmarked on or before September 1st. Cherries destined for fresh market that were purchased or delivered after August 1st, the assessment report is due in the commission office postmarked on or before October 1st. If a final report cannot be completed within these time frames an estimated report is due by the dates specified above. If an estimate is used, the final report is due by October 1st for cherries purchased or delivered on or before August 1st or due by November 1st for cherries purchased or delivered after August 1st. (Also see item 4 below.)

(b) Cherries destined for brining, canning, and or freezing that were purchased or delivered to the first purchaser before December 1st, the assessment report is due in the commission office postmarked on or before December 15th. Cherries destined for brining, canning, and or freezing that were purchased or delivered to the first purchaser after December 1st, the assessment report is due in the commission office postmarked on or before May 15th.

(2) When a first purchaser or handler has completed, signed, and forwarded a report covering his or her final purchase of sweet cherries for the crop season, he or she may mark such report in large letters "FINAL REPORT FOR THIS CROP SEASON." No further reports are necessary by such first purchaser unless or until additional purchases are made.

(3) When a first purchaser lives or has his or her office in another state, or is a federal or governmental agency, the producer will report to this Commission all sales made to such purchaser as required by section (1) of this rule and will pay the assessment directly to the Commission, unless such first purchaser voluntarily makes the proper deduction and remits the proceeds to this Commission.

(4) At the time that reports are due the Commission from the first purchaser or first handler, as required in section (1) of this rule, the first purchaser or first handler will attach or forward payment to the Commission for the assessment due as set forth in each such report. If an estimated report is used the payment accompanying it must equal a minimum 75% of the total assessments due for the crop year as calculated in the final report to avoid penalty and interest for late payment. The forms will be signed by the first purchaser or first handler and completely filled out, and will include, in addition to all other required information and figures, the name and complete mailing address of each producer, the crop year, the tonnage and amount of assessment deducted and withheld.

(5) Any producer who performs the handling or processing functions on all or part of his or her production of the commodity, which normally would be performed by another person as the first purchaser thereof, will report his or her sales of such commodity of his or her own production on forms provided by, and pay the assessment moneys directly to, the Commission, unless the first purchaser from such producer voluntarily makes the proper deduction and remits the proceeds to the Commission. (Examples would be the sale by a producer direct to a peddler, to a retail store, etc.)

Stat. Auth.: ORS 576
Stats. Implemented: ORS 576
Hist.: RSC 1(Temp), f. 6-11-74, ef. 6-15-74 thru 10-12-74; RSC 4, f. 11-15-74, ef. 12-11-74; RSC 1-1985, f. & ef. 9-17-85; OSC 1-1989, f. 5-24-89, cert. ef. 6-1-89; OSC 1-1989, f. 5-24-89, cert. ef. 6-1-89; OSCC 1-2001, f. & cert. ef. 2-16-01; OSCC 1-2004, f. & cert. ef. 1-13-04; OSCC 2-2005, f. 8-23-05, cert. ef. 8-26-05

**669-010-0030**
**Penalties**

Penalty for delaying transmittal of assessment moneys (ORS 576.355), "In addition to the penalties prescribed in ORS 576.99, any person who delays transmittal of funds beyond the time set by a Commission shall pay a penalty of ten percent of the amount due and shall also pay one and one-half percent interest per month on the unpaid balance of the assessment. If seeking a waiver of the penalties, a written explanation of the circumstances that caused the payment delay must be submitted to the Commission office for review. Penalties may be waived by a majority vote of the Commission.

Stat. Auth.: ORS 576 & 2003 OL Ch. 604
Stats. Implemented: ORS 576 & 2003 OL Ch. 604
Hist.: RSC 1(Temp), f. 6-11-74, ef. 6-15-74 thru 10-12-74; RSC 4, f. 11-15-74, ef. 12-11-74; OSC 1-1989, f. 5-24-89, cert. ef. 6-1-89; OSCC 1-2004, f. & cert. ef. 1-13-04; OSCC 2-2005, f. 8-23-05, cert. ef. 8-26-05

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

**Adm. Order No.:** BCD 20-2005
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 5-1-05
**Rules Amended:** 918-225-0240, 918-225-0430, 918-225-0560, 918-225-0660
**Subject:** Updates the Oregon Boiler and Pressure Vessel Specialty Code to the current editions of the ASME Boiler and Pressure Vessel Code, ASME Code for Pressure Piping and the National Board Inspection Code (NBIC).
**Rules Coordinator:** Nicole M. Jantz—(503) 373-7438

**918-225-0240**
**Definitions**

As used in OAR chapter 918, division 225, unless the context requires otherwise:

(1) "Agricultural Purposes" means:

(a) Sowing, tending, and harvesting of products of the soil grown under natural conditions;

(b) Raising of poultry or fowl;

(c) Pasturage or raising of livestock or other animals; or

(d) Original processing of the farm product, but not the processing of the product of a different operator, or reprocessing work as freezing, canning, or packing if performed substantially for commercial purposes.

(2) "Available" to determine inspection fees at cost, means the vessels must be due for inspection in the year the notification is applicable, and must all be ready for inspection at the time designated by the inspector.

(3) "Board" is defined in ORS 480.515(1).

(4) "Boiler Room" means any enclosed room or designated space within a building, intended by design or by usage to contain a boiler that is connected and available for use. A boiler located in an area not meeting the definition of "boiler room" under OAR 918-225-0465 shall apply to any space within 20 feet of any burner.

(5) "Building Service Piping" means piping systems operating at or less than 150 psig steam; and water at or less than 160 psig and 250∞ F. as described in **ANSI/ASME Standard B31.9**.

(6) "Chief Inspector" means the inspector appointed by the Director pursuant to ORS 480.565(1).

(7) "Farm" means an area of land:

(a) Located in a rural district;

(b) Of sufficient size to generally be considered as a farm in its locale; and

(c) Devoted primarily to tillage and raising crops under natural conditions, or to raising animals, fowl, or poultry.

(8) "Emergency" as used in ORS 480.630(7) means an unplanned circumstance requiring immediate repair, installation, replacement or shutdown because of risk to health, life or property.

(9) "Hobby" or "Demonstration" means recreational or other non-commercial use.

(10) "Immediate Safety Hazard" means hazardous conditions exist requiring immediate correction to a boiler, pressure vessel or pressure piping system to preserve the safety of people or property.

(11) "Installer," as used in the boiler or pressure vessel laws and rules, means the person making the water, steam, air, refrigerant or other product piping connection to the boiler or pressure vessel. A person who transports or merely positions the boiler or pressure vessel is not an "installer." An electrician making electrical connections is not an "installer."

(12) "National Board" means the National Board of Boiler and Pressure Vessel Inspectors.

(13) "Operating" means any vessel connected and ready for service.

(14) "Person" means any individual, partnership, corporation, association, governmental subdivision or public or private organization of any character.

(15) "Place of Public Assembly" means a building used or held for use, in whole or in part, for worship, health treatment, rest, recuperation or

retirement living; child care nurseries or institutions; public meetings; education; instruction; entertainment; eating; recreation; or awaiting transportation.

(16) "Pressure Piping" means piping systems and components under the scope of **ASME B31.1**, **B31.3**, **B31.5** and **B31.9**.

(17) "Pressure Relief Valve" means a valve activated by inlet static pressure which opens in proportion to the increase in pressure over the opening pressure range. Only ASME approved valves are allowed under the boiler rules.

(18) "Pressure Vessel" is defined in ORS 480.515(9).

(19) "Psig" means pounds per square inch gauge pressure.

(20) "Quantity," to determine inspection fees at cost, means six or more vessels.

(21) "Related Appurtenance" is defined in ORS 480.515(11).

(22) "Safety Valve" means a valve activated by inlet static pressure and characterized by rapid opening or pop action. Only ASME approved valves are allowed under the boiler rules.

(23) "Same Location," to determine inspection fees at cost, means that all vessels are within 2,000 feet of one another.

(24) "Service of Process" means deposit in the U.S. mail a copy of a notice addressed to the respondent at the respondent's last known address.

(25) "Single Private Residence" means a one-family dwelling structure.

(26) "Process Piping Inspector" means the owner's inspector, for the inspection of **ASME B31.3 Process Piping**, Category "M" fluid service only.

(27) "Structure" means a building or shed with a roof and enclosed on the sides 75 percent or more.

(28) "Traction Boiler" means a boiler constructed before January 1, 1961, designed to operate or pull equipment, or to convert steam power into a flywheel energy driving apparatus such as a thresher, road roller, or grinding equipment.

(29) "Vessel That is Considered Subject to Corrosion or Erosion" means the vessel contains or is intended to contain contents having a corrosive or erosive effect on any portion of the vessel. The use of glass linings leaves a vessel subject to corrosion unless all portions of the vessel are impervious to the corrosive or erosive effects of the contents.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 480.545 & 455.030
Stats. Implemented: ORS 480.525, 480.545, 480.550, 480.560 & 480.565
Hist.: DC 17, f. 7-31-72, ef. 8-15-72; DC 3-1982, f. & ef. 2-3-82; DC 1-1984, f. & ef. 1-5-84; BCA 4-1989, f. & cert. ef. 4-17-89; Renumbered from 814-025-0003; BCA 4-1989, f. & cert. ef. 4-17-89; BCA 5-1991, f. & cert. ef. 3-15-91; BCA 36-1993, f. 12-30-93, cert. ef. 1-1-94; Renumbered from 918-225-0005; BCD 18-1997, f. 12-3-97, cert. ef. 1-1-98; BCD 26-1998, f. 12-30-98, cert. ef. 1-1-99; BCD 36-2000, f. 12-29-00, cert. ef. 1-1-01; BCD 4-2003, f. & cert. ef. 3-14-03; BCD 17-2005(Temp), f. & cert. ef. 7-12-05 thru 9-30-05; BCD 20-2005, f. 9-15-05, cert. ef. 10-1-05

**918-225-0430**
**Designation of Effective Codes**

The **Boiler and Pressure Vessel Specialty Code** containing the minimum safety standards for boilers, pressure vessels, pressure piping, nuclear components, parts, items, and repair and alteration procedures in Oregon is:

(1) ORS 480.510 to 480.665 and OAR chapter 918, division 225;

(2) The **Boiler and Pressure Vessel Code of The American Society of Mechanical Engineers (ASME)**, **2004 Edition** as published of Section I; Section II, Parts A, B,C and D; Section IV; Section V; Section VI; Section VII; Section VIII, Division 1, 2 and 3; Section IX; and Section X.

(3) The **2004 Edition** of the **ANSI/ASME B31.1 Power Piping Code**.

(4) The **2004 Edition** of the **ANSI/ASME B31.3 Process Piping Code**.

(5) The **2001 Edition** of the **ANSI/ASME B31.5 Refrigeration Piping Code**.

(6)The **1996 Edition** of the **ANSI/ASME B31.9 Building Service Piping Code**.

(7) The **2004 Edition** of the **National Board Inspection Code ANSI/NB 23**;

(8) The **2004 Edition of NFPA 85**, **Boiler and Combustion Systems Hazards Code**.

(9) The **2004 Edition of ASME CSD-1**, Controls for Safety; and

(10) The alternate methods provisions under OAR 918-225-0440.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.020, 480.545 & 480.550
Stats. Implemented: ORS 480.545, 480.550 & 480.560
Hist.: DC 17, f. 7-31-72, ef. 8-15-72; DC 19, f. 6-21-73, ef. 7-1-73; DC 27(Temp), f. & ef. 12-31-73; DC 33, f. 5-6-74, ef. 5-25-74; DC 38(Temp), f. & ef. 11-1-74; DC 50, f. 7-2-75, ef. 7-25-75; DC 89, f. & ef. 6-2-77; DC 93, f. & ef. 7-19-76; DC 1-1978, f. 1-5-78, ef. 1-15-78; DC 4-1980, f. & ef. 5-30-80; DC 6-1982, f. & ef. 2-4-82; DC 23-1982, f. & ef. 11-9-82; DC 18-1983, f. & ef. 8-11-1983; DC 21-1983, f. & ef. 9-29-83; DC 1-1984, f. & ef. 1-5-84; DC 18-1984, f. & ef. 5-9-84; DC 36-1984, f. & ef. 12-4-84; DC 16-1985, f. & ef. 7-1-85; DC 6-1986, f. & ef. 5-5-86; DC 2-1987, f. & ef. 2-18-87; BCA 5-1987, f. & ef. 8-24-87; BCA 15-1988, f. & cert. ef. 11-16-88; BCA 25-1989, f. & cert. ef. 7-27-89; Renumbered from 814-025-0006; BCA 5-1990, f. & cert. ef. 2-6-90; BCA 26-1990, f. & cert. ef. 10-30-90; BCA 36-1993, f. 12-30-93, cert. ef. 1-1-94; Renumbered from 918-225-0015; BCD 17-1996, f. & cert. ef. 9-17-96; BCD 18-1997, f. 12-3-97, cert. ef. 1-1-98; BCD 26-1998, f. 12-30-98, cert. ef. 1-1-99; BCD 36-2000, f. 12-29-00, cert. ef. 1-1-01; BCD 13-2002, f. 6-28-02, cert. ef. 7-1-02; BCD 17-2005(Temp), f. & cert. ef. 7-12-05 thru 9-30-05; BCD 20-2005, f. 9-15-05, cert. ef. 10-1-05

**918-225-0560**
**Responsibility of Inspectors**

(1) All deputy and special inspectors shall perform boiler, pressure vessel and pressure piping inspections in accordance with the **Boiler and Pressure Vessel Specialty Code** adopted in OAR 918-225-0430 and the following requirements of the division:

(a) For new boilers, the inspector shall verify that the controls and safety devices required by **ASME CSD-1** or other construction codes are installed and function as designed in accordance with manufacturer's instructions;

(b) External boiler inspections shall be performed with the boiler in normal operation. The inspector shall examine all controls, safety devices, water columns and gauge glasses for evidence of tampering and shall verify that all testing has been performed to ensure proper functioning;

(c) Internal boiler inspections shall be performed in a thorough and complete manner. Manways and other inspection openings necessary to perform a particular inspection shall be removed for access to the boiler internals. Water columns, feed water controllers and feed piping shall be inspected internally. The inspector shall visually examine pressure boundary retaining devices, boiler refractory, hangers, clips, boiler tubes and headers and drum internals for damage, corrosion, overheating, welded repairs, feedwater treatment or any detrimental conditions;

(d) The inspector shall explain to the owner or user that any boiler, pressure vessel or pressure piping deficiency requires correction under the **Oregon Boiler Specialty Code**. The inspector shall require conditions not hazardous to health or safety to be corrected within 30 days. The inspector shall require conditions hazardous to health or safety to be corrected prior to operating the equipment. The owner or user of the equipment may apply to the chief inspector for extension of the 30-day correction requirement; and

(e) All inspectors witnessing installation, repair or alteration of boilers, pressure vessels or pressure piping shall verify that the contractor and workers performing the work are appropriately licensed and hold valid permits as required by ORS 480.630.

(2) Failure to comply with subsections (1)(a) through (e) of this rule, or failure of an owner or user to perform a required deficiency correction may cause additional inspections to be performed per ORS 480.570 as directed by the chief inspector.

(3) The responsibilities of process piping inspectors are located in OAR 918-225-0562.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 455.030 & 480.545
Stats. Implemented: ORS 480.545, 480.555, 480.560, 480.565 & 480.570
Hist.: DC 17, f. 7-31-72, ef. 8-15-72; DC 37-1984, f. & ef. 12-4-84; Renumbered from 814-025-0020; BCA 36-1993, f. 12-30-93, cert. ef. 1-1-94; Renumbered from 918-225-0045; BCD 26-1998, f. 12-30-98, cert. ef. 1-1-99; BCD 4-2003, f. & cert. ef. 3-14-03; BCD 17-2005(Temp), f. & cert. ef. 7-12-05 thru 9-30-05; BCD 20-2005, f. 9-15-05, cert. ef. 10-1-05

**918-225-0660**
**Certification of Special Inspectors**

(1) An application for special inspector certification shall be filed by an employer described in ORS 480.565(3) using forms provided by the division and submitting the appropriate application fee.

(2) The person to be certified shall meet the experience requirements in OAR 918-225-0650 and shall have passed the National Board of Boiler and Pressure Vessel Inspectors Examination.

(3) An examination covering the Oregon Boiler and Pressure Vessel Law, ORS 480.510 to 480.990 and OAR chapter 918, division 225, the **National Board Inspection Code** and **ASME CSD-1** shall be given by the chief inspector to all special inspector applicants.

(4) Special inspector certifications shall be renewed annually, by paying a renewal fee of $25 prior to January 1 of each year.

(5) When a special inspector leaves the employment of the employer covered by ORS 480.565, the employer shall notify the division and return the special inspector certification.

(6) Process piping inspectors shall be certified pursuant to OAR 918-225-0665.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 455.030 & 480.545
Stats. Implemented: ORS 480.565
Hist.: DC 17, f. 7-31-72, ef. 8-15-72; DC 27(Temp), f. & ef. 12-31-73; DC 33, f. 5-6-74, ef. 5-25-74; Renumbered from 814-025-0065; BCA 36-1993, f. 12-30-93, cert. ef. 1-1-94; Renumbered from 918-225-0135; BCD 18-1997, f. 12-3-97, cert. ef. 1-1-98; BCD 4-2003, f. & cert. ef. 3-14-03; BCD 17-2005(Temp), f. & cert. ef. 7-12-05 thru 9-30-05; BCD 20-2005, f. 9-15-05, cert. ef. 10-1-05

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

**Adm. Order No.:** FCS 2-2005
**Filed with Sec. of State:** 8-25-2005
**Certified to be Effective:** 8-25-05
**Notice Publication Date:** 8-1-05
**Rules Adopted:** 441-720-0210
**Rules Amended:** 441-710-0000, 441-710-0020, 441-710-0070, 441-710-0075, 441-710-0240, 441-710-0260, 441-710-0270, 441-710-0325, 441-710-0400
**Rules Repealed:** 441-710-0030, 441-710-0036, 441-710-0130, 441-710-0170, 441-710-0210, 441-710-0230, 441-710-0250, 441-710-0300, 441-710-0310, 441-710-0320, 441-710-0330, 441-720-0000, 441-720-0010, 441-720-0090
**Rules Renumbered:** 441-710-0045 to 441-710-0460, 441-710-0090 to 441-710-0515, 441-710-0120 to 441-710-0530, 441-710-0160 to 441-720-0200
**Rules Ren. & Amended:** 441-710-0010 to 441-710-0500, 441-710-0015 to 441-710-0505, 441-710-0038 to 441-710-0450, 441-710-0080 to 441-710-0510, 441-710-0100 to 441-710-0520, 441-710-0110 to 441-710-0525, 441-710-0140 to 441-710-0535, 441-710-0180 to 441-720-0215, 441-710-0190 to 441-720-0220, 441-710-0200 to 441-720-0225, 441-710-0220 to 441-720-0230
**Subject:** These modifications to the credit union rules simplify some filing requirements, repeal unnecessary rules, make clarifications, and update rules based on powers equivalent to those granted to federal credit unions.
**Rules Coordinator:** Berri Leslie—(503) 947-7478

**441-710-0000**
**Definitions**

As used in Oregon Administrative Rules chapter 441, divisions 710 and 720:

(1) "Abandoned premises" means former credit union premises from the date of relocation to new quarters, and property originally acquired for future expansion for which such use is no longer contemplated.

(2) "Banker's acceptance" means a time draft that is drawn on and accepted by a bank and that represents an irrevocable obligation of the bank.

(3) "Borrowing repurchase transaction" means a transaction in which the credit union agrees to sell a security to a counterparty and to repurchase the same or an identical security from that counterparty at a specified future date and at a specified price.

(4) "CUSO" or "credit union service organization" means an agency, association or corporation in which a credit union is authorized by ORS 723.602(5) to invest or to which it is authorized by ORS 723.602(5) to loan funds. A CUSO may be organized for one or more of the purposes described in ORS 723.006 or 723.602(5).

(5) "Eligible obligation" means a loan or group of loans.

(6) "Federal funds transaction" means a short-term or open-ended unsecured transfer of immediately available funds by one depository institution to another depository institution or entity.

(7) "Fixed assets" means premises and furniture, fixtures and equipment.

(8) "Furniture, fixtures and equipment" means all office furnishings (e.g., tables, chairs, desks, file cabinets, curtains, drapes, rugs, etc.), office machines, computer hardware and software, automated terminals, heating and cooling equipment.

(9) "Investment in fixed assets" means:

(a) Any investment in real property (improved or unimproved) which is being used or is intended to be used as premises;

(b) Any leasehold improvement on premises;

(c) The aggregate of the lease payments pursuant to a lease agreement on fixed assets; or

(d) Any investment in furniture, fixtures and equipment.

(10) "Investment repurchase transaction" means a transaction in which an investor agrees to purchase a security from a counterparty and to resell the same or an identical security to that counterparty at a specified future date and at a specified price.

(11) "Members of the immediate family" means:

(a) All of the following relatives of the member: grandparents, parents, spouse, children, stepchildren, grandchildren, brothers, sisters, half-brothers, half-sisters, aunts and uncles;

(b) The domestic partner of a member provided the domestic partner and the primary member attest that the following conditions apply:

(A) They share the same regular and permanent address;

(B) Have a close personal relationship; and

(C) Have agreed to be jointly responsible for basic living expenses and each others common welfare; and

(c) The immediate family members of those persons described in subsections (11)(a) and (11)(b) of this rule.

(12) "Mobile facility" means a movable physical facility held out by the credit union as a place of business.

(13) "NCUA" means the National Credit Union Administration.

(14) "Paid-in and unimpaired capital and surplus" means shares and deposits plus post-closing, undivided earnings, but does not include regular reserves or special reserves required by statute, administrative rule or special agreement between the credit union and the director or its share insurer.

(15) "Premises" means any office, branch office, service center, parking lot, other facility or real estate where the credit union transacts or will transact business.

(16) "Student loan" means a loan granted to finance attendance at an institution of higher education or at a vocational school, which is secured by and on which payment of the outstanding principal and interest has been deferred in accordance with the insurance or guarantee of the federal government, a state government, or any agency of either.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.152, 723.156 & 723.172
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; BB 1-1984, f. & ef. 2-8-84; Renumbered from 805-072-0005; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0020**
**Membership in General**

The rules in this section create procedures for establishing and expanding the membership of a credit union. These rules do not invalidate or change the field of membership of any credit union approved prior to March 31, 2000.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.172
Hist.: FCS 2-1989, f. 1-18-89, cert. ef. 2-1-89; Renumbered from 805-072-0050; FCS 6-2000; f. & cert. ef. 3-31-00; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0070**
**Procedures for Amending Bylaws on Field of Membership**

(1) When a credit union wishes to expand its field of membership, it shall amend its bylaws to describe the group or groups to be added to the field of membership. The proposed amendment to the bylaws and the application for approval of the amendment filed with the Director shall include:

(a) The bylaw that defines the field of membership of the credit union with the text of the proposed amendment to the bylaw showing the new language underlined and deleted language, if any, bracketed;

(b) The credit union's most recent financial statement;

(c) An updated plan of business for the credit union that takes into account the implications of the anticipated increased membership, deposits, responsibilities and effect on capital level of the credit union;

(d) An updated budget;

(e) If the amendment proposes to add a separate employment group to the field of membership; the names and addresses of individuals who represent the group;

(f) If the amendment proposes to add a group with a separate bond of occupation or association, the credit union shall submit evidence:

(A) That the group does not contain more than 3,000 members;

(B) That the group could not feasibly or reasonably establish a new credit union due to a lack of volunteer resources, financial resources or other factors important to the likelihood of successful formation of a new credit union; or

(C) That the group proposes to transfer to the credit union in connection with a merger, consolidation or transfer approved by the director, or in connection with the liquidation of another credit union.

(g) Any other evidence in support of the application, including relevant correspondence from the group to be added.

(2) Any requirement in section (1) of this rule may be waived by the Director if the requirement is not necessary for the purposes of that application.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.022, 723.156 & 723.172
Hist.: FCS 2-1989, f. 1-18-89, cert. ef. 2-1-89; Renumbered from 805-072-0075; FCS 6-2000; f. & cert. ef. 3-31-00; FCS 2-2004, f. & cert. ef. 8-5-04; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0075**
**Underserved Areas**

(1) A credit union may apply to the Director to add any underserved, well-defined local community, neighborhood or rural district to its field of membership if:

(a) The area is underserved by other depository institutions; and

(b) The credit union is prepared and able to establish and maintain an office or facility within the area to be added.

(c) "Underserved by other depository institutions" means the aggregate number of depository institution branches per capita is below the state average as established by the Director on an annual basis as of December 31.

(d) "Office or facility" means a place where shares are accepted for members' accounts, loan applications are accepted and loans are disbursed. This definition includes:

(A) A credit union owned branch;

(B) A shared branch that belongs to a shared branching network;

(C) A mobile branch;

(D) An office operated on a regularly scheduled weekly basis; or

(E) A credit union owned electronic facility that meets, at a minimum, the requirements of this subsection. An ATM, by itself, does not constitute an "office or facility."

(2) A credit union applying to add an underserved area to its field of membership must complete and submit to the Director an application to include at least the following information:

(a) Copy of the Board of Director minutes approving the request for expansion to an underserved area;

(b) Bylaws or amendment to bylaws showing the current and revised field of membership;

(c) Identification of the area the credit union wishes to serve and the population of the proposed community. Quote the source for the population figures;

(d) Map of proposed area;

(e) Data and the source of that data that demonstrates the area is underserved by other depository institutions.

(f) Most recent monthly financial statement, including income and expense statement;

(g) Business plan showing how the credit union will provide service to the underserved area; and

(h) Information on the proposed office or facility location as required by ORS 723.172(7)(b).

(3) The credit union may establish that the well-defined local community, neighborhood or rural district is underserved by other depository institutions by showing that the area:

(a) Encompasses or is located in an empowerment zone or enterprise community designated under section 1391 of the Internal Revenue Code of 1986; or

(b) Meets at least one of the following objective criteria of economic distress developed by the Community Development Financial Institutions Fund:

(A) The percentage of the population living in poverty is at least 20%.

(B) The median family income shall be at or below 80% of:

(i) The Metropolitan Area median family income or the National Metropolitan Area median family income, whichever is greater for an Investment Area within a Metropolitan area; or

(ii) The statewide non-Metropolitan Area median family income or the national non-Metropolitan Area median family income, whichever is greater for an Investment Area outside a Metropolitan area;

(C) The unemployment rate as reported in the most recently completed Unemployment Rates Report by the Oregon Department of Employment or the decennial census published by the US Bureau of the Census, whichever is more current, is at least 1.5 times the national average;

(D) In areas located outside of a Metropolitan Area:

(i) The county population loss in the period between the most recent decennial census and the previous decennial census is at least 10%; or

(ii) The county net migration loss (outmigration minus inmigration) over the five year period preceding the most recent decennial census is at least 5%; or

(E) The area to be added is an "investment area", as defined in section 103(16) of the Community Development Banking and Financial Institutions Act of 1994 (12 U.S.C. 4702).

(4) After the application is complete, the Director's staff will review the application, determine whether the various criteria of the Director are met and determine whether the granting of the application will adversely impact the safety and soundness of the applicant. The Director will approve or deny the application accordingly and provide the applicant with the Director's determination and the reasons for the determination.

(5) An applicant whose application is denied will have the right to a contested case hearing and rights of appeal pursuant to the provisions of ORS Chapter 183.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.172
Hist.:FCS 5-2002, f. 11-6-02 cert. ef. 11-14-02; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0240**
**Limitations on Ownership of Fixed Assets**

Under ORS 723.152(4), a credit union has the power to acquire, lease, hold and dispose of property necessary or incidental to its operations. A credit union's ownership of fixed assets is limited as described by OAR 441-710-0240 to 441-710-0270.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.152
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0305; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0260**
**Investment in Fixed Assets**

(1) A credit union shall not, without the prior approval of the Director, invest in fixed assets if the aggregate of all such investments exceeds five percent of total assets.

(2) A credit union shall submit such statements and reports as the Director may require in support of a request for approval of an investment in fixed assets in excess of the limit specified by section (1) of this rule. Such reports and statements shall include, but need not be limited to:

(a) A narrative, describing the proposal in terms of costs, usage, location and method of financing;

(b) Current financial data; and

(c) A pro forma projected balance sheet and statements of income and expenses for each of the ensuing three years based upon the assumption that the proposal will be approved.

(3) If the Director determines that the proposal will not adversely affect the credit union, an aggregate dollar amount or percentage of assets will be approved for investment in fixed assets for that credit union.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.152
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0315; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0270**
**Investment in Premises**

(1) When real property is acquired for future expansion, at least partial utilization should be accomplished within a reasonable period, which shall not exceed three years unless otherwise approved in writing by the Director. After real property acquired for future expansion has been held for one year, a board resolution with definitive plans for utilization must be available for inspection by the Director's examiners.

(2) Investments in premises will be recorded on the credit union's books in accordance with generally accepted accounting principles. The cost of land shall be carried on the books of the credit union in an account separate from the cost of improvements thereon.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.152
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0320; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0325**
**Housing Agency Low Income Rental Housing Fund Client Trust Accounts**

(1) Every financial institution as defined in ORS 706.008, authorized by law to offer client trust accounts established pursuant to ORS 696.241 and to accept deposits to such accounts in Oregon may:

(a) Make available to its depositors, client trust accounts, hereafter designated as Housing Agency Low Income Rental Housing Fund Accounts ("Housing Fund Accounts"); and

(b) Pay interest on all funds deposited in each Housing Fund Account at the same rate payable on similar accounts.

(2) Each Housing Fund Account shall be created and maintained according to written agreement between the financial institution and participating depositor. Each agreement shall authorize the financial institution to pay all interest earned, net of fees and expenses imposed by the financial institution, to the Housing Agency Low Income Rental Housing Fund designated in Chapter 916, Oregon Laws 1989 and Chapter 716, Oregon Laws 1991.

(3) Fees and Expenses:

(a) Each Housing Fund Account may be subject to fees and expenses which are reasonable and are customarily assessed by the financial institution for similar accounts;

(b) In no event shall a financial institution collect fees and expenses from a Housing Fund Account in excess of earned interest.

(4) Interest Remittances and Reports:

(a) Each participating financial institution shall remit to the Housing Agency any interest earned on each Housing Fund Account, net of reasonable fees and expenses. Remittance, if any, shall be made at least quarterly;

(b) Remittance may be made in a single aggregate installment representing net interest payable from all Housing Fund Accounts maintained by the financial institution;

(c) Each participating financial institution shall report to the Housing Agency information as to every Housing Fund Account maintained by the financial institution. The information shall be in writing and include identity of the Housing Fund Account by name, account number, interest earned, fees and charges, and net interest remitted, if any. Reports shall be made at least quarterly and may accompany any remittances.

(5) If a financial institution is required to produce tax information returns (Form 1099), the financial institution shall designate the State of Oregon Housing Agency Low Income Rental Housing Fund, as payee or recipient. Tax identification information shall be provided by the Housing Agency to participating financial institutions upon request.

Stat. Auth.: ORS 723.102
Stats. Implemented: Ch. 916 OL 1989 & Ch. 716 OL 1991
Hist.: FCS 8-1989, f. 12-14-89, cert. ef. 1-1-90; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0400**
**Loans to Officials**

(1) Any single loan to a person described in ORS 723.532(2) or the aggregate of all outstanding loans for which such person is directly or indirectly obligated to repay which exceeds $100,000 shall be approved by the Board of Directors.

(2) If the credit union has a staff of three persons or less, all loans to a person described in ORS 723.532(2) shall be approved by the Board of Directors.

(3) This rule shall not apply to loans secured by share or deposit accounts.

Stat. Auth.: ORS 723.532
Stats. Implemented: ORS 723.532
Hist.: FCS 3-2001, f. & cert. ef. 2-13-01; FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0450**
**Mergers of Community Charters**

(1) A community charter credit union may not merge into an occupational or associational credit union unless:

(a) The situation involves a well-defined local community, neighborhood or rural district that is underserved by other depository institutions as referenced in ORS 723.172(7)(a) or is an emergency merger under section (2) of this rule.

(b) The merger does not impact the safety and soundness of the continuing credit union; and

(c) The continuing credit union maintains a service facility within the community boundaries. “Service Facility” means a place where shares are accepted for members’ accounts, loan applications are accepted, and loans are disbursed. This definition includes a credit union owned branch, a shared branch that belongs to the shared branching network, a mobile home, an office operated on a regularly scheduled weekly basis, or a credit union owned electronic facility that meets, at a minimum, these requirements. It does not include an ATM.

(2) For purposes of this rule, “emergency merger” involves the director’s determination that:

(a) A credit union is insolvent or likely to become insolvent;

(b) Expeditious action is necessary;

(c) Other reasonable alternatives are not available; and

(d) The public interest would best be served by approving the merger.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.172 & 723.682
Hist.: FCS 6-2000; f. & cert. ef. 3-31-00; FCS 2-2004, f. & cert. ef. 8-5-04; Renum bered from 441-710-0038, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0460**
**Notice to Members of Merger Plan**

(1) After approval of a plan of merger by the board of directors of two or more credit unions, the plan of merger, in summary form, must be presented to the members of the merging credit union(s) prior to the affirmative vote required by ORS 723.682. Unless waived by the director, the summary of the merger plan must contain the following, as applicable:

(a) Current financial reports for each credit union, consisting of the most currently filed NCUA Form 5300 pages reflecting assets and liabilities, income and expenses, and net worth ratio;

(b) A combined financial report as submitted to the director;

(c) An analysis of share values, and any proposed share adjustments;

(d) An explanation of any changes concerning insurance of member accounts;

(e) The reason(s) for the merger;

(f) The name and location of the continuing credit union, including branches, expected to be open after the merger;

(g) A description of the organization of the continuing credit union board of directors and the identity, if known, of its members and committees;

(h) An explanation of any new or expanded products and services to be made available to members, and any services or products expected to be discontinued, as a result of and expected to be effective within 30 days of the closing date of the merger;

(i) A statement of whether any senior management officials (vice president level and above) of the merging credit union are subject to employment agreements, deferred compensation agreements, or other employee benefit arrangements not offered to employees generally, and if so, whether any such agreements or arrangements contain provisions effecting compensation or benefits changes in the event of a merger;

(j) A statement of whether any agreements, plans or arrangements identified in subsection (1)(i) will be modified or superseded in connection with the merger, or whether any senior management officials (vice president and above) of the merging credit union will be offered new employment agreements, deferred compensation arrangements, incentive plans, retirement packages or other employee benefit arrangements not offered to employees generally. Provide a summary description of the arrangements identified in this subsection, disclosed in the aggregate, and not by individual employee, with a brief explanation of how such arrangements differ from existing arrangements of such employees; and

(k) An estimate itemized by general categories of the cost of the merger.

(2) Before dissemination to the members, the merger plan summary described in section (1) will be made available for inspection by the director or the director’s employees at the offices of the credit union(s) or by viewing a web site maintained by the credit union(s) to which the director is provided access. The credit union(s) will notify the director when the merger plan summary becomes available for review. The credit union may disseminate the merger plan summary to the members at the time the director grants preliminary approval of the merger or five business days after the merger plan summary is made available for inspection by the director, whichever is later.

(3) The summary may be communicated to members by means of:

(a) United States postal mail;

(b) Electronic mail;

(c) Facsimile;

(d) Access to an Internet web page which may be password-protected if deemed necessary by the credit union;

(e) Permitting members to pick up materials at a main or branch office; or

(f) Any other method identified by the credit union and approved by the director that allows for access by the members to the information.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.682
Hist.: FCS 5-2004, f. & cert. ef. 11-30-04; Renumbered from 441-710-0045, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0500**
**Fees and Charges Credit Unions Pay the Director**

(1) Effective February 15, 2001, the annual regulatory fee under ORS 723.114(1), which is due and payable on March 1 of each calendar year, by each credit union, with assets of:

(a) Less than $10 million, is $375 plus .0001920 of all assets;

(b) $10 million or more but less than $20 million, is $1,234 plus .000173 of all assets;

(c) $20 million or more but less than $50 million, is $1300 plus .000165 of all assets;

(d) $50 million or more but less than $100 million, is $1500 plus .0001120 of all assets;

(e) $100 million or more but less than $200 million, is $7100 plus .000099 of all assets;

(f) $200 million or more is $7,906 plus .000095 of all assets; or

(g) If the credit union is a corporate credit union, effective January 3, 2000, the fee schedule is $16,800 plus .0000345 of all assets.

(2) The rate of charge payable by a credit union is $60 an hour for each examiner used in an examination for extra services provided a credit union under ORS 723.114(2).

(3) Notwithstanding the rate of charge fixed by section (2) of this rule:

(a) If an examiner from the division or the Supervisor is required to travel out of state for an examination or to provide extra service, the rate of charge payable by the credit union is $60 an hour per person, plus actual expenses for travel and subsistence;

(b) If the examination or the extra service is performed by a consultant hired by contract for the particular work, the charge payable by the credit union is the actual cost to the division of the contract consultant.

(4) In addition to the charges fixed by sections (2) and (3) of this rule, the Director will collect from a credit union any additional costs directly attributable to extra services given the credit union under ORS 723.114(2).

(5) As used in this rule:

(a) “Assets” means the average value of total assets reported by the credit union for the four calendar quarters ending with the quarter immediately preceding the due date of the fee. However, if a credit union was not in existence or doing business in this state during all of the prior calendar year “assets” means the average assets reported on the quarterly reports for the quarters for which reports were required to be filed during the calendar year immediately preceding the due date of the fee;

(b) “Extra service” means any special examination or examination in connection with a conversion.

(6) The annual regulatory fee of a credit union that is party to a merger or conversion, or is liquidated or dissolved:

(a) Is not subject to refund in whole or in part if the merger, conversion, liquidation or dissolution occurs prior to the end of the calendar years for which a fee has been paid;

(b) Is not subject to pro ration if the credit union operated during any part of the calendar year during which the merger, conversion, liquidation or dissolution occurred.

(7) The Director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 705.620, 723.102 & 723.532
Stats. Implemented: ORS 723.114 & 723.532
Hist.: FID 9-1985, f. & ef. 12-31-85; FCS 2-1988, f. 1-29-88, cert. ef. 2-1-88; Renumbered from 805-072-0010; FCS 1-1989, f. 1-18-89, cert. ef. 2-1-89; FCS 1-1991, f. 1-28-91, cert. ef. 2-15-91; FCS 3-1994, f. 2-1-94, cert. ef. 2-15-94; Administrative correction 9-29-97; FCS 3-2000, f. & cert. ef. 3-9-00; FCS 3-2001, f. & cert. ef. 2-13-01; FCS 1-2005(Temp), f. & cert. ef. 3-4-05 thru 8-30-05; Renumbered from 441-710-0010, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0505**
**Amendment and Late Charge Fees**

(1) The fees for amendments authorized by ORS 723.022 are as follows for each submission:

(a) Amendment of articles of incorporation, $25;

(b) Amendment of bylaws, $25.

(2) The following charges apply to late reports filed by the credit union with the director. The fine is for each day the report is late:

(a) Quarterly call reports; $100;

(b) Supervisory Committee Report, $10;

(c) Examination report reply, $10;

(d) Monthly reports when required by the director, $10. The reports may include, but are not limited to:

(A) Financial statement, including income and expenses;

(B) Board of Director minutes.

Stat. Auth.: ORS 723.022 & 723.106
Stats. Implemented: ORS 723.022 & 723.106
Hist.: FCS 5-1991(Temp), f. & cert. ef. 9-30-91; FCS 6-1991, f. 10-29-91, cert. ef. 11-1-91; Renumbered from 441-710-0015, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0510**
**Annual Audit; Qualified Persons to Perform; Content; Time for Filing, Reporting Action Taken**

(1) The person performing the comprehensive annual audit required by ORS 723.322 must be qualified by knowledge and experience to perform credit union audits and must be approved by the Director as so qualified.

(2) The audit should test whether or not the accounting systems and methods used by the credit union, and the accounts of the credit union, accurately reflect the condition of the business. The auditor shall prepare the audit report in accordance with the guidelines furnished by the Director. The audit report shall include a management letter; and the management letter shall include, but need not be limited to:

(a) An evaluation of the soundness of the credit union;

(b) An evaluation of its internal controls;

(c) The state of its compliance with applicable statutes and rules; and

(d) An evaluation of the extent and effectiveness of its use of generally accepted accounting principles.

(3) A copy of the audit, including the management letter, shall be filed with the Director by the auditor within 30 days after the report is delivered to the credit union. Within 65 days after the audit report is received by the credit union, the credit union shall report to the Director the action it has taken or is taking in response to the report.

(4) Each credit union must file a notice with the director within 15 days after the engagement of a new independent auditor, or the resignation or dismissal of the independent auditor previously engaged. The notice must include the reasons for the event in reasonable detail.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.322
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0150; Renumbered from 441-710-0080, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0515**
**Required “Additional Reports” Defined**

(1) As used in ORS 723.106(1), “additional reports” includes call reports of condition, lists of officers and other management officials, Supervisory committee audits, management letters, liquidity reserve reports, and other reports required by the Director.

(2) If a credit union is investing in or has loans outstanding to a CUSO, “additional reports” as used in ORS 723.106(1) includes reports and other information of the CUSO of the kinds described by section (1) of this rule.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.106
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; BB 1-1984, f. & ef. 2-8-84; Renumbered from 805-072-0155; Renumbered from 441-710-0090, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0520**
**Reports and Filings When Credit Union Invests in CUSO**

(1) When a credit union first invests in or loans funds to a CUSO, the credit union shall, within 30 days after the funds are first invested or loaned, file with the Director a copy of:

(a) The charter, articles of association or incorporation, or partnership agreement, of the CUSO;

(b) The bylaws of the CUSO; and

(c) The most recent financial statement of the CUSO.

(2) Any amendments of the documents described by section (1) of this rule shall be filed with the Director by the credit union within 30 days after the amendment becomes effective.

(3) While a credit union has funds invested in or loaned to a CUSO, the credit union shall each year file the annual financial statement of the CUSO with the Director within 30 days after the statement is issued.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.106 & 723.602
Hist.: BB 1-1984, f. & ef. 2-8-84; Renumbered from 805-072-0156; Renumbered from 441-710-0100, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0525**
**Duty to Report Changes in Accounting Systems, Methods or Procedures**

(1) A credit union shall report to the Director any major change that affects bookkeeping or accounting systems, methods and procedures at least 60 days prior to implementation of the change to permit the Director to schedule examinations appropriately.

(2) Any contract or agreement by a credit union to purchase accounting services shall include a clause acknowledging the right of the Director or authorized representatives to examine any and all records of the credit union on the premises of the servicer.

Stat. Auth.: ORS 723.102

Stats. Implemented: ORS 723.116 & 723.152
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0160; Renumbered from 441-710-0110, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0530**
**Accrual Accounts, When Required**

Each credit union with assets in excess of $5 million shall use accrual accounting.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.116
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0165; Renumbered from 441-710-0120, FCS 2-2005, f. & cert. ef. 8-25-05

**441-710-0535**
**Back-Up Records; Off-Site Storage Required**

(1) To insure the viability and reasonable continuity of the credit union in the event of a catastrophe that would destroy or make its records at the place of business useless, every credit union shall store off-site records that could be used to reconstruct the credit union's records. The credit union shall, at the credit union, maintain a log of the records stored off-site.

(2) The adequacy of the plan of each credit union for complying with this rule is subject to the approval of the Director. Each credit union shall submit its plan, and any major revision of its plan, to the Director for approval. The submission shall identify the kinds of records to be stored off-site, the procedure used to collect the records and to transport them to storage, and the place where stored.

Stat. Auth.: ORS 723.116
Stats. Implemented: ORS 723.116
Hist.: BB 4-1982, f. 8-24-82, ef. 9-1-82; Renumbered from 805-072-0175; Renumbered from 441-710-0140, FCS 2-2005, f. & cert. ef. 8-25-05

**441-720-0200**
**Purpose, Authority for Federal Tie-In Rules**

ORS 723.156 authorizes the Director to grant to state chartered credit unions powers federally chartered credit unions have notwithstanding state law, if it would serve the public convenience and advantage, and equalize and maintain the quality of competition between state chartered credit unions and federally chartered credit unions. The tie-in rules hereafter adopted are done pursuant to ORS 723.156.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.156
Hist.: FID 5-1986, f. & ef. 8-27-86; Renumbered from 805-072-0250; Renumbered from 441-710-0160, FCS 2-2005, f. & cert. ef. 8-25-05

**441-720-0210**
**Adoption of Federal Regulations Concerning Purchase, Sale and Pledge of Eligible Obligations**

(1) A credit union may purchase, in whole or in part, within the limitations of the board of directors' written purchase policies:

(a) Eligible obligations of its members, from any source, if either:

(A) They are loans it is empowered to grant; or

(B) They are refinanced with the consent of the borrowers, within 60 days after they are purchased, so that they are loans it is empowered to grant.

(b) Eligible obligations of a liquidating credit union's individual members, from the liquidating credit union;

(c) Student loans, from any source, if the purchaser is granting student loans on an ongoing basis and if the purchase will facilitate the purchasing credit union's packaging of a pool of such loans to be sold or pledged on the secondary market; and

(d) Real estate-secured loans, from any source, if the purchaser is granting real estate secured loans on an ongoing basis and if the purchase will facilitate the purchasing credit union's packaging of a pool of such loans to be sold or pledged on the secondary mortgage market. A pool must include a substantial portion of the credit union's members' loans and must be sold promptly.

(2) A credit union may make purchases in accordance with section (1) of this rule provided:

(a) The board of directors or investment committee approves the purchase;

(b) A written agreement and a schedule of the eligible obligations covered by the agreement are retained in the credit union's office; and

(c) For purchases from a liquidating credit union, any advance written approval required from the director is obtained before consummation of such purchase.

(3) The aggregate of the unpaid balance of eligible obligations purchased under paragraph (a)(A) and subsection (b) of section (1) of this rule may not exceed 5% of the paid-in and unimpaired capital and surplus of the credit union. In calculating this 5% limitation, the credit union can exclude an indirect lending or indirect leasing arrangement that is classified as a loan and not the purchase of an eligible obligation because the credit union makes the final underwriting decision and the sales or lease contract is assigned to the credit union promptly after it is signed by the member and the dealer or leasing company.

(4) A credit union may sell, in whole or in part, to any source, eligible obligations of its members, and obligations and loans purchased in accordance with subsections (b), (c) and (d) of section (1) of this rule, within the limitations of the board of directors' written sale policies, provided:

(a) The board of directors or investment committee approves the sale; and

(b) A written agreement and a schedule of the eligible obligations covered by the agreement are retained in the credit union's office.

(5) A credit union may pledge, in whole or in part, to any source, eligible obligations of its members, and obligations and loans purchased in accordance with subsections (b), (c) and (d) of section (1) of this rule, within the limitations of the board of directors' written pledge policies, provided:

(a) The board of directors or investment committee approves the pledge;

(b) Copies of the original loan documents are retained; and

(c) A written agreement covering the pledging arrangement and identifying the eligible obligations is retained in the credit union's office.

(6) A credit union may agree to service any eligible obligation it purchases or sells in whole or in part.

(7) The total indebtedness owing to any credit union by any person, inclusive of retained and reacquired interests, shall not exceed the loan limit described in ORS 723.512.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.156, 723.512, 723.526 & 723.602
Hist.: FCS 2-2005, f. & cert. ef. 8-25-05

**441-720-0215**
**Procedures Required Prior to Exercise of Certain Investment Powers**

(1) A credit union shall not exercise the investment powers granted credit unions by OAR 441-720-0220 and 441-720-0225, unless it first adopts investment procedures and policies covering the type of investment programs it intends to engage in.

(2) The investment policies and procedures shall:

(a) Describe the particular type of investment it intends to engage in, summarize the procedures and policies developed for each program and describe investment objectives for the program;

(b) Name the person who will do the investing and any professionals who will be used as adviser; and

(c) Show the ability and training of the person that qualifies the person to do the investing.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.156 & 723.602
Hist.: FID 5-1986, f. & ef. 8-27-86; Renumbered from 805-072-0260; Renumbered from 441-710-0180, FCS 2-2005, f. & cert. ef. 8-25-05

**441-720-0220**
**Investments in Investment and Borrowing Repurchase Agreements, Bankers Acceptances, Participation in Federal Funds Authorized; Adoption of Federal Statutes, Regulations on Such Investments**

A state credit union is authorized to invest in investment and borrowing repurchase agreements, bankers acceptances and federal funds permissible for federal credit unions as described in the following provisions.

(1) A credit union may sell Federal funds to a financial institution defined in ORS 706.008, as long as the interest or other consideration received from the financial institution is at the market rate for Federal funds transactions.

(2) A credit union may enter into an investment repurchase transaction so long as:

(a) Any securities the credit union receives are permissible investments for federal credit unions;

(b) The credit union, or its agent, either:

(A) Takes physical possession or control of the repurchase securities; or

(B) Is recorded as owner of them through the Federal Reserve Book Entry Securities Transfer System.

(c) The credit union, or its agent, receives a daily assessment of their market value, including accrued interest;

(d) The credit union maintains adequate margins that reflect a risk assessment of the securities and the term of the transaction; and

(e) The credit union has entered into signed contracts with all approved counterparties.

(3) A credit union may enter into a borrowing repurchase transaction so long as:

(a) The transaction meets the requirements of section (2) of this rule;

(b) Any cash the credit union receives is subject to a borrowing limit of 50% of paid-in and unimpaired capital and surplus;

(c) Any investments the credit union purchases with that cash are permissible for credit unions; and

(d) The investments purchased with that cash mature no later than the maturity of the borrowing repurchase transaction.

(4) A credit union may invest in banker's acceptances issued by a financial institution defined in ORS 706.008.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.156 & 723.602
Hist.: FID 5-1986, f. & ef. 8-27-86; Renumbered from 805-072-0265; Renumbered from 441-710-0190, FCS 2-2005, f. & cert. ef. 8-25-05

**441-720-0225**
**Adoption of Federal Statutes, Rulings, Policy Regarding Mortgage Assumptions**

(1) A state credit union is authorized to exercise the powers to allow nonmembers to assume real estate mortgages of members conferred on a federally chartered credit union as follows:

(a) The assumption is in conjunction with the nonmember's purchase of the member's principal residence;

(b) The nonmember assumes only the remaining unpaid balance of the loan;

(c) The terms of the loan remain unchanged; and

(d) There is no extension of the original maturity date specified in the loan agreement with the member.

(2) An assumption is impermissible if the original loan was made with the intent of having a nonmember assume the loan.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.156 & 723.602
Hist.: FID 5-1986, f. & ef. 8-27-86; Renumbered from 805-072-0270; Renumbered from 441-710-0200, FCS 2-2005, f. & cert. ef. 8-25-05

**441-720-0230**
**Adoption of Federal Statutes and Regulations Concerning Loan Participations**

(1) Federal Tie-In: A state credit union is authorized to participate in making loans with financial institutions as defined in ORS 706.008 within the limitations of the board of directors' written participation loan policies, provided:

(a) No credit union may obtain an interest in a participation loan if the sum of that interest and any indebtedness owed to the credit union by the borrower exceeds 10 per cent of the credit union's unimpaired capital and surplus;

(b) A written master participation agreement is properly executed, acted upon by the credit union's board of directors, or if the board has so delegated in its policy, by the investment committee or senior management official(s) and retained in the credit union's office. The master agreement must include provisions for identifying, either through a document that is incorporated by reference into the master agreement, or directly in the master agreement, the participation loan or loans prior to their sale; and

(c) A credit union may sell to or purchase from any participant the servicing of any loan in which it owns a participation interest.

(2) An originating lender which is a state credit union must:

(a) Originate loans only to its members;

(b) Retain an interest of at least 10 per cent of the face amount of each loan;

(c) Retain the original or copies of the loan documents; and

(d) Require the credit committee or loan officer to use the same underwriting standards for participation loans used for loans that are not being sold in a participation agreement unless there is a participation agreement in place prior to the disbursement of the loan. Where a participation agreement is in place prior to disbursement, either the credit union's loan policies or the participation agreement shall address any variance from non-participation loan underwriting standards.

(3) A participant state credit union that is not an originating lender must:

(a) Participate only in loans it is empowered to grant, having a participation policy in place that sets forth the loan underwriting standards prior to entering into a participation agreement;

(b) Participate in participation loans only if made to its own members or members of another participating credit union;

(c) Retain the original or a copy of the written participation loan agreement and a schedule of the loans covered by the agreement; and

(d) Obtain the approval of the board of directors or investment committee of the disbursement of proceeds to the originating lender.

(4) Additional State Requirements:

(a) In addition to the requirements of the federal provisions stated in this rule, a state credit union must file with the Director:

(A) A representation that the board of directors has adopted written policies and procedures concerning loan participations and recourse;

(B) An undertaking that it will not keep or acquire any loan participation interest which exceeds the loan to one borrower requirements in ORS 723.512 and, except for this provision, will follow the guidelines for loan participations stated in this rule; and

(C) An undertaking that each loan agreement will contain a provision that provides complete access to the agency to all records of each participant concerning the loan transaction.

(b) Any provision of subsection (a) of this section except paragraph (a)(B) of this section may be waived or modified by order of the Director if no undue risk is created by the waiver or modification and the credit union has policies, procedures, and strategies covering the changed items or where it is necessary for regulatory purposes.

Stat. Auth.: ORS 723.102
Stats. Implemented: ORS 723.156
Hist.: FCS 10-1987, f. 11-13-87, ef. 12-1-87; Renumbered from 805-072-0280; Renumbered from 441-710-0220, FCS 2-2005, f. & cert. ef. 8-25-05

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**Adm. Order No.:** FCS 3-2005
**Filed with Sec. of State:** 9-6-2005
**Certified to be Effective:** 9-6-05
**Notice Publication Date:** 8-1-05
**Rules Amended:** 441-730-0030, 441-740-0010, 441-745-0310, 441-810-0150, 441-830-0040, 441-860-0020, 441-930-0270
**Subject:** These amendments add a provision to each rule setting fees for certain non-depository financial services entities regulated by the director. The added provision allows the director by order to reduce fees assessed in any of these programs for any year or other licensing period.
**Rules Coordinator:** Berri Leslie—(503) 947-7478

**441-730-0030**
**Fees, Charges Licensees Pay the Director**

(1) Effective January 1, 2005, the annual license fee under ORS 725.185 is $520, and is due and payable on March 1 of each calendar year.

(2) A licensee who surrenders a license before the March 1 payment date must pay a fee of $55 as a limited annual license fee.

(3) The rate of charge payable by a licensee is $60 an hour per person payable by the licensee for the Director and each examiner and other division employee used in an examination conducted under ORS 725.312 and for extra services provided a licensee under ORS 725.185(2).

(4) Notwithstanding the rate of charge fixed by section (3) of this rule:

(a) If an examiner from the division or the Director is required to travel out of state in conducting the examination or providing the extra services, the rate of charge payable by the licensee is $60 an hour per person, plus actual cost of travel; actual travel costs include air fare, lodging, food, car usage out of state, mileage to the Oregon airport and return, and travel time beginning from the departure time and ending at the departure time at the destination city;

(b) If the extra services or examination is performed by a consultant hired by contract for the particular service or examination, the charge payable by the licensee is the actual cost to the division of the contract consultant.

(5) As used in this rule, "extra services" means any attention other than an examination given under ORS 725.310.

(6) In addition to the charges fixed by sections (3) and (4) of this rule, the Director will collect from a licensee any additional costs directly attributable to extra services given the licensee under ORS 725.185 or a special examination given the licensee under ORS 725.310.

(7) The director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 725.185
Stats. Implemented: ORS 725.185
Hist.: FID 8-1985, f. & ef. 12-31-85; FCS 2-1988, f. 1-29-88, cert. ef. 2-1-88; Renumbered from 805-075-0015; FCS 12-1988, f. 7-20-88, cert. ef. 8-1-88; FCS 1-1989, f. 1-18-89, cert. ef. 2-1-89; FCS 1-2001, f. 1-22-01, cert. ef. 2-1-01; FCS 4-2003, f. 12-30-03 cert. ef. 1-1-04; FCS 4-2004, f. 11-1-04, cert. ef. 1-1-05; FCS 3-2005, f. & cert. ef. 9-6-05

**441-740-0010**
**Fees Payable by Pawnbrokers to the Administrator**

(1) For calendar year 2002 and thereafter, the annual fees paid pursuant to ORS 726.125(1) and (2) shall be $350.

(2) Whenever the Director provides extra services to a pawnbroker under ORS 726.125(3) or conducts an examination of a licensed pawnbroker under ORS 726.250, the Director will collect the cost to the Division for the Director and the examiners and other Division employees used in providing the extra services or conducting the examination. The rate of charge is $60 an hour per person.

(3) In addition to the charges fixed by section (2) of this rule, the Director will collect any additional costs directly attributable to extra services provided under ORS 726.125(3) or an examination made under ORS 726.250.

(4) The director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 726.125 & 726.250
Stats. Implemented: ORS 726.125 & 726.250
Hist.: FID 7-1985, f. & ef. 12-31-85; Renumbered from 805-076-0100; FCS 5-1994, f. & cert. ef. 4-25-94; FCS 11-2000, f. 10-5-00, cert. ef. 9-1-01; FCS 8-2001, f. & cert. ef. 8-1-01; FCS 4-2002, f. & cert. ef. 10-25-02; FCS 3-2005, f. & cert. ef. 9-6-05

**441-745-0310**
**Renewal of License**

(1) A licensee may renew their license to conduct the business of a Money Transmitter by submitting:

(a) A completed renewal application.

(b) A renewal fee of $500.00 pursuant to ORS 717.240(1).

(c) The information required pursuant to ORS 717.240(2).

(2) The director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 717.240 & 717.310
Stats. Implemented: ORS 717.240
Hist.: FCS 8-2000, f. & cert. ef. 6-27-00; FCS 3-2005, f. & cert. ef. 9-6-05

**441-810-0150**
**Fees**

(1) Fees established for the Program are:

(a) Initial registration, $350;

(b) Registration renewal, $120;

(c) Duplicate registration, $10;

(d) Certification of registration, $5.

(2) The director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 697.031
Stats. Implemented: ORS 697.031
Hist.: DC 7-1981(Temp), f. & ef. 7-1-81; DC 15-1982, f. & ef. 7-26-82; CD 22-1983(Temp), f. 10-14-83, ef. 11-1-83; DC 3-1984, f. & ef. 1-16-84; Renumbered from 814-101-0035; Renumbered from 814-101-0100; FCS 9-1988, f. 4-12-88, cert. ef. 5-1-88; FCS 9-2000, f. & cert. ef. 9-13-00; FCS 3-2005, f. & cert. ef. 9-6-05

**441-830-0040**
**Fees**

(1) Fees established for the Program are:

(a) Annual registration, $350.

(b) Duplicate registration, $10.

(c) Certification of registration, $5.

(2) The director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 646.396
Stats. Implemented: ORS 646.386
Hist.: FCS 1-1994, f. & cert. ef. 1-4-94; FCS 2-2004, f. & cert. ef. 8-5-04; FCS 3-2005, f. & cert. ef. 9-6-05

**441-860-0020**
**Application Procedure**

Each person desiring to obtain a mortgage banker or mortgage broker license shall apply to the Director by submitting the following:

(1) A completed application on a form approved by the Director;

(2) A surety bond or letter of credit pursuant to ORS 59.850(4) and OAR 441-860-0090;

(3) Financial statements prepared in accordance with generally accepted accounting principles, consisting of a balance sheet and a statement of income or operations which is dated not more than six months prior to submission of the application:

(a) The financial statements may be prepared by the licensee, except that if the Director finds it in the public interest, the Director may require that a licensee submit financial statements prepared by an independent accountant;

(b) If the financial statements are more than six months old, interim period financial statements prepared by the licensee for the period ending the last full month prior to the date of application shall also be submitted.

(4) Written Authorization to examine the applicant's Clients' Trust Account pursuant to ORS 59.935(3) or, in the case of a neutral escrow depository, a copy of the escrow agreement pursuant to OAR 441-875-0040(3);

(5) A copy of the written Notice to Financial Institution of Establishment of Clients' Trust Accounts pursuant to ORS 59.940. In the event the applicant does not receive client funds except at the time of closing, an Affidavit and Undertaking in the form and on terms approved by the Director;

(6) The name of the registered agent of the mortgage banker or mortgage broker as filed with the Corporations Division of the Secretary of State for the State of Oregon;

(7)(a) Each of the following persons shall submit the information required under the provisions of subsections (b) and (c) of this section:

(A) Any director, officer, and shareholder with ownership of greater than or equal to 10 percent of outstanding shares of a corporate applicant;

(B) Owner, if the applicant is an unincorporated sole proprietorship; and

(C) Each managing partner of a limited or general partnership.

(b) A biographical statement including name, address, social security number, date of birth, and a description of any material litigation for the preceding ten years. If more than one name or social security number has been used by any of the persons submitting the biographical statement, all names and social security numbers must be submitted; and

(c) An employment history for the ten years prior to the date of the application which shall include the name of each employer, job position and title, date each employment began and date each employment ended.

(d) Each branch supervisor shall submit an employment history for the ten years prior to the date of the application, or the date of employment as a supervisor. The employment history shall include the name of each employer, job position and title, date each employment began and date each employment ended.

(8) The information required pursuant to OAR 441-880-0030 for loan originators.

(9) The information required pursuant to OAR 441-860-0030 for each branch office.

(10) Initial fees. An initial application fee composed of a fixed component in the amount of $825 and a variable component in the amount of $60 for each reported loan originator to be employed by or associated with the firm to do business in this state, plus a fee of $165 for each initial branch office operated by a licensee that will do business in this state.

(11) Additional branch offices. A fee of $247.50 for each branch office added after the mortgage banker or mortgage broker license is issued.

(12)(a) In the event the Director determines that the amount of licensing fees assessed pursuant to this rule, combined with other fees assessed pursuant to ORS 59.840 through 59.960 and OAR 441-850-0005 through 441-885-0010 is insufficient to fund the administration of ORS 59.840 through 59.960, the Director may amend this rule to increase the fees to an amount necessary to fund the administration of ORS 59.840 through 59.960 plus a reasonable emergency fund;

(b) In the event the Director determines that the amount of licensing fees assessed pursuant to this rule, combined with other fees assessed pursuant to ORS 59.840 through 59.960 and OAR 441-850-0005 through 441-885-0010, exceeds the amount necessary to fund the administration of ORS 59.840 through 59.960, the Director may amend this rule to decrease the fees to an amount necessary to administer ORS 59.840 through 59.960 plus a reasonable emergency fund;

(c) If the Director finds that the balance of revenues collected exceeds the amount necessary to administer ORS 59.840 through 59.980 and provide a reasonable emergency fund, the Director may issue an Order granting a partial rebate of fees due from each applicant or licensee over a period of time specified in the Order.

(13) If an applicant for a license submits an application which is incomplete in any respect, the Director will contact the applicant to request the missing information. The applicant will have 30 days to respond to the request for information from the Director. If the applicant fails to respond, the application will be withdrawn.

Stat. Auth.: ORS 59.850, 59.855 & 59.900
Stats. Implemented: ORS 59.845 & 59.969
Hist.: FCS 3-1993, f. & cert. ef. 11-15-93; FCS 11-1994, f. 11-4-94, cert. ef. 11-15-94; FCS 1-1996, f. 11-20-96, cert. ef. 12-1-96; Administrative correction 8-4-97; FCS 4-1999, f. & cert. ef. 12-23-99; FCS 10-2000, f. & cert. ef. 9-13-00; FCS 10-2001, f. 12-24-01, cert. ef. 1-1-02; FCS 7-2003, f. 12-30-03 cert. ef. 1-1-04; FCS 6-2004, f. 12-14-04, cert. ef. 1-1-05; FCS 3-2005, f. & cert. ef. 9-6-05

**441-930-0270**
**Fees Assessed to Certified Providers and Registered Master Trustees**

(1) The Director shall collect the following fees from each registered master trustee and certified provider:

(a) A registration or certification fee — $335.

(b) Annual Report Fee — $335 per trustee, provider and/or cemetery or crematorium location. For purposes of the annual report fee, each branch location of a registrant's funeral establishment is a separate establishment and each location of a cemetery or crematorium is a separate location.

(c) Short form Annual Report Fee — $10.

(d) Exam Fees — $60 per hour for each examiner, plus costs of an examination.

(2) If the books and records are located outside Oregon, the certified provider or master trustee must pay travel and per diem expenses.

(3) In addition to the charges fixed by this rule, the Director shall collect any additional costs directly attributable to extra services provided under ORS 97.923 to 97.949 or these rules.

(4) The director may by order reduce the fees assessed for any specific year.

Stat. Auth.: ORS 97.933 & 97.935
Stats. Implemented: ORS 97.933 & 97.935
Hist.: DO 1-2002, f. & cert. ef. 1-10-02; Renumbered from 440-300-0270; FCS 3-2004, f. & cert. ef. 9-30-04; FCS 7-2004, f. 12-14-04, cert. ef. 1-1-05; FCS 3-2005, f. & cert. ef. 9-6-05

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## Department of Consumer and Business Services, Insurance Division Chapter 836

**Adm. Order No.:** ID 11-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 9-15-05 thru 3-10-06
**Notice Publication Date:**
**Rules Amended:** 836-080-0430, 836-080-0438
**Subject:** This temporary rulemaking corrects an error in a recent amendment to this rule. OAR 836-080-0430 was amended in 2004 to delete provisions relating to the use of credit history or insurance score in connection with rating a policy at renewal in order to conform the rule to 2003 legislation but a subsequent amendment in 2005 for another purpose inadvertently restored the deleted wording. This temporary rulemaking also corrects and updates an obsolete statutory reference in a related rule.
**Rules Coordinator:** Sue Munson—(503) 947-7272

**836-080-0430**
**Disclosure of Use of Credit History or Insurance Scores**

(1) Before an insurer or its insurance producer may obtain the credit history or insurance score of a consumer in response to a request by the consumer relating to insurance coverage, the insurer or insurance producer shall notify the consumer that the insurer or insurance producer will check the credit history or insurance score of the consumer. The notice may be oral, in writing or in the same medium as the medium in which communication between the consumer and the insurer or insurance producer is conducted.

(2) An insurance producer need provide only one notice under section (1) of this rule to a consumer for the inquiry or inquiries that the insurance producer makes to one or more insurers in response to the request by the consumer.

(3) An insurer who uses credit histories or insurance scores for underwriting or rating coverage shall instruct each of its insurance producer that before an insurance producer may obtain a consumer's credit history or insurance score, the insurance producer must notify the consumer that the consumer's credit history or insurance score of the consumer will be checked.

(4) An insurer that uses the credit history or insurance score of a consumer when considering the consumer's application for insurance must notify the consumer during the application process that the consumer may request a written statement describing its use of credit histories or insurance scores. The notice to the consumer may be either in writing or in the same medium as the medium in which the application is made. The statement must address the following items:

(a) Why the insurer uses credit history or insurance scores.

(b) How the insurer uses credit histories or insurance scores.

(c) What kinds of credit information are used by the insurer.

(d) Whether a consumer's lack of credit history will affect the insurer's consideration of an application.

(e) Where the consumer may go with questions.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.015 & 746.240
Hist.: ID 25-2002, f. 12-17-02, cert. ef. 6-1-03; ID 7-2004, f. & cert. ef. 10-5-04; ID 8-2005, f. 5-18-05, cert. ef. 8-1-05; ID 11-2005(Temp), f. & cert. ef. 9-15-05 thru 3-6-06

**836-080-0438**
**Definition of Adverse Underwriting Decision; Notice**

(1) For the purpose of the notice required by ORS 746.650(5), an adverse underwriting decision as defined in ORS 746.600(1)(a)(G)(iii) occurs when an insurer accepting an application for insurance would have given the consumer a lower rate if the consumer's credit history or the credit factors in the consumer's insurance score were more favorable.

(2) An insurer shall include in a notice of adverse underwriting decision required by ORS 746.650(5) an explanation of the consumer's right to request, no more than once annually, that the insurer rerate the consumer, and of potential negative consequences of rerating, if any.

Stat. Auth.: ORS 731.244
Stats. Implemented: ORS 746.600 & 746.650
Hist.: ID 7-2004, f. & cert. ef. 10-5-04; ID 11-2005(Temp), f. & cert. ef. 9-15-05 thru 3-6-06

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

**Adm. Order No.:** OMIPB 1-2005(Temp)
**Filed with Sec. of State:** 8-26-2005
**Certified to be Effective:** 8-26-05 thru 2-20-06
**Notice Publication Date:**
**Rules Amended:** 443-002-0060, 443-002-0080
**Subject:** OMIP is amending the above rules in order to comply with Senate Bill 117 (2005) and House Bills 2987 and 3431 (2003), which broaden the category of Oregonians who are eligible to join the high risk pool.
**Rules Coordinator:** Nicole Shuba—(503) 378-4676

**443-002-0060**
**Eligibility**

(1) Individuals applying for OMIP coverage must meet the following eligibility requirements:

(a) The applicant must be a resident of the State of Oregon.

(A) A resident is defined as a person who resides permanently in Oregon; or

(B) A person who maintains a permanent place of residence in Oregon, spends more than 180 days per year in Oregon and files income taxes in Oregon.

(b) The applicant must meet one of the medical eligibility requirements set forth in subsection (c), one of the portability eligibility requirements set forth in subsection (d) or the Federal Trade Act of 2002 eligibility requirements set forth in subsection (e).

(c) The applicant must meet one of the following medical eligibility requirements:

(A) Applicant received a declination of individual health insurance coverage within the last six months due to health reasons; or

(B) A health insurance agent refused the applicant's request to submit an application for individual health insurance within the last six months because the agent believed that the insurance carrier would refuse to provide coverage due to the health condition of the applicant; or

(C) Applicant received a notice of termination of individual health insurance coverage within the last six months due to health reasons; or

(D) Applicant was offered individual health insurance coverage that contained a waiver that excluded coverage for a specific medical condition; or

(E) Applicant was offered individual health insurance but was limited by the choice of plans the carrier was willing to offer due to a specific medical condition; or

(F) The applicant is transferring from another state's high risk pool and has moved to Oregon permanently.

(d) The applicant must apply for OMIP coverage within sixty-three (63) days of losing the prior group health insurance coverage and must have had the prior group coverage in place for a period of not less than 180 days and must meet one of the following portability eligibility requirements:

(A) Applicant was covered under a group health benefit plan from an Oregon employer but is ineligible for portability coverage from employer's insurance carrier because the applicant no longer resides in the carrier's service area; or

(B) Applicant has exhausted COBRA benefits and portability coverage is not available because the carrier is not required to offer it; or

(C) Applicant is moving to Oregon after leaving group coverage in another state, has exhausted all rights under federal or Oregon state law to continue that coverage (i.e. COBRA or Oregon state continuation), and does not have portability coverage available.

(e) The applicant is eligible for the health insurance tax credit under section 35 of the Internal Revenue Code effective for taxable years beginning after December 31, 2001.

(2) If an applicant meets the eligibility requirements outlined in section 1 above, the applicant may also apply for OMIP coverage for their dependent(s).

(a) Dependents include a legal spouse and any unmarried children, under the age of 23 that live with the primary applicant. Other unmarried children, under age 23 are also eligible if the applicant is required to contribute toward their support. Also unmarried children, under the age of 23 who are enrolled as a full time student at an accredited institution of higher learning, are eligible even if he/she does not live in the applicants home.

(b) Children are defined as:

(A) The applicants natural child; or

(B) Stepchildren living in the home or non-resident step children if there is a qualified medical child support order that requires the applicant to provide health insurance; or

(C) Legally Adopted children.

(3) Applicants and/or dependents of applicants will be ineligible for OMIP coverage under the following conditions regardless of whether they satisfy other eligibility requirements:

(a) The applicant or dependent is 65 years of age and is eligible for Medicare;

(b) The applicant or dependent is eligible for and receiving a comprehensive health care benefit package under ORS Chapter 414 (Medicaid);

(c) The applicant or dependent is a patient or an inmate of a State correctional or mental institution;

(d) The applicant or dependent terminated OMIP coverage within the last twelve (12) months for a reason other than becoming eligible for health care benefits under Medicaid, including non-payment of OMIP premiums;

(e) The applicant or dependent received $1,000,000 in OMIP benefits under a prior OMIP policy(s);

(f) As of the effective date of OMIP coverage, the applicant or dependent is covered by health insurance or a self-insurance arrangement that is substantially equivalent to OMIP coverage;

(g) A public entity or a health care provider pays or reimburses the OMIP premiums for the applicant or dependent for the sole purpose of reducing the financial loss or obligation of that entity or provider;

(h) A business with two or more employees employs the applicant or the dependent and an insurance agent or insurance company directed the applicant to apply for OMIP coverage for the purpose of separating the applicant or dependent from health insurance benefits offered or provided in connection with the employer;

(i) The dependent is 23 years of age or older and is not mentally or physically incapacitated;

(j) The dependent is under 23 years of age but there is a court order requiring that someone other than the applicant provide insurance for the dependent;

(k) The dependent is under 23 years of age but is married, independent, or is not a full-time student in an accredited institution of higher education.

(l) Rules 443-002-0060(3)(a) through (k) are applicable except where they may conflict with federal rules regarding applicants who qualify under the Federal Health Tax Credit and are eligible for subsidy under the Federal Trade Act of 2002. In such circumstances, section 35 (f) of subpart C, Part IV subchapter A of chapter 1 of the Internal Revenue Code, effective for taxable years beginning after December 31, 2001, shall prevail over the OMIP rules (a) through (k) above.

(4) Applicants must submit proof of eligibility for pool coverage together with the application. Proof of eligibility consists of the following:

(a) Proof of residency must be established with one of the following documents:

(A) A current valid Oregon driver's license or identification card issued by the Oregon Department of Motor Vehicles.

(B) A current valid Oregon voter registration card.

(C) A copy of the prior year's Oregon income tax return that includes applicant's name and current address.

(D) A dated rental agreement that shows the applicant's current residence address, which identifies the applicant as the current tenant and includes the signature of both the applicant and the landlord.

(E) A utility bill listing applicant's name, current residence address, and current dates of service.

(F) Any other document deemed appropriate by the Administering Insurer.

(b) If applying for pool coverage due to medical eligibility, proof of medical eligibility must be established with one of the following:

(A) A letter from an insurance company dated within the last six (6) months declining applicant for individual health insurance coverage due to health reasons; or

(B) A letter from an insurance company dated within the last six (6) months terminating applicant for individual health insurance coverage due to health reasons and not for non-payment of premiums; or

(C) A health insurance agent licensed to transact health insurance in the state of Oregon completes and signs the agent section of the OMIP application certifying that the agent is refusing to apply to an insurance company that he/she represents on behalf of applicant due to health reasons; or

(D) A letter from an insurance company dated within the last six (6) months offering insurance coverage but containing a waiver that excludes coverage for a specific medical condition; or

(E) A letter from an insurance company dated within the last six (6) months offering insurance coverage but limiting the applicant's choice of plans due to the applicant's specific medical condition(s); or

(F) Applicant has moved to Oregon permanently and is transferring from another state's high risk pool.

(c) If applying for pool coverage due to portability eligibility, proof of portability eligibility must be established by a Certificate of Coverage completed by the applicant's previous health insurer that provides the date coverage began and the date coverage ended. The coverage must have been in place for a period of not less than 180 days, and the applicant must apply for OMIP coverage within sixty-three (63) days of the termination date from the coverage.

(d) If applying for pool coverage due to being eligible for the Federal Trade Act of 2002 health insurance tax credit, an applicant will be required to establish proof of eligibility with the following documents:

(A) A letter from the Health Care Tax Credit attesting to eligibility.

(B) Certificate(s) of Creditable Coverage completed by your prior health insurance carrier(s) that provides the date coverage began and the date coverage ended. The coverage must have been in place for a period of not less than 90 days, and the most recent coverage must be within 63 days of application for enrollment in the plan.

Stat. Auth.: ORS 735.610(6), 735.615 & 735.616
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 1-2005(Temp), f. & cert. ef. 8-26-05 thru 2-20-06

**443-002-0080**
**Premiums**

(1) Individuals eligible for OMIP due to Medical Eligibility or are eligible because they qualify for the health insurance tax credit under the Federal Trade Act of 2002 must pay a premium rate determined by the OMIP Board in accordance with ORS 735.625(4)(c), but not more than 125% of the applicable rate.

(2) Individuals eligible for OMIP due to Portability Eligibility pursuant to OAR 443-002-0060 must pay a premium rate not to exceed 100% of the applicable rate as determined by the OMIP Board in accordance with ORS 735.625(4)(c) and 735.616(3)(c) provided that they apply to OMIP within 63 days of the prior health benefit coverage termination date and that they had the prior group coverage in place for not less than 180 days.

(3) The Board will review the premium rates on an annual basis as defined in ORS 735.625.

(4) Premiums will be based on the age of the oldest enrolled person under the OMIP policy and are rated incrementally with 5-year age bands.

(5) Premiums may also be based on the geographic location in which an enrolled member lives.

Stat. Auth.: ORS 735.610(6). 735.616 & 735.625
Stats. Implemented: ORS 735.600 - 735.650
Hist.: OMIPB 2-2004, f. 12-30-04, cert. ef. 1-1-05; OMIPB 1-2005(Temp), f. & cert. ef. 8-26-05 thru 2-20-06

**Department of Corrections**
**Chapter 291**

**Adm. Order No.:** DOC 11-2005
**Filed with Sec. of State:** 8-19-2005
**Certified to be Effective:** 8-22-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 291-062-0110, 291-062-0120, 291-062-0130, 291-062-0140, 291-062-0150, 291-062-0160
**Subject:** These rule modifications are necessary to provide further clarification for inmate selection, compliance credit for inmates on transitional leave, and modification of the Assessment, Assignment, and Supervision of Inmates for Work Assignments and Unfenced Minimum Housing rule as it relates to eligibility for work crews and unfenced minimum housing for inmates in an alternative incarceration program.
**Rules Coordinator:** Janet R. Worley—(503) 945-0933

**291-062-0110**
**Definitions**

(1) Alternative Incarceration Program: A highly structured corrections program that includes intensive interventions, rigorous personal responsibility and accountability, physical labor, and service to the community.

(2) Custody Cycle: The time period during which an offender begins incarceration with the Department of Corrections and/or is under the supervision of community corrections until discharge from all Department of Corrections and community corrections incarceration and supervision.

(3) Short-Term Transitional Leave: A leave for a period not to exceed 90 days preceding an established release date which allows an inmate opportunity to secure appropriate transitional support when necessary for successful reintegration into the community in accordance with ORS 421.148, 421.510 and the department's rule on Short-Term Transitional Leave, Emergency Leaves and Supervised Trips (OAR 291-063). The department may grant a transitional leave of up to 30 days for inmates who are not participating in an alternative incarceration program.

(4) Static 99: An actuarial instrument designed to estimate the probability of sexual recidivism among adults. It is used to determine which offenders will be designated "predatory".

Stat. Auth.: ORS 179.040, 421.500 - 421.512, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 421.500 - 421.512, 423.020, 423.030, 423.075
Hist.: DOC 1-2004(Temp), f. & cert. ef. 1-14-04 thru 6-12-04; DOC 5-2004, f. & cert. ef. 7-12-04; DOC 11-2005, f. 8-19-05, cert. ef. 8-22-05

**291-062-0120**
**General**

(1) The Department of Corrections has established and operates two types of alternative incarceration programs. One of the alternative incarceration programs is an intensive cognitive program based in part on a military model of intervention, and is a maximum of 270 days duration. The other is an intensive alternative incarceration addictions program that includes intensive addiction intervention and treatment, and is a minimum of 270 days duration. Each alternative incarceration program includes two components – a structured institution program and a period of structured short-term transitional leave. However, the department in its discretion may require individual program participants to complete their assigned program without a period of transitional leave. Each alternative incarceration program will require its participants to engage in a minimum of 14 hours of highly structured routine every day for the duration of the program.

(2) Inmates are required to participate in and successfully complete transition classes offered as a condition of program graduation. The number and frequency of these classes will be determined by each facility.

(3) The department in its discretion may grant individual inmates a period of structured, short-term transitional leave as part of their alternative incarceration program assignment if the inmate has identified viable self-support options in the community or if the supervising community corrections agency has approved a temporary subsidy that will allow the inmate to successfully transition in the community.

Stat. Auth.: ORS 179.040, 421.500 - 421.512, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 421.500 - 421.512, 423.020, 423.030, 423.075
Hist.: DOC 1-2004(Temp), f. & cert. ef. 1-14-04 thru 6-12-04; DOC 5-2004, f. & cert. ef. 7-12-04; DOC 11-2005, f. 8-19-05, cert. ef. 8-22-05

**291-062-0130**
**Inmate Eligibility**

(1) The department will identify inmates eligible to participate in alternative incarceration programs. To be eligible to participate in the program an inmate must:

(a) Be sentenced to the legal and physical custody of the department and be subject to a term of post-prison supervision upon satisfaction of a term of incarceration in a Department of Corrections facility;

(b) Be at least 18 years of age at the time of entry into the program, or may be under 18 years of age and have been convicted of a crime upon remand from juvenile court; and

(c) Be assigned minimum custody status in accordance with the department's rule on Classification (Inmate) (OAR 291-104) and have no more than 36 months to serve at the time of program entry.

(2) An inmate is not eligible to participate in alternative incarceration programs during service of a sentence for conviction of a crime described in:

(a) ORS 163.095 (Aggravated Murder);
(b) ORS 163.115 (Murder);
(c) ORS 163.118 (Manslaughter I);
(d) ORS 163.235 (Kidnapping I);
(e) ORS 163.355 (Rape III);
(f) ORS 163.365 (Rape II);
(g) ORS 163.375 (Rape I);
(h) ORS 163.385 (Sodomy III);
(i) ORS 163.395 (Sodomy II);
(j) ORS 163.405 (Sodomy I);
(k) ORS 163.408 (Unlawful Sexual Penetration II);
(l) ORS 163.411 (Unlawful Sexual Penetration I);
(m) ORS 163.415 (Sexual Abuse III);
(n) ORS 163.425 (Sexual Abuse II);
(o) ORS 163.427 (Sexual Abuse I);
(p) ORS 163.435 (Contributing to the Delinquency of a Minor);
(q) ORS 163.525 (Incest);
(r) ORS 164.325 (Arson I); or
(s) ORS 164.415 (Robbery I).

(3) An inmate is not eligible to participate in alternative incarceration programs if the inmate is serving a sentence under the provisions of ORS 137.635.

(4) An inmate is not eligible to participate in alternative incarceration programs if the inmate is serving a sentence under ORS 161.610 until the inmate completes the minimum incarceration term imposed by the court less earned time under ORS 421.121.

(5) An inmate is not eligible to participate in alternative incarceration programs if the inmate:

(a) Has an adult conviction for felony escape which was committed within three years prior to the time of program entry, or has a conviction for unauthorized departure from the legal and/or physical custody of the Oregon Department of Corrections or its authorized agents which was committed within three years prior to the time of program entry.

(b) Is serving non-sentencing guidelines prison terms (sentences with crime dates prior to November 1, 1989), unresolved criminal prosecutions, consecutive county jail terms, or any other circumstance that would conflict with his/her release from prison upon satisfactory completion of an alternative incarceration program.

(c) Has a current detainer. Inmates with detainers lodged with the department after they have been selected and assigned to one of the programs, and the detainer is discovered after the inmate has completed approximately one-half of the program may be permitted to continue their participation in the program at the discretion of the superintendent/designee based on their program performance to date.

(d) Is currently assigned to special security housing for reasons of protective custody, and the inmate's assignment to the program is otherwise determined by department officials to pose a threat to the safe, secure and orderly operation and management of the program, including the safety of department staff and inmates.

(e) Has less than ten months to serve from the first day of program entry. May have nine months to serve with superintendent's/designee's approval.

(f) Is serving a parole or post-prison supervision violation sanction pursuant to ORS 421.168(1) and 144.108(3)(b).

(6) An inmate is not eligible to participate in alternative incarceration programs if the inmate is serving a sentence under the provision of ORS 137.700 or 137.707 until completion of the mandatory minimum incarceration term. For crimes committed on or after December 5, 1996, the inmate

is eligible after completion of the mandatory minimum incarceration term only upon order of the sentencing court as directed in the judgment pursuant to ORS 137.750.

(7) An inmate is not eligible to participate in alternative incarceration programs if the inmate, on or after April 1, 1995, commits and is convicted of:

(a) Assault II as defined in ORS 163.175(1)(b) (Intentionally or knowingly causes physical injury to another by means of a deadly or dangerous weapon);

(b) Kidnapping II (ORS 163.225); or

(c) Robbery II (ORS 164.405); unless the sentencing court, notwithstanding ORS 137.700 and 137.707, has imposed a lesser sentence pursuant to ORS 137.712 and (for crimes committed on or after December 5, 1996) only upon order of the sentencing court as directed in the judgment pursuant to ORS 137.750.

(8) An inmate is not eligible to participate in alternative incarceration programs if the inmate on or after October 23, 1999, commits and is convicted of Manslaughter II as defined in ORS 163.125, unless the sentencing court, notwithstanding ORS 137.700 and 137.707, has imposed a lesser sentence pursuant to ORS 137.712 and only upon order of the sentencing court as directed in the judgment pursuant to ORS 137.750.

(9) An inmate is not eligible to participate in alternative incarceration programs if the inmate is serving a sentence under the provisions of ORS 161.725 or 161.737 (dangerous offenders) for a crime committed on or after November 1, 1989. An inmate shall not be allowed to participate in alternative incarceration programs even after completion of the required minimum incarceration term (determinate sentence) even if the Board of Parole and Post-Prison Supervision finds that the person is no longer dangerous or finds that the person remains dangerous but can be adequately controlled with supervision and mental health treatment and sets a post-prison supervision release date.

(10) If otherwise eligible under Oregon law, any person sentenced for a crime committed on or after December 5, 1996, shall be eligible for alternative incarceration programs only upon order of the sentencing court as directed in the judgment pursuant to ORS 137.750.

Stat. Auth.: ORS 179.040, 421.500 - 421.512, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 421.500 - 421.512, 423.020, 423.030, 423.075
Hist.: DOC 1-2004(Temp), f. & cert. ef. 1-14-04 thru 6-12-04; DOC 5-2004, f. & cert. ef. 7-12-04; DOC 11-2005, f. 8-19-05, cert. ef. 8-22-05

**291-062-0140**
**Inmate Selection**

(1) The department in its discretion may accept eligible inmates into an alternative incarceration program based on its determination that the inmate's participation in such a program is consistent with the safety of the community, the welfare of the applicant, the program objectives and the rules of the department. The superintendent/ designee of each facility that has an alternative incarceration program shall appoint a committee that will be responsible for making recommendations to the superintendent/designee on the placement of inmates in the program.

(2) An inmate will not be accepted into an alternative incarceration program unless the inmate submits a written request to participate.

(a) The request must contain a statement signed by the inmate applicant providing that he/she:

(A) Is physically and mentally able to withstand the rigors of the program; and

(B) Has reviewed the alternative incarceration program descriptions provided by the department and agrees to comply with each of the requirements.

(b) Otherwise eligible inmate applicants with a physical and/or mental disability will be evaluated individually by the department to determine whether they may successfully participate in the fundamental components of an alternative incarceration program.

(c) The department shall make the final determination regarding an inmate's physical or mental ability to withstand the rigors of the program.

(3) Inmates who score a four or higher on the Static 99 will be reviewed for program entry on a case-by-case basis.

Stat. Auth.: ORS 179.040, 421.500 - 421.512, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 421.500 - 421.512, 423.020, 423.030, 423.075
Hist.: DOC 1-2004(Temp), f. & cert. ef. 1-14-04 thru 6-12-04; DOC 5-2004, f. & cert. ef. 7-12-04; DOC 11-2005, f. 8-19-05, cert. ef. 8-22-05

**291-062-0150**
**Removal or Suspension From an Alternative Incarceration Program**

(1) The superintendent/designee in his/her discretion may remove or suspend an inmate from any portion of an alternative incarceration program, and may reassign the inmate to another Department of Corrections facility to serve the balance of the inmate's court-imposed incarceration term(s), for administrative or disciplinary reasons. The decision to remove or suspend an inmate from the program will be made in consultation with a committee appointed by the superintendent/designee that is responsible to review the performance of inmates participating in an alternative incarceration program.

(2) Administrative Removal/ Suspension:

(a) The superintendent/designee in his/her discretion may immediately remove or suspend an inmate from the program and reassign the inmate to another Department of Corrections facility without a hearing, for administrative reasons.

(b) An inmate who is not available to participate substantially in the program (e.g., physical and mental illness, court appearance(s), disciplinary segregation, etc.) for up to 30 days following placement will have his/her program participation suspended and be evaluated by the committee to determine whether the inmate will be removed from the program or accepted back into the program at the program level deemed appropriate by the superintendent/designee.

(c) Any change in status that would cause an inmate to be ineligible to continue participating in the program as described in OAR 291-062-0130 (e.g., discovery of a detainer), may result in a suspension. If suspended, the inmate will have 30 days to resolve his/her eligibility status with the department. If the inmate's eligibility status remains unresolved, the inmate will be removed from the program.

(d) Inmates are expected to participate in all aspects of their program assignment at a level consistent with the length of time they have been assigned to the program. The superintendent/designee in his/her discretion may suspend an inmate from the program for 30 days or more when, in consultation with the program performance review committee, the superintendent/designee determines that the inmate is not making adequate program progress. During the suspension, the inmate will be given an opportunity to come into compliance with established program standards. If the inmate comes into compliance, he/she will be placed at a program level deemed appropriate by the superintendent/designee. If the inmate fails to meet program expectations, he/she may be removed from the program. If the inmate is assigned to an intensive alternative incarceration addiction program, the inmate may have the length of his/her program extended beyond 270 days.

(e) Administrative Review of Removal for Administrative Removal:

(A) When the superintendent/designee removes an inmate from the inmate's program assignment for an administrative removal, the inmate will be notified in writing of the reason(s) for the removal decision, and the opportunity for administrative review of the decision.

(B) To obtain an administrative review of the removal decision, an inmate must send a request for administrative review in writing to the Assistant Director for Transitional Services/designee, together with any supporting documentation. The Assistant Director for Transitional Services/designee must receive the request within 15 calendar days of the date of the notice of the administrative removal. The review should be completed within 15 days after receiving an inmate's review request. The Assistant Director for Transitional Services/designee's decision on administrative review shall be final.

(3) Disciplinary Removal/Suspension: An inmate who after a hearing in accordance with procedures provided in the department's rule on Prohibited Inmate Conduct and Processing Disciplinary Actions (OAR 291-105) is found to have committed a major disciplinary rule violation may be removed from the program and transferred to another Department of Corrections facility at the discretion of the superintendent/designee.

(4) Voluntary Removal: An inmate may elect to remove himself/herself from an alternative incarceration program; however, to do so the inmate must sign a document requesting removal from the program to the superintendent/designee. Voluntary removal from the program constitutes a program failure.

(5) Once an inmate has been removed from an alternative incarceration program as a program failure, he/she will be ineligible to participate in another alternative incarceration program during the same custody cycle. If the failure is from an alternative incarceration addictions program, he/she will be ineligible to participate in any other alcohol and drug treatment program during the same custody cycle (this does not include dual diagnosis programs).

Stat. Auth.: ORS 179.040, 421.500 - 421.512, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 421.500 - 421.512, 423.020, 423.030, 423.075
Hist.: DOC 1-2004(Temp), f. & cert. ef. 1-14-04 thru 6-12-04; DOC 5-2004, f. & cert. ef. 7-12-04; DOC 11-2005, f. 8-19-05, cert. ef. 8-22-05

**291-062-0160**
**Alternative Incarceration Program Prison Management**

(1) To the extent that other Department of Corrections rules may conflict with provisions in these rules (OAR 291-062-0100 to 291-062-0160, such rules are inapplicable to alternative incarceration programs and are modified as provided below to reflect the purposes of alternative incarceration programs and the relatively short period of confinement.

(2) Modified Rules:

(a) Short-Term Transitional Leave, Emergency Leaves and Supervised Trips (OAR 291-063):

(A) An inmate who completes, to the department's satisfaction, all of the requirements of the structured institution program may be released into the community on short-term transitional leave. Upon successfully conforming to directed activities while participating in the short-term transitional leave component of the program, an inmate shall be released into the community on post-prison supervision.

(B) Because alternative incarceration program participants who successfully complete their program will effectively receive a reduction in their incarceration terms, they will be held to a higher standard of behavior on transitional leave than other inmates on short-term transitional leave. Therefore, OAR 291-063 is modified with respect to alternative incarceration program participants to provide that violations of transitional leave conditions will be addressed in accordance with Department of Corrections rule on Structured Intermediate Sanctions, OAR 291-058. Additionally, an inmate's transitional leave agreement will constitute the Department of Corrections expectations for both behavior and programming compliance. Accordingly, if an inmate violates his/her conditions of transitional leave, he/she will not be awarded either institutional conduct or programming compliance credit for the period of time while on transitional leave status.

(b) Hygiene, Grooming and Sanitation (Inmate) (OAR 291-123) and Personal Property (Inmate) (OAR 291-117): The superintendents in the facilities where alternative incarceration programs are provided may establish separate and distinct standards for personal grooming and hygiene as a means to support program goals. Canteen operations and purchases, food services and educational requirements for participants may be modified by those facilities where alternative incarceration programs are offered as a means of supporting program goals. Each facility may develop internal processes for staff and inmates outlining the applicable requirements and/or restrictions specific to these programs.

(c) Performance Recognition and Award System (PRAS) (OAR 291-077): Inmates assigned to an alternative incarceration program will receive a standard number of points for their PRAS award as determined by the department for work and program participation. Inmates are eligible for special recognition awards pursuant to the department's rule on Performance Recognition and Award System.

(d) Mail (Inmate) (OAR 291-131): Inmates participating in the military model of intervention alternative incarceration program may not be allowed to correspond with inmates participating in the same program, and/or may not be allowed to correspond with other inmates housed in general population at the facility where the program is operating.

(e) Prison Term Modification (OAR 291-097): Inmates who begin an alternative incarceration program will be considered to be participating in their primary program plan. If an inmate fails to complete any portion of the program because of inadequate program performance, disciplinary reasons, or voluntary removal, the inmate will be considered noncompliant with his/her primary program plan, and will not be granted earned time credit for programming during that review period.

(f) Assessment, Assignment, and Supervision of Inmates for Work Assignments and Unfenced Minimum Housing (OAR 291-082): Inmates participating in the military model of intervention alternative incarceration program and who are otherwise ineligible for outside work crews and unfenced minimum housing may participate in outside work crews after reaching red hat status and reside in an unfenced minimum housing so long as the victim of their crime does not reside in the area.

Stat. Auth.: ORS 179.040, 421.500 - 421.512, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 421.500 - 421.512, 423.020, 423.030, 423.075
Hist.: DOC 1-2004(Temp), f. & cert. ef. 1-14-04 thru 6-12-04; DOC 5-2004, f. & cert. ef. 7-12-04; DOC 11-2005, f. 8-19-05, cert. ef. 8-22-05

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**Adm. Order No.:** DOC 12-2005(Temp)
**Filed with Sec. of State:** 9-6-2005
**Certified to be Effective:** 9-7-05 thru 3-6-06
**Notice Publication Date:**
**Rules Amended:** 291-104-0010, 291-104-0015, 291-104-0030, 291-104-0035
**Subject:** These rule amendments are necessary to ensure inmates housed within department facilities are assigned the appropriate custody level (classification). The department's recent revision to its administrative rule for inmate disciplinary rule violations has resulted in a need to revise the disciplinary severity scale, a classification tool which assesses institutional risk of inmates.

Additional amendments are necessary to provide clarification for scoring the classification guide in the following areas: time remaining to serve, detainers and institutional misconduct. Other changes are necessary to update terminology and to reflect operational changes that have occurred since the previous amendments.
**Rules Coordinator:** Janet R. Worley—(503) 945-0933

**291-104-0010**
**Definitions**

(1) Classification Review: The process used by the Department to re-evaluate and/or change an inmate's assigned custody level.

(2) Classification Unit: Central Office staff responsible for the development, implementation, training, oversight, and management of the classification function within the Department.

(3) Current Offense: Any and all crimes for which the inmate is currently under commitment to the Department of Corrections. Interstate compact inmates or inmates serving a concurrent sentence from a jurisdiction other than Oregon will have those convictions considered as current offenses.

(4) Custody Classification Guide and Matrix: A classification instrument used by the Department to assist it in assigning inmates an appropriate custody level. The classification instrument incorporates numerically weighted custody classification criteria and a scoring matrix to achieve a resulting proposed custody level. The classification criteria include the following elements:

(a) Public Risk Criteria:

(A) Crime Severity: (Severity of current offense);

(B) Extent of violence;

(C) Use of weapon(s);

(D) History of violence;

(E) Escape history;

(F) Time left to serve; and

(G) Felony detainers.

(b) Institutional Risk Criteria:

(A) Frequency of institutional misconduct;

(B) Severity of institutional misconduct;

(C) Primary program compliance;

(D) Security Threat Group affiliation;

(E) Substance abuse; and

(F) Age.

(5) Custody Level: One of four levels of supervision assigned each inmate through initial and classification review procedures:

(a) Maximum Custody: An inmate assigned this custody level presents extreme risk of escape, violence, and/or disruption to the safe, secure, and orderly operation of a Department of Corrections facility. Inmates committed with a sentence of death will be scored or overridden to maximum custody.

(b) Close Custody: An inmate assigned this custody level presents a serious risk of escape, violence, and/or disruption to the safe, secure, and orderly operation of a Department of Corrections facility.

(c) Medium Custody: An inmate assigned this custody level presents moderate risk of escape, violence, and/or disruption to the safe, secure, and orderly operation of a Department of Corrections facility.

(d) Minimum Custody: An inmate assigned this custody level presents minimal risk of escape, violence, and/or disruption to the safe, secure, and orderly operation of a Department of Corrections facility.

(6) Department of Corrections Facility: Any institution, facility or staff office, including the grounds, operated by the Department of Corrections.

(7) Direct Supervision: The responsibilities of authorized supervisors to ensure the on site presence of an inmate while outside the institution security perimeter and to immediately report any unauthorized absence.

(8) Disciplinary Severity Scale: A classification tool used by the Department, in conjunction with the Custody Classification Guide and Matrix, to assist it in assigning inmates an appropriate custody level. The Disciplinary Severity Scale assigns certain institution disciplinary rule violations as high, moderate and low severity for purposes of scoring the Institutional Risk element of the classification instrument.

(9) Escape: The unlawful departure from within the security perimeter of a facility, from the immediate control of Department of Corrections staff while outside the facility perimeter, or from the direct supervision of non-Department personnel authorized to supervise an inmates while outside the facility perimeter.

(10) Initial Classification: The process used by the Department of Corrections to assign an inmate a custody level upon his/her admission to the physical custody of the Department.

(11) Inmate: Any person under the supervision of the Department of Corrections who is not on parole, probation, or post-prison supervision status.

(12) Institutional Classification Committee: A committee within each facility consisting of at least three persons (one representative from management service, one representative from security, and one representative from program functions) that reviews classification appeals.

(13) Institutional Risk: Factors considered to assess the likelihood an inmate will be disruptive to the safe, secure, and orderly operation of a Department of Corrections facility.

(14) Override: A documented condition or fact involving an unusual issue or issues not addressed in the classification factors or a degree of seriousness in a classification factor so extreme that the factor does not adequately reflect the reasonable weight the element warrants, that justifies a higher or lower custody level than indicated by the classification instrument.

(15) Public Risk: Factors considered to assess the severity of criminal behavior that an inmate has presented to the community.

(16) Serious Management Concerns: Participation either individually, or in a group, in behavior which poses a threat to the safe and secure operation of the facility, including but not limited to, threatening or inflicting serious bodily harm on inmates or staff, posing an immediate risk of escape, promoting or engaging in group disruptive behavior, promoting security threat group activities, or being involved in the planning of any activities that would significantly threaten the safe and secure operation of the facility; and which poses a sufficient threat that such behavior can only be adequately controlled in appropriate special housing.

(17) Unauthorized Departure: The unlawful departure of an inmate while on temporary release from a facility and not under direct supervision.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 2-1989, f. & cert. ef. 2-6-89; CD 14-1991, f. & cert. ef. 6-7-91; CD 18-1993, f. 6-7-93, cert. ef. 6-9-93; CD 20-1994, f. 9-21-94, cert. ef. 10-1-94; DOC 12-2005(Temp), f. 9-6-05, cert. ef. 9-7-05 thru 3-6-06

**291-104-0015**
**Initial Classification**

(1) The Department of Corrections shall assign inmates an initial custody level in accordance with the Department's Custody Classification Guide and Matrix (Attachment 1), Disciplinary Severity Scale (Attachment 2) and these rules. An inmate will generally be assigned an initial custody level within 30 days of admission to the physical custody of the Department of Corrections.

(2) Upon admission to the physical custody of the Department of Corrections, an inmate's assigned counselor will determine a proposed custody level for the inmate by entering the required information into the Department's information system. After entry of the required information, the Department's information system will generate a classification summary report which scores the numerically weighted custody classification criteria and assigns a proposed custody level in accordance with the Custody Classification Guide and Matrix, and Disciplinary Severity Scale.

(3) After generating a classification summary, the assigned counselor will review it for accuracy. After assuring the accuracy of the scoring, the assigned counselor will forward the classification summary to the functional unit manager or designee for approval of the proposed custody level or, in appropriate cases, for approval of the counselor's recommendation for override of the proposed custody level.

(4) No classification action is official until the functional unit manager or designee approves the classification summary. Maximum custody classifications are not official until approved by the Classification Unit. All official classification summaries will be placed and retained in the inmate's file.

[ED. NOTE: Attachments referenced are available from the agency.]
Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 2-1989, f. & cert. ef. 2-6-89; CD 14-1991, f. & cert. ef. 6-7-91; CD 18-1993, f. 6-7-93, cert. ef. 6-9-93; CD 20-1994, f. 9-21-94, cert. ef. 10-1-94; DOC 10-1998, f. & cert. ef. 5-1-98; DOC 12-2005(Temp), f. 9-6-05, cert. ef. 9-7-05 thru 3-6-06

**291-104-0030**
**Override**

(1) Override of a proposed custody level may be recommended by the assigned counselor in those cases where the counselor believes that circumstances justify a higher or lower custody level than indicated by the classification instrument. Final approval/denial of an override will be made at the institution level except for maximum custody, which will be made by the Classification Unit.

(2) The Classification Unit may modify any classification action. In such cases, the affected facility will be formally notified of the reason(s) for the modification.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 2-1989, f. & cert. ef. 2-6-89; CD 14-1991, f. & cert. ef. 6-7-91; CD 18-1993, f. 6-7-93, cert. ef. 6-9-93; CD 20-1994, f. 9-21-94, cert. ef. 10-1-94; DOC 12-2005(Temp), f. 9-6-05, cert. ef. 9-7-05 thru 3-6-06

**291-104-0035**
**Administrative Review**

(1) An inmate may obtain an administrative review of classification actions affecting him/her by writing to the appropriate reviewing body/staff designated in these rules, and requesting an administrative review using the Department of Corrections Request for Administrative Review form (CD 1120aD). To obtain an administrative review, an inmate must complete the portions of a CD 1120aD request form required in these rules, specifying the body/staff to whom the administrative review request is being submitted, the grounds/reason(s) for administrative review, and any documentation (attached to the request form) supporting the inmate's grounds/reason(s) for the requested administrative review.

(2) Issues Subject to Administrative Review: Administrative review is available to an inmate to contest three aspects of classification actions: the accuracy of the non-maximum classification scoring, the reason(s) for an override of a scored custody level, and an inmate's maximum custody classification.

(a) Accuracy of Scoring (Minimum, Medium, Close Custody).

(A) To obtain an administrative review of a classification score, an inmate must complete the top portion of a CD 1120aD form, and send the completed form, together with any supporting documentation, to the Institution Classification Committee at the facility where the inmate is housed. The Committee must receive the review request within 15 calendar days of the classification approval date. The Committee should complete its review within 15 days after receiving an inmate's review request.

(B) If, after receiving the review decision of the Institution Classification Committee, an inmate is not satisfied with the decision, the inmate may obtain further review of the classification score by sending another completed CD 1120aD form requesting administrative review, together with any supporting documentation, and the Committee's review decision, to the functional unit manager or designee. The functional unit manager or designee must receive the review request within 15 calendar days of the Committee's review decision. The functional unit manager or designee should complete his/her review within 15 days after receiving the inmate's review request. There shall be no further administrative review of a classification score.

(b) Overrides: To obtain an administrative review of an override of a proposed custody level, an inmate must complete the bottom portion of a CD 1120aD form, and send the completed form to the administrator or designee responsible for the Classification Unit, together with any supporting documentation. The Classification Unit must receive the review request within 15 calendar days of the classification action approval date. The Classification Unit should complete its review within 15 days after receiving an inmate's review request. There shall be no further administrative review of an override decision.

(c) Maximum Custody: Maximum custody classification may be administratively reviewed utilizing the bottom portion of the CD 1120aD with the review request being submitted to the administrator or designee responsible for the Classification Unit. The request for review shall include any supporting documentation by the inmate to be considered in reviewing the appropriateness of the maximum custody classification. The matter may be reviewed only once and the completed review shall be final.

(3) A copy of administrative review decisions will be provided to the inmate and retained in the central institution file.

Stat. Auth.: ORS 179.040, 423.020, 423.030 & 423.075
Stats. Implemented: ORS 179.040, 423.020, 423.030 & 423.075
Hist.: CD 2-1989, f. & cert. ef. 2-6-89; CD 14-1991, f. & cert. ef. 6-7-91; CD 18-1993, f. 6-7-93, cert. ef. 6-9-93; CD 20-1994, f. 9-21-94, cert. ef. 10-1-94; DOC 12-2005(Temp), f. 9-6-05, cert. ef. 9-7-05 thru 3-6-06

**Department of Environmental Quality**
**Chapter 340**

**Adm. Order No.:** DEQ 9-2005
**Filed with Sec. of State:** 9-9-2005
**Certified to be Effective:** 9-9-05
**Notice Publication Date:** 3-1-05
**Rules Amended:** 340-200-0040, 340-204-0030, 340-204-0040, 340-224-0060, 340-225-0020
**Subject:** The rulemaking adopted a plan and associated rule amendments for Lakeview and its Urban Growth Boundary and one for La Grande and its Urban Growth Boundary that are designed to maintain compliance with the federal public health standards for particulate matter ten microns and smaller (PM10). The action will change the status of Lakeview and La Grande from "nonattainment" to "maintenance" for PM10. The State's designation of "maintenance" indicates that the areas have met the federal health standard continuously for several years and are predicted to continue meeting the standard for at least ten more years. The action includes a request to EPA to change the federal designation of Lakeview and La Grande as in "Attainment" with the PM10 standard.
**Rules Coordinator:** Larry McAllister—(503) 229-6412

**340-200-0040**
**State of Oregon Clean Air Act Implementation Plan**

(1) This implementation plan, consisting of Volumes 2 and 3 of the State of Oregon Air Quality Control Program, contains control strategies, rules and standards prepared by the Department of Environmental Quality and is adopted as the state implementation plan (SIP) of the State of Oregon pursuant to the federal Clean Air Act, 42 U.S.C.A §7401 to 7671q.

(2) Except as provided in section (3), revisions to the SIP will be made pursuant to the Commission's rulemaking procedures in division 11 of this chapter and any other requirements contained in the SIP and will be submitted to the United States Environmental Protection Agency for approval.

(3) Notwithstanding any other requirement contained in the SIP, the Department may:

(a) Submit to the Environmental Protection Agency any permit condition implementing a rule that is part of the federally-approved SIP as a source-specific SIP revision after the Department has complied with the public hearings provisions of 40 CFR 51.102 (July 1, 2002); and

(b) Approve the standards submitted by a regional authority if the regional authority adopts verbatim any standard that the Commission has adopted, and submit the standards to EPA for approval as a SIP revision.

**NOTE:** Revisions to the State of Oregon Clean Air Act Implementation Plan become federally enforceable upon approval by the United States Environmental Protection Agency. If any provision of the federally approved Implementation Plan conflicts with any provision adopted by the Commission, the Department shall enforce the more stringent provision.
Stat. Auth.: ORS 468.020
Stats. Implemented: ORS 468A.035
Hist.: DEQ 35, f. 2-3-72, ef. 2-15-72; DEQ 54, f. 6-21-73, ef. 7-1-73; DEQ 19-1979, f. & ef. 6-25-79; DEQ 21-1979, f. & ef. 7-2-79; DEQ 22-1980, f. & ef. 9-26-80; DEQ 11-1981, f. & ef. 3-26-81; DEQ 14-1982, f. & ef. 7-21-82; DEQ 21-1982, f. & ef. 10-27-82; DEQ 1-1983, f. & ef. 1-21-83; DEQ 6-1983, f. & ef. 4-18-83; DEQ 18-1984, f. & ef. 10-16-84; DEQ 25-1984, f. & ef. 11-27-84; DEQ 3-1985, f. & ef. 2-1-85; DEQ 12-1985, f. & ef. 9-30-85; DEQ 5-1986, f. & ef. 2-21-86; DEQ 10-1986, f. & ef. 5-9-86; DEQ 20-1986, f. & ef. 11-7-86; DEQ 21-1986, f. & ef. 11-7-86; DEQ 4-1987, f. & ef. 3-2-87; DEQ 5-1987, f. & ef. 3-2-87; DEQ 8-1987, f. & ef. 4-23-87; DEQ 21-1987, f. & ef. 12-16-87; DEQ 31-1988, f. 12-20-88, cert. ef. 12-23-88; DEQ 2-1991, f. & cert. ef. 2-14-91; DEQ 19-1991, f. & cert. ef. 11-13-91; DEQ 20-1991, f. & cert. ef. 11-13-91; DEQ 21-1991, f. & cert. ef. 11-13-91; DEQ 22-1991, f. & cert. ef. 11-13-91; DEQ 23-1991, f. & cert. ef. 11-13-91; DEQ 24-1991, f. & cert. ef. 11-13-91; DEQ 25-1991, f. & cert. ef. 11-13-91; DEQ 1-1992, f. & cert. ef. 2-4-92; DEQ 3-1992, f. & cert. ef. 2-4-92; DEQ 7-1992, f. & cert. ef. 3-30-92; DEQ 19-1992, f. & cert. ef. 8-11-92; DEQ 20-1992, f. & cert. ef. 8-11-92; DEQ 25-1992, f. 10-30-92, cert. ef. 11-1-92; DEQ 26-1992, f. & cert. ef. 11-2-92; DEQ 27-1992, f. & cert. ef. 11-12-92; DEQ 4-1993, f. & cert. ef. 3-10-93; DEQ 8-1993, f. & cert. ef. 5-11-93; DEQ 12-1993, f. & cert. ef. 9-24-93; DEQ 15-1993, f. & cert. ef. 11-4-93; DEQ 16-1993, f. & cert. ef. 11-4-93; DEQ 17-1993, f. & cert. ef. 11-4-93; DEQ 19-1993, f. & cert. ef. 11-4-93; DEQ 1-1994, f. & cert. ef. 1-3-94; DEQ 5-1994, f. & cert. ef. 3-21-94; DEQ 14-1994, f. & cert. ef. 5-31-94; DEQ 15-1994, f. 6-8-94, cert. ef. 7-1-94; DEQ 25-1994, f. & cert. ef. 11-2-94; DEQ 9-1995, f. & cert. ef. 5-1-95; DEQ 10-1995, f. & cert. ef. 5-1-95; DEQ 14-1995, f. & cert. ef. 5-25-95; DEQ 17-1995, f. & cert. ef. 7-12-95; DEQ 19-1995, f. & cert. ef. 9-1-95; DEQ 20-1995 (Temp), f. & cert. ef. 9-14-95; DEQ 8-1996(Temp), f. & cert. ef. 6-3-96; DEQ 15-1996, f. & cert. ef. 8-14-96; DEQ 19-1996, f. & cert. ef. 9-24-96; DEQ 22-1996, f. & cert. ef. 10-22-96; DEQ 23-1996, f. & cert. ef. 11-4-96; DEQ 24-1996, f. & cert. ef. 11-26-96; DEQ 10-1998, f. & cert. ef. 6-22-98; DEQ 15-1998, f. & cert. ef. 9-23-98; DEQ 16-1998, f. & cert. ef. 9-23-98; DEQ 17-1998, f. & cert. ef. 9-23-98; DEQ 20-1998, f. & cert. ef. 10-12-98; DEQ 21-1998, f. & cert. ef. 10-12-98; DEQ 1-1999, f. & cert. ef. 1-25-99; DEQ 5-1999, f. & cert. ef. 3-25-99; DEQ 6-1999, f. & cert. ef. 5-21-99; DEQ 10-1999, f. & cert. ef. 7-1-99; DEQ 14-1999, f. & cert. ef. 10-14-99, Renumbered from 340-020-0047; DEQ 15-1999, f. & cert. ef. 10-22-99; DEQ 2-2000, f. 2-17-00, cert. ef. 6-ƒ1-01; DEQ 6-2000, f. & cert. ef. 5-22-00; DEQ 8-2000, f. & cert. ef. 6-6-00; DEQ 13-2000, f. & cert. ef. 7-28-00; DEQ 16-2000, f. & cert. ef. 10-25-00; DEQ 17-2000, f. & cert. ef. 10-25-00; DEQ 20-2000 f. & cert. ef. 12-15-00; DEQ 21-2000, f. & cert. ef. 12-15-00; DEQ 2-2001, f. & cert. ef. 2-5-01; DEQ 4-2001, f. & cert. ef. 3-27-01; DEQ 6-2001, f. 6-18-01, cert. ef. 7-1-01; DEQ 15-2001, f. & cert. ef. 12-26-01; DEQ 16-2001, f. & cert. ef. 12-26-01; DEQ 17-2001, f. & cert. ef. 12-28-01; DEQ 4-2002, f. & cert. ef. 3-14-02; DEQ 5-2002, f. & cert. ef. 5-3-02; DEQ 11-2002, f. & cert. ef. 10-8-02; DEQ 5-2003, f. & cert. ef. 2-6-03; DEQ 14-2003, f. & cert. ef. 10-24-03; DEQ 19-2003, f. & cert. ef. 12-12-03; DEQ 1-2004, f.& cert. ef. 4-14-04; DEQ 10-2004, f. & cert. ef. 12-15-04; DEQ 1-2005, f. & cert. ef. 1-4-05; DEQ 2-2005, f. & cert. ef. 2-10-05; DEQ 4-2005, f. 5-13-05, cert. ef. 6-1-05; DEQ 7-2005, f. & cert. ef. 7-12-05; DEQ 9-2005, f. & cert. ef. 9-9-05

**340-204-0030**
**Designation of Nonattainment Areas**

The following areas are designated as Nonattainment Areas:

(1) Carbon Monoxide Nonattainment Areas: The Salem Nonattainment Area for Carbon Monoxide is the Salem-Kaiser Area Transportation Study as defined in OAR 340-204-0010.

(2) PM10 Nonattainment Areas:

(a) The Eugene Nonattainment Area for PM10 is the Eugene-Springfield UGB as defined in OAR 340-204-0010.

(b) The Oakridge Nonattainment Area for PM10 is the Oakridge UGB as defined in OAR 340-204-0010.

(3) Ozone Nonattainment Areas: The Salem Nonattainment Area for Ozone is the Salem-Kaiser Area Transportation Study as defined in OAR 340-204-0010.

**NOTE:** This rule is included in the State of Oregon Clean Air Act Implementation Plan as adopted by the Environmental Quality Commission under OAR 340-200-0040.
Stat. Auth.: ORS 468.020
Stats. Implemented: ORS 468A.025
Hist.: DEQ 14-1995, f. & cert. ef. 5-25-95; DEQ 18-1996, f. & cert. ef. 8-19-96; DEQ 15-1998, f. & cert. ef. 9-23-98; DEQ 1-1999, f. & cert. ef. 1-25-99; DEQ 14-1999, f. & cert. ef. 10-14-99, Renumbered from 340-031-0520; DEQ 15-1999, f. & cert. ef. 10-22-99; DEQ 16-2000, f. & cert. ef. 10-25-00; DEQ 6-2001, f. 6-18-01, cert. ef. 7-1-01; DEQ 11-2002, f. & cert. ef. 10-8-02; DEQ 1-2005, f. & cert. ef. 1-4-05; DEQ 9-2005, f. & cert. ef. 9-9-05

**340-204-0040**
**Designation of Maintenance Areas**

The following areas are designated as Maintenance Areas:

(1) Carbon Monoxide Maintenance Areas:

(a) The Eugene Maintenance Area for Carbon Monoxide is the Eugene-Springfield AQMA as defined in OAR 340-204-0010.

(b) The Portland Maintenance Area for Carbon Monoxide is the Portland Metropolitan Service District as referenced in OAR 340-204-0010.

(c) The Medford Carbon Monoxide Maintenance Area is the Medford UGB as defined in OAR 340-204-0010.

**NOTE:** EPA maintenance plan approval and redesignation pending.

(d) The Grants Pass Carbon Monoxide Maintenance Area is the Grants Pass CBD as defined in OAR 340-204-0010.

(e) The Klamath Falls Carbon Monoxide Maintenance Area is the Klamath Falls UGB as defined in OAR 340-204-0010.

(2) Ozone Maintenance Areas:

(a) The Medford Maintenance Area for Ozone is the Medford-Ashland AQMA as defined in OAR 340-204-0010.

(b) The Oregon portion of the Portland-Vancouver Interstate Maintenance Area for Ozone is the Portland AQMA, as defined in OAR 340-204-0010.

(3) PM10 Maintenance Areas:

(a) The Grants Pass PM10 Maintenance Area is the Grants Pass UGB as defined in OAR 340-204-0010.

(b) The Klamath Falls PM10 Maintenance Area is the Klamath Falls UGB as defined in OAR 340-204-0010.

(c) The Medford-Ashland PM10 Maintenance Area is the Medford-Ashland AQMA as defined in OAR 340-204-0010.

**NOTE:** EPA maintenance plan approval and redesignation pending.

(d) The La Grande PM10 Maintenance Area is the La Grande UGB as defined in OAR 340-204-0010.

**NOTE:** EPA maintenance plan approval and redesignation pending.

(e) The Lakeview PM10 Maintenance Area is the Lakeview UGB as defined in OAR 340-204-0010.

**NOTE:** EPA maintenance plan approval and redesignation pending.
**NOTE:** This rule is included in the State of Oregon Clean Air Act Implementation Plan as adopted by the Environmental Quality Commission under OAR 340-200-0040.
Stat. Auth.: ORS 468.020
Stats. Implemented: ORS 468A.025
Hist.: DEQ 14-1995, f. & cert. ef. 5-25-95; DEQ 18-1996, f. & cert. ef. 8-19-96; DEQ 15-1998, f. & cert. ef. 9-23-98; DEQ 1-1999, f. & cert. ef. 1-25-99; DEQ 14-1999, f. & cert. ef.

10-14-99, Renumbered from 340-031-0530; DEQ 15-1999, f. & cert. ef. 10-22-99; DEQ 16-2000, f. & cert. ef. 10-25-00; DEQ 11-2002, f. & cert. ef. 10-8-02; DEQ 1-2005, f. & cert. ef. 1-4-05; DEQ 9-2005, f. & cert. ef. 9-9-05

**340-224-0060**
**Requirements for Sources in Maintenance Areas**

Proposed major sources and major modifications that would emit a maintenance pollutant within a designated maintenance area, including VOC or NOx in a designated ozone maintenance area, must meet the requirements listed below:

(1) Best Available Control Technology (BACT). Except as provided in section (5) and (6) of this rule, the owner or operator must apply BACT for each maintenance pollutant emitted at a SER.

(a) For a major modification, the requirement for BACT applies only to:

(A) Each new emissions unit that emits the pollutant in question and was installed since the baseline period or the most recent New Source Review construction approval for that pollutant; and

(B) Each modified emissions unit that increases the actual emissions of the pollutant in question above the netting basis.

(b) For phased construction projects, the BACT determination must be reviewed at the latest reasonable time before commencement of construction of each independent phase.

(c) When determining BACT for a change that was made at a source before the current NSR application, the technical and economic feasibility of retrofitting required controls may be considered, provided:

(A) The change was made in compliance with NSR requirements in effect when the change was made; and

(B) No limit is being relaxed that was previously relied on to avoid NSR.

(d) Individual modifications with potential to emit less than 10 percent of the significant emission rate are exempt from this section unless:

(A) They are not constructed yet;

(B) They are part of a discrete, identifiable larger project that was constructed within the previous 5 years and that is equal to or greater than 10 percent of the significant emission rate; or

(C) They were constructed without, or in violation of, the Department's approval.

(2) Air Quality Protection:

(a) Offsets and Net Air Quality Benefit. Except as provided in subsections (b), (c) and (d) of this section, the owner or operator must obtain offsets and demonstrate that a net air quality benefit will be achieved in the area as specified in OAR 340-225-0090.

(b) Growth Allowance. The requirements of this section may be met in whole or in part in an ozone or carbon monoxide maintenance area with an allocation by the Department from a growth allowance, if available, in accordance with the applicable maintenance plan in the SIP adopted by the Commission and approved by EPA. An allocation from a growth allowance used to meet the requirements of this section is not subject to OAR 340-225-0090. Procedures for allocating the growth allowances for the Oregon portion of the Portland-Vancouver Interstate Maintenance Area for Ozone and the Portland Maintenance Area for Carbon Monoxide are contained in OAR 340-242-0430 and 340-242-0440.

(c) In a carbon monoxide maintenance area, a proposed carbon monoxide major source or major modification is exempt from subsections (a) and (b) of this section if the owner or operator can demonstrate that the source or modification will not cause or contribute to an air quality impact equal to or greater than 0.5 mg/m3 (8 hour average) and 2 mg/m3 (1-hour average). The demonstration must comply with the requirements of OAR 340-225-0045.

(d) In a PM10 maintenance area, a proposed PM10 major source or major modification is exempt from subsection (a) of this section if the owner or operator can demonstrate, pursuant to the requirements of OAR 340-225-0045, that the source or modification will not cause or contribute to an air quality impact in excess of:

(A) 120 µg/m3 (24-hour average) or 40 µg/m3 (annual average) in the Grants Pass PM10 maintenance area;

(B) 140 µg/m3 (24-hour average) or 47 µg/m3 (annual average) in the Klamath Falls PM10 maintenance area; or

(C) 140 µg/m3 (24-hour average) or 45 µg/m3 (annual average) in the Lakeview PM10 maintenance area. In addition, a single source impact is limited to an increase of 5 µg/m3 (24-hour average) in the Lakeview PM10 maintenance area.

(3) The owner or operator of a source subject to this rule must provide an air quality analysis in accordance with OAR 340-225-0050(1) and (2), and 340-225-0060.

(4) Additional Requirements for Federal Major Sources: The owner or operator of a federal major source subject to this rule must provide an analysis of the air quality impacts for the proposed source or modification in accordance with OAR 340-225-0050(3) and 340-225-0070. In addition to the provisions of this section, provisions of section 340-224-0070 also apply to federal major sources.

(5) Contingency Plan Requirements. If the contingency plan in an applicable maintenance plan is implemented due to a violation of an ambient air quality standard, this section applies in addition to other requirements of this rule until the Commission adopts a revised maintenance plan and EPA approves it as a SIP revision.

(a) The requirement for BACT in section (1) of this rule is replaced by the requirement for LAER contained in OAR 340-224-0050(1).

(b) An allocation from a growth allowance may not be used to meet the requirement for offsets in section (2) of this rule.

(c) The exemption provided in subsection (2)(c) and (2)(d) of this rule for major sources or major modifications within a carbon monoxide or PM10 maintenance area no longer applies.

(6) Medford-Ashland AQMA: Proposed major sources and major modifications that would emit PM10 within the Medford-Ashland AQMA must meet the LAER emission control technology requirements in OAR 340-224-0050.

(7) Pending Redesignation Requests. This rule does not apply to a proposed major source or major modification for which a complete application to construct was submitted to the Department before the maintenance area was redesignated from nonattainment to attainment by EPA. Such a source is subject to OAR 340-224-0050.

**NOTE:** This rule is included in the State of Oregon Clean Air Act Implementation Plan as adopted by the EQC under OAR 340-200-0040.
[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 468.020
Stats. Implemented: ORS 468A.025
Hist.: DEQ 26-1996, f. & cert. ef. 11-26-96; DEQ 15-1998, f. & cert. ef. 9-23-98; DEQ 1-1999, f. & cert. ef. 1-25-99; DEQ 14-1999, f. & cert. ef. 10-14-99, Renumbered from 340-028-1935; DEQ 6-2001, f. 6-18-01, cert. ef. 7-1-01; DEQ 11-2002, f. & cert. ef. 10-8-02; DEQ 1-2005, f. & cert. ef. 1-4-05; DEQ 9-2005, f. & cert. ef. 9-9-05

**340-225-0020**
**Definitions**

The definitions in OAR 340-200-0020 and this rule apply to this division. If the same term is defined in this rule and OAR-340-200-0020, the definition in this rule applies to this division.

(1) "Allowable Emissions" means the emissions rate of a stationary source calculated using the maximum rated capacity of the source (unless the source is subject to federally enforceable limits which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

(a) The applicable standards as set forth in 40 CFR parts 60, 61 and 63;

(b) The applicable State Implementation Plan emissions limitation, including those with a future compliance date; or

(c) The emissions rate specified as a federally enforceable permit condition.

(2) "Background Light Extinction" means the reference levels (Mm-1) shown in the estimates of natural conditions as referenced in the FLAG to be representative of the PSD Class I or Class II area being evaluated.

(3) "Baseline Concentration" means:

(a) Except as provided in subsection (c), the ambient concentration level for sulfur dioxide and PM10 that existed in an area during the calendar year 1978. If no ambient air quality data is available in an area, the baseline concentration may be estimated using modeling based on actual emissions for 1978. Actual emission increases or decreases occurring before January 1, 1978 must be included in the baseline calculation, except that actual emission increases from any source or modification on which construction commenced after January 6, 1975 must not be included in the baseline calculation;

(b) The ambient concentration level for nitrogen oxides that existed in an area during the calendar year 1988.

(c) For the area of northeastern Oregon within the boundaries of the Umatilla, Wallowa-Whitman, Ochoco, and Malheur National Forests, the ambient concentration level for PM10 that existed during the calendar year 1993. The Department may allow the source to use an earlier time period if

the Department determines that it is more representative of normal emissions.

(d) For PM10 in the Medford-Ashland AQMA: the ambient PM10 concentration levels that existed during the year that EPA redesignates the AQMA to attainment for PM10.

(4) "Competing PSD Increment Consuming Source Impacts" means the total modeled concentration above the modeled Baseline Concentration resulting from increased emissions of all other sources since the baseline concentration year that are within the Range of Influence of the source in question. Allowable Emissions may be used as a conservative estimate, in lieu of Actual Emissions, in this analysis.

(5) "Competing NAAQS Source Impacts" means total modeled concentration resulting from allowable emissions of all other sources that are within the Range of Influence of the source in question.

(6) "FLAG " refers to the Federal Land Managers' Air Quality Related Values Work Group Phase I Report. See 66 Federal Register 2, January 3, 2001 at 382 to 383.

(7) "General Background Concentration" means impacts from natural sources and unidentified sources that were not explicitly modeled. The Department may determine this as site-specific ambient monitoring or representative ambient monitoring from another location.

(8) "Predicted Maintenance Area Concentration" means the future year ambient concentration predicted by the Department in the applicable maintenance plan as follows:

(a) The future year (2015) concentrations for the Grants Pass UGB are 89 µg/m3 (24-hour average) and 21 µg/m3 (annual average).

(b) The future year (2015) concentrations for the Klamath Falls UGB are 114 µg/m3 (24-hour average) and 25 µg/m3 (annual average).

(c) The future year (2025) concentrations for the Lakeview UGB are 126 µg/m3 (24-hour average) and 27 µg/m3 (annual average).

(9) "Nitrogen Deposition" means the sum of anion and cation nitrogen deposition expressed in terms of the mass of total elemental nitrogen being deposited. As an example, Nitrogen Deposition for NH4NO3 is 0.3500 times the weight of NH4NO3 being deposited.

(10) "Ozone Precursor Distance" means the distance in kilometers from the nearest boundary of a designated ozone nonattainment or maintenance area within which a major new or modified source of VOC or NOx is considered to significantly affect that designated area. The determination of significance is made by either the formula method or the demonstration method.

(a) The Formula Method.

(A) For sources with complete permit applications submitted before January 1, 2003: D = 30 km

(B) For sources with complete permit applications submitted on or after January 1, 2003: D = (Q/40) x 30 km

(C) D is the Ozone Precursor Distance in kilometers. The value for D is 100 kilometers when D is calculated to exceed 100 kilometers. Q is the larger of the NOx or VOC emissions increase from the source being evaluated in tons/year, and is quantified relative to the netting basis.

(D) If a source is located at a distance less than D from the designated area, the source is considered to have a significant effect on the designated area. If the source is located at a distance equal to or greater than D, it is not considered to have a significant effect.

(b) The Demonstration Method. An applicant may demonstrate to the Department that the source or proposed source would not significantly impact a nonattainment area or maintenance area. This demonstration may be based on an analysis of major topographic features, dispersion modeling, meteorological conditions, or other factors. If the Department determines that the source or proposed source would not significantly impact the nonattainment area or maintenance area under high ozone conditions, the Ozone Precursor Distance is zero kilometers.

(11) "Ozone Precursor Offsets" means the emission reductions required to offset emission increases from a major new or modified source located inside the designated nonattainment or maintenance area or within the Ozone Precursor Distance. Emission reductions must come from within the designated area or from within the Ozone Precursor Distance of the offsetting source as described in OAR 340-225-0090. The offsets determination is made by either the formula method or the demonstration method.

(a) The Formula Method.

(A) Required offsets (RO) for new or modified sources are determined as follows:

(i) For sources with complete permit applications submitted before January 1, 2003: RO = SQ

(ii) For sources with complete permit applications submitted on or after January 1, 2003: RO = (SQ minus (40/30 * SD))

(B) Contributing sources may provide offsets (PO) calculated as follows: PO = CQ minus (40/30 * CD)

(C) Multiple sources may contribute to the required offsets of a new source. For the formula method to be satisfied, total provided offsets (PO) must equal or exceed the required offset (RO).

(D) Definitions of factors used in paragraphs (A) (B) and (C) of this subsection:

(i) RO is the required offset of NOx or VOC in tons per year as a result of the source emissions increase. If RO is calculated to be negative, RO is set to zero;

(ii) SQ is the source emissions increase of NOx or VOC in tons per year above the netting basis;

(iii) SD is the source distance in kilometers to the nonattainment or maintenance area. SD is zero for sources located within the nonattainment or maintenance area.

(iv) PO is the provided offset from a contributing source and must be equal to or greater than zero;

(v) CQ is the contributing emissions reduction in tons per year quantified relative to contemporaneous pre-reduction actual emissions (OAR 340-268-0030(1)(b)).

(vi) CD is the contributing source distance in kilometers to the nonattainment or maintenance area. For a contributing source located within the nonattainment or maintenance area, CD equals zero.

(b) The Demonstration Method. An applicant may demonstrate to the Department using dispersion modeling or other analyses the level and location of offsets that would be sufficient to provide actual reductions in concentrations of VOC or NOx in the designated area during high ozone conditions. The modeled reductions of ambient VOC or NOx concentrations resulting from the emissions offset must be demonstrated over a greater area and over a greater period of time within the designated area as compared to the modeled ambient VOC or NOx concentrations resulting from the emissions increase from the source subject to this rule. If the Department determines that the demonstration is acceptable, then the Department will approve the offsets proposed by the applicant. The demonstration method does not apply to sources located inside an ozone nonattainment area.

(12) "Range of Influence (ROI)" means:

(a) For PSD Class II and Class III areas, the Range of Influence of a competing source (in kilometers) is defined by:

(A) ROI (km) = Q (tons/year) / K (tons/year km).

(B) Definition of factors used in paragraph (A) of this subsection:

(i) ROI is the distance a source has an effect on an area and is compared to the distance from a potential competing source to the Significant Impact Area of a proposed new source. Maximum ROI is 50 km, however the Department may request that sources at a distance greater than 50 km be included in a competing source analysis.

(ii) Q is the emission rate of the potential competing source in tons per year.

(iii) K (tons/year km) is a pollutant specific constant as defined in the table below: [Table not included. See ED. NOTE.]

(b) For PSD Class I areas, the Range of Influence of a competing source includes emissions from all sources that occur within the modeling domain of the source being evaluated. The Department determines the modeling domain on a case-by-case basis.

(13) "Source Impact Area" means a circular area with a radius extending from the source to the largest distance to where predicted impacts from the source or modification equal or exceed the Significant Air Quality Impact levels set out in Table 1 of OAR 340 division 200. This definition only applies to PSD Class II areas and is not intended to limit the distance for PSD Class I modeling.

(14) "Sulfur Deposition" means the sum of anion and cation sulfur deposition expressed in terms of the total mass of elemental sulfur being deposited. As an example, sulfur deposition for (NH4)2SO4 is 0.2427 times the weight of (NH4)2SO4 being deposited.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 468.020

Stats. Implemented: ORS 468A

Hist.: DEQ 6-2001, f. 6-18-01, cert. ef. 7-1-01; DEQ 11-2002, f. & cert. ef. 10-8-02; DEQ 12-2002(Temp), f. & cert. ef. 10-8-02 thru 4-6-03; Administrative correction 11-10-03; DEQ 1-2004, f.& cert. ef. 4-14-04; DEQ 1-2005, f. & cert. ef. 1-4-05; DEQ 9-2005, f. & cert. ef. 9-9-05

**Department of Fish and Wildlife**
**Chapter 635**

**Adm. Order No.:** DFW 90-2005(Temp)
**Filed with Sec. of State:** 8-17-2005
**Certified to be Effective:** 8-17-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-042-0031
**Rules Suspended:** 635-042-0031(T)
**Subject:** Amend rule to extend the fall commercial salmon fishery in the Columbia River mainstem. Modification is consistent with action taken by the Columbia River Compact.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-042-0031**
**Early Fall Salmon Season**

(1) Salmon and sturgeon may be taken for commercial purposes in the waters of the Columbia River, Zones 1–5, as identified in OAR 635-042-0001.

(2) The Grays River, Elokomin-A, Cowlitz River, Kalama-A, Lewis-A, Washougal and Sandy River sanctuaries are in effect.

(3) Open fishing periods are:

(a) 7:00 p.m. August 4 to 7:00 a.m. August 5, 2005;

(b) 7:00 p.m. August 7 to 7:00 a.m. August 8, 2005;

(c) 7:00 p.m. August 9 to 7:00 a.m. August 10, 2005;

(d) 7:00 p.m. August 11 to 7:00 a.m. August 12, 2005.

(4) Salmon and sturgeon may be taken for commercial purposes in the waters of the Columbia River, Zones 2–5, as identified in OAR 635-042-0001. Sanctuaries identified in (2) are in effect.

(5) The open fishing periods are:

(a) 7:00 p.m. August 14 to 7:00 a.m. August 15, 2005;

(b) 7:00 p.m. August 17 to 7:00 a.m. August 18, 2005.

(6) Gear is restricted to gill nets with an 8-inch minimum mesh size and 9-3/4-inch maximum mesh size.

(7) A maximum of five green or white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open. During the fishing periods identified in (3) and (5), the weekly aggregate sturgeon limit applies to possession and sales in the Columbia River mainstem fishery, the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 496.118, 506.109 & 506.129
Stats. Implemented: ORS 506.119 & 507.030
Hist.: FWC 63-1987, f. & ef. 8-7-87; FWC 67-1988, f. & cert. ef. 8-15-88; FWC 68-1988(Temp), f. & cert. ef. 8-15-88; FWC 54-1989(Temp), f. & cert. ef. 8-7-89; FWC 56-1989(Temp), f. & cert. ef. 8-11-89; FWC 58-1989(Temp), f. & cert. ef. 8-14-89; FWC 80-1989(Temp), f. 8-28-89, cert. ef. 8-29-89; FWC 80-1990(Temp), f. 8-7-90, cert. ef. 8-8-90; FWC 85-1991, f. 8-7-91, cert. ef. 8-12-91; FWC 91-1991(Temp), f. & cert. ef. 8-29-91; FWC 73-1992(Temp), f. & cert. ef. 8-10-92; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 53-1996(Temp), f. & cert. ef. 9-16-96; FWC 49-1997, f. 8-20-97, cert. ef. 8-24-97; DFW 74-1998(Temp), f. & cert. ef. 8-25-98 thru 8-26-98; DFW 59-1999(Temp), f. & cert. ef. 8-23-99 thru 9-11-99; DFW 75-1999(Temp), f. 9-29-99, cert. ef. 9-30-99 thru 10-22-99; Administrative correction 11-17-99; DFW 50-2000(Temp), f. 8-18-00, cert. ef. 8-21-00 thru 9-9-00; DFW 52-2000(Temp), f. 8-23-00, cert. ef. 8-23-00 thru 8-24-00; Administrative correction 6-20-01; DFW 68-2001(Temp), f. 8-7-01, cert. ef. 8-8-01 thru 8-9-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 79-2001(Temp), f. & cert. ef. 8-22-01 thru 12-31-01; DFW 80-2001(Temp), f. & cert. ef. 8-24-01 thru 12-31-01; DFW 86-2001(Temp), f. & cert. ef. 9-4-01 thru 12-31-01; DFW 81-2002(Temp), f. 8-2-02, cert. ef. 8-4-02 thru 8-9-02; DFW 87-2002(Temp), f. & cert. ef. 8-9-02 thru 8-12-02; DFW 89-2002(Temp), f. 8-16-02, cert. ef. 8-18-02 thru 12-31-02; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 77-2003(Temp), f. & cert. ef. 8-13-03 thru 12-31-03; DFW 82-2003(Temp), f. & cert. ef. 8-25-03 thru 12-31-03; DFW 87-2003(Temp), f. & cert. ef. 8-27-03 thru 12-31-03; DFW 81-2004(Temp), f. & cert. ef. 8-12-04 thru 12-31-04; DFW: 82-2004(Temp), f. & cert. ef. 8-16-04 thru 12-31-04; DFW 86-2004 (Temp), f. 8-19-04 thru 12-31-04: DFW 88-2004(Temp), f. & cert. ef. 8-23-04 thru 12-31-04; Administrative correction, 2-18-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 88-2005(Temp), f. 8-11-05, cert. ef. 8-14-05 thru 12-31-05; DFW 90-2005(Temp), f. & cert. ef. 8-17-05 thru 12-31-05

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**Adm. Order No.:** DFW 91-2005
**Filed with Sec. of State:** 8-19-2005
**Certified to be Effective:** 8-19-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 635-008-0070, 635-008-0105, 635-008-0130, 635-008-0140, 635-008-0185, 635-008-0190, 635-045-0000, 635-051-0000, 635-052-0000, 635-053-0000, 635-054-0000, 635-060-0000
**Subject:** Rules were amended regarding the harvest of game birds, including the 2005-06 season dates, open areas, and bag limits. Changes were also made to department Wildlife Area regulations.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-008-0070**
**Coyote Springs Wildlife Area**

The Coyote Springs Wildlife Area is open to wildlife-oriented public use unless otherwise excluded or restricted by the following rules:

(1) All dogs must be on a leash except during authorized game bird hunting seasons, or by permit.

(2) Camping is permitted only in designated parking areas. Camping more than seven days in any consecutive 14-day period is prohibited.

(3) Open fires between April 1 and November 30 are prohibited.

(4) Discharging a shotgun is prohibited except as authorized during game bird and game mammal seasons.

(5) Discharging firearms other than shotguns is prohibited except as authorized by a permit issued by the Department.

(6) Possession or use of shot other than federally-approved nontoxic shot is prohibited, except for deer hunters using slugs or buckshot.

(7) Entry into the area between 10 p.m. and 4 a.m. is prohibited except in designated parking areas.

(8) Leaving decoys set out overnight (10 p.m. through 4 a.m.) is prohibited.

(9) Placing waterfowl hunting site closer than 200 yards apart is prohibited.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(3); FWC 53-1994, f. & cert. ef. 8-25-95; DFW 91-2005, f. & cert. ef. 8-19-05

**635-008-0105**
**Irrigon Wildlife Area**

The Irrigon Wildlife Area is open to wildlife-oriented public use unless otherwise excluded or restricted by the following rules:

(1) All dogs must be on a leash except during authorized game bird hunting seasons, or by permit.

(2) Camping is permitted only in designated parking areas. Camping more than seven days in any consecutive 14-day period is prohibited.

(3) Horses must stay on the Lewis and Clark Heritage trail.

(4) Trapping may occur during authorized trapping seasons (trapping permit required).

(5) Open fires between April 1 and November 30 are prohibited.

(6) Discharging a shotgun is prohibited except as authorized during game bird and game mammal seasons.

(7) Discharging firearms other than shotguns is prohibited except as authorized by a permit issued by the Department.

(8) Possession or use of shot other than federally-approved nontoxic shot is prohibited, except for deer hunters using slugs or buckshot

(9) Entry into the area between 10 p.m. and 4 a.m. is prohibited except in designated parking areas.

(10) Leaving decoys set out overnight (10 p.m. through 4 a.m.) is prohibited.

(11) Placing waterfowl hunting site closer than 200 yards apart is prohibited.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(8); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 91-2005, f. & cert. ef. 8-19-05

**635-008-0130**
**Power City Wildlife Area**

The Power City Wildlife Area is open to wildlife-oriented public use unless otherwise excluded or restricted by the following rules:

(1) All dogs must be on a leash except during authorized game bird hunting seasons or by permit.

(2) Camping is permitted only in designated parking areas. Camping more than seven days in any consecutive 14-day period is prohibited.

(3) Open fires between April 1 and November 30 are prohibited.

(4) Discharging a shotgun is prohibited except as authorized during game bird and game mammal seasons.

(5) Discharging firearms other than shotguns is prohibited except as authorized by a permit issued by the Department.

(6) Possession or use of shot other than federally-approved nontoxic shot is prohibited, except for deer hunters using slugs or buckshot.

(7) Entry into the area between 10 p.m. and 4 a.m. is prohibited except in designated parking areas.

(8) Leaving decoys set out overnight (10 p.m. through 4 a.m.) is prohibited.

(9) Placing waterfowl hunting site closer than 200 yards apart is prohibited.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(13); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 91-2005, f. & cert. ef. 8-19-05

**635-008-0140**
**Riverside Wildlife Area**

The Riverside Wildlife Area is open to wildlife-oriented public use unless otherwise excluded or restricted by the following rules:

(1) Camping is prohibited.

(2) Open fires are prohibited.

(3) Motorized vehicle travel is restricted to open roads.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(15); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 91-2005, f. & cert. ef. 8-19-05

**635-008-0185**
**Willow Creek Wildlife Area**

The Willow Creek Wildlife Area is open to wildlife-oriented public use unless otherwise excluded or restricted by the following rules:

(1) All dogs must be on a leash except during authorized game bird hunting seasons, or by permit.

(2) Camping is permitted only in designated parking areas. Camping more than seven days in any consecutive 14-day period is prohibited.

(3) Open fires between April 1 and November 30 are prohibited.

(4) Discharging a shotgun is prohibited except as authorized during game bird and game mammal seasons.

(5) Discharging firearms other than a shotgun is prohibited except during, and as authorized for, eastern Oregon controlled deer seasons, or by permit issued by the Department.

(6) Possession or use of shot other than federally approved nontoxic shot for all game bird hunting is prohibited.

(7) Entry into the area between 10 p.m. and 4 a.m. is prohibited except in designated parking areas.

(8) Leaving decoys set out overnight (10 p.m. through 4 a.m.) is prohibited.

(9) Placing waterfowl hunting site closer than 200 yards apart is prohibited.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(23); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 91-2005, f. & cert. ef. 8-19-05

**635-008-0190**
**E.E. Wilson Wildlife Area**

The E. E. Wilson Wildlife Area is open to wildlife-oriented public use compatible with the goals and objectives contained in the E. E. Wilson Wildlife Area Long Range Plan unless otherwise excluded or restricted by the following rules:

(1) Hunting is prohibited except as authorized in annual game bird and big game regulations.

(2) Discharging firearms is prohibited except as authorized during game bird and game mammal seasons, or by permit.

(3) Discharging rifles and handguns is prohibited.

(4) All dogs must be on a leash except during authorized hunting seasons, or by permit.

(5) Camping is prohibited except by permit.

(6) Horses and other domestic livestock use are restricted to established roads only.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.992
Hist.: GC 64, f. 4-3-57; GC 232, f. 8-13-70, ef. 9-11-70; GC 252, f. 5-11-72, ef. 6-1-72, Renumbered from 630-010-0500, Renumbered from 635-015-0005; FWC 63-1980, f. & ef. 11-4-80; FWC 2-1981(Temp), f. & ef. 1-20-81; FWC 30-1982, f. & ef. 5-18-82, Renumbered from 635-008-0005(24); FWC 53-1994, f. & cert. ef. 8-25-94; DFW 91-2005, f. & cert. ef. 8-19-05

**635-045-0000**
**Purpose**

(1) The purpose of these rules is to list definitions pursuant to hunting seasons for big game and game birds.

(2) The documents entitled "**2005-2006 Oregon Game Bird Regulations**", and "**2005 Oregon Big Game Regulations**", are incorporated by reference into these rules. These documents are available at hunting license vendors and regional, district and headquarters offices of the Oregon Department of Fish and Wildlife.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 36-1988, f. & cert. ef. 6-13-88; FWC 47-1989, f. & cert. ef. 7-25-89; FWC 14-1990, f. & cert. ef. 2-2-90; FWC 91-1990, f. & cert. ef. 9-4-90; FWC 42-1996, f. & cert. ef. 8-12-96; FWC 53-1997, f. & cert. ef. 9-3-97; DFW 61-1998, f. & cert. ef. 8-10-98; DFW 75-1998, f. & cert. ef. 9-4-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 56-1999, f. & cert. ef. 8-13-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 51-2000, f. & cert. ef. 8-22-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 73-2001, f. & cert. ef. 8-15-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 88-2002, f. & cert. ef. 8-14-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 76-2003, f. & cert. ef. 8-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 84-2004, f. & cert. ef. 8-18-04; DFW 91-2005, f. & cert. ef. 8-19-05

**635-051-0000**
**Purpose**

(1) The purpose of these rules is to establish dates, areas and other restrictions for hunting game birds pursuant to ORS Chapter 496.

(2) The document entitled "**2005-2006 Oregon Game Bird Regulations**," is incorporated by reference into these rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 8-1988, f. & cert. ef. 9-2-88; FWC 45-1997, f. & cert. ef. 8-13-97; FWC 53-1997, f. & cert. ef. 9-3-97; DFW 61-1998, f. & cert. ef. 8-10-98; DFW 75-1998, f. & cert. ef 9-4-98; DFW 56-1999, f. & cert. ef. 8-13-99; DFW 51-2000, f. & cert. ef. 8-22-00; DFW 73-2001, f. & cert. ef. 8-15-01; DFW 3-2002(Temp), f. & cert. ef. 1-3-02 thru 1-23-02; DFW 88-2002, f. & cert. ef. 8-14-02; DFW 76-2003, f. & cert. ef. 8-13-03; DFW 84-2003(Temp), f. & cert. ef. 8-26-03 thru 2-20-04; DFW 84-2004, f. & cert. ef. 8-18-04; DFW 91-2005, f. & cert. ef. 8-19-05

**635-052-0000**
**Purpose**

(1) The purpose of these rules is to establish season dates, areas and bag limits for migratory upland game birds pursuant to ORS Chapter 496.

(2) The document entitled "**2005-2006 Oregon Game Bird Regulations**," is incorporated by reference into these rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 61-1988, f. & cert. ef. 7-28-88; FWC 45-1997, f. & cert. ef. 8-13-97; DFW 61-1998, f. & cert. ef. 8-10-98; DFW 56-1999, f. & cert. ef. 8-13-99; DFW 82-1999(Temp), f. & cert. ef. 10-25-99 thru 2-1-00; DFW 51-2000, f. & cert. ef. 8-22-00; DFW 73-2001, f. & cert. ef. 8-15-01; DFW 88-2002, f. & cert. ef. 8-14-02; DFW 76-2003, f. & cert. ef. 8-13-03; DFW 84-2004, f. & cert. ef. 8-18-04; DFW 91-2005, f. & cert. ef. 8-19-05

**635-053-0000**
**Purpose**

(1) The purpose of these rules is to establish season dates, bag limits, areas and other restrictions for hunting upland game birds pursuant to ORS Chapter 496.

(2) The document entitled "**2005-2006 Oregon Game Bird Regulations**," is incorporated by reference into these rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 81-1988, f. & cert. ef. 9-2-88; FWC 33-1996, f. & cert. ef. 6-7-96; FWC 45-1997, f. & cert. ef. 8-13-97; DFW 61-1998, f. & cert. ef. 8-10-98; DFW 75-1998, f. & cert. ef. 9-4-98; DFW 56-1999, f. & cert. ef. 8-13-99; DFW 82-1999(Temp), f. & cert. ef. 10-25-99 thru 2-1-00; DFW 51-2000, f. & cert. ef. 8-22-00; DFW 73-2001, f. & cert. ef. 8-15-01; DFW 3-2002(Temp), f. & cert. ef. 1-3-02 thru 1-23-02; DFW 88-2002, f. & cert. ef. 8-14-02; DFW 76-2003, f. & cert. ef. 8-13-03; DFW 2-2004(Temp), f. 1-13-04, cert. ef. 1-16-04 thru 1-31-04; DFW 84-2004, f. & cert. ef. 8-18-04; DFW 91-2005, f. & cert. ef. 8-19-05

**635-054-0000**
**Purpose**

(1) The purpose of these rules is to establish season dates, bag limits, areas and other restrictions for hunting ducks, geese, coots, common snipe and crow pursuant to ORS Chapter 496.

(2) The document entitled "**2005-2006 Oregon Game Bird Regulations**," is incorporated by reference into these rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 82-1988, f. & cert. ef. 9-2-88; FWC 45-1997, f. & cert. ef. 8-13-97; FWC 53-1997, f. & cert. ef. 9-3-97; DFW 61-1998, f. & cert. ef. 8-10-98; DFW 75-1998, f. & cert. ef. 9-4-98; DFW 95-1998(Temp), f. & cert. ef. 12-1-98 thru 12-18-98; DFW 98-1998(Temp) f. & cert. ef. 12-18-98 thru 2-28-99; DFW 56-1999, f. & cert. ef. 8-13-99; DFW 82-1999(Temp), f. & cert. ef. 10-25-99 thru 2-1-00; DFW 51-2000, f. & cert. ef. 8-22-00; DFW

73-2001, f. & cert. ef. 8-15-01; DFW 99-2001(Temp), f. & cert. ef. 10-12-01 thru 4-10-02; DFW 3-2002(Temp), f. & cert. ef. 1-3-02 thru 1-23-02; DFW 88-2002, f. & cert. ef. 8-14-02; DFW 76-2003, f. & cert. ef. 8-13-03; DFW 84-2004, f. & cert. ef. 8-18-04; DFW 87-2004(Temp), f. & cert. ef. 8-18-04 thru 9-16-04; Administrative correction 10-25-04; DFW 91-2005, f. & cert. ef. 8-19-05

**635-060-0000**
**Purpose and General Information**

(1) The purpose of these rules is to describe the requirements and procedures for controlled hunts pursuant to ORS 496.162.

(2) The documents entitled "**2005-2006 Oregon Game Bird Regulations**," and "**2005 Oregon Big Game Regulations**," are incorporated by reference into these rules. These documents are available at hunting license agents and regional, district, and headquarters offices of the Oregon Department of Fish and Wildlife.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: FWC 118, f. & ef. 6-3-77; FWC 25-1978, f. & ef. 5-26-78; FWC 32-1978, f. & ef. 6-30-78; FWC 29-1979, f. & ef. 8-2-79; FWC 33-1980, f. & ef. 6-30-80; FWC 7-1981, f. 2-18-81, ef. 6-1-81; FWC 10-1981, f. & ef. 3-31-81; FWC 22-1981, f. & ef. 6-29-81; FWC 21-1982, f. & ef. 3-31-82; FWC 38-1982, f. & ef. 6-25-82; FWC 34-1984, f. & ef. 7-24-84; FWC 16-1985, f. & ef. 4-11-85; FWC 43-1985, f. & ef. 8-22-85; FWC 35-1986, f. & ef. 8-7-86; FWC 11-1987, f. & ef. 3-6-87; FWC 40-1987, f. & ef. 7-6-87; FWC 12-1988, f. & cert. ef. 3-10-88; FWC 37-1988, f. & cert. ef. 6-13-88; FWC 14-1989, f. & cert. ef. 3-28-89; FWC 48-1989, f. & cert. ef. 7-25-89; FWC 23-1990, f. & cert. ef. 3-21-90; FWC 71-1997, f. & cert. ef. 12-29-97; DFW 61-1998, f. & cert. ef. 8-10-98; DFW 1-1999, f. & cert. ef. 1-14-99; DFW 56-1999, f. & cert. ef. 8-13-99; DFW 92-1999, f. 12-8-99, cert. ef. 1-1-00; DFW 51-2000, f. & cert. ef. 8-22-00; DFW 82-2000, f. 12-21-00, cert. ef. 1-1-01; DFW 73-2001, f. & cert. ef. 8-15-01; DFW 121-2001, f. 12-24-01, cert. ef. 1-1-02; DFW 3-2002(Temp), f. & cert. ef. 1-3-02 thru 1-23-02; DFW 28-2002(Temp), f. 4-1-02, cert. ef. 4-2-02 thru 9-28-02; DFW 59-2002, f. & cert. ef. 6-11-02; DFW 88-2002, f. & cert. ef. 8-14-02; DFW 2-2003, f. & cert. ef. 1-17-03; DFW 76-2003, f. & cert. ef. 8-13-03; DFW 118-2003, f. 12-4-03, cert. ef. 1-1-04; DFW 84-2004, f. & cert. ef. 8-18-04; DFW 122-2004, f. 12-21-04, cert. ef. 1-1-05; DFW 91-2005, f. & cert. ef. 8-19-05

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**Adm. Order No.:** DFW 92-2005
**Filed with Sec. of State:** 8-19-2005
**Certified to be Effective:** 8-19-05
**Notice Publication Date:** 5-1-05
**Rules Repealed:** 635-090-0170, 635-090-0180
**Subject:** Rules were repealed in regards to the deer and elk auction and raffle program.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

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**Adm. Order No.:** DFW 93-2005
**Filed with Sec. of State:** 8-19-2005
**Certified to be Effective:** 8-19-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 635-100-0125
**Subject:** Rules were amended to delist the Aleutian Canada goose from the state list of Threatened and Endangered Species.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-100-0125**
**State List of Threatened and Endangered Species**

The state list of threatened and endangered species is as follows: [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 496.004, 496.171, 496.172, 496.182, 496.192 & 498.026
Stats. Implemented: ORS 496.004, 496.171, 496.172, 496.182, 496.192, 498.026
Hist.: FWC 50-1988, f. & cert. ef. 6-24-88; FWC 108-1988, f. & cert. ef. 12-29-88; FWC 40-1989, f. 6-20-89, cert. ef. 7-1-89; FWC 46-1991, f. 5-1-91, cert. ef. 5-6-91; FWC 130-1991, f. & cert. ef. 11-4-91; FWC 132-1991, f. 11-19-91, cert. ef. 11-20-91; FWC 69-1993, f. & cert. ef. 11-1-93; FWC 44-1995, f. & cert. ef. 5-30-95; FWC 93-1995, f. & cert. ef. 12-8-95; Administrative Correction 3-10-98; DFW 18-1999(Temp), f. 3-12-99, cert. ef. 4-1-99 thru 9-27-99; DFW 24-1999(Temp), f. 4-14-99, cert. ef. 5-1-99 thru 10-27-99; DFW 33-1999(Temp), f. 5-7-99, cert. ef. 6-1-99 thru 11-27-99; DFW 44-1999(Temp), f. & cert. ef. 7-1-99 thru 12-27-99; DFW 49-1999(Temp), f. 7-13-99, cert. ef. 8-1-99 thru 1-27-00; DFW 51-1999, f. & cert. ef. 7-22-99; DFW 54-1999(Temp), f. 8-10-99, cert. ef. 9-1-99 thru 2-27-00; DFW 63-1999(Temp), f. 9-10-99, cert. ef. 10-1-99 thru 3-28-00; DFW 80-1999(Temp), f. 10-11-99, cert. ef. 11-1-99 thru 4-27-00; DFW 91-1999(Temp), f. 12-2-99, cert. ef. 1-1-00 thru 6-28-00; DFW 2-2000(Temp), f. & cert. ef. 2-1-00 thru 7-28-00; DFW 5-2000, f. 2-3-00, cert. ef. 2-4-00; DFW 66-2005(Temp), f. & cert. ef. 7-1-05 thru 12-12-05; DFW 93-2005, f. & cert. ef. 8-19-05

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**Adm. Order No.:** DFW 94-2005
**Filed with Sec. of State:** 8-19-2005
**Certified to be Effective:** 8-19-05
**Notice Publication Date:** 2-1-05
**Rules Adopted:** 635-140-0000, 635-140-0005, 635-140-0010, 635-140-0025
**Subject:** Rules were adopted in regards to numerical population and habitat goals to provide protection to Greater Sage Grouse in Oregon.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-140-0000**
**Purpose**

These administrative rules establish the state policy for the protection and enhancement of Greater Sage-Grouse in Oregon. The Commission anticipates that these policies will be implemented by Department staff as described in the Department's "Greater Sage-Grouse Conservation Assessment and Strategy for Oregon" plan, which is not, however, incorporated into this rule. (Copies of the plan are available through the Oregon Department of Fish and Wildlife.)

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 94-2005, f. & cert. ef. 8-19-05

**635-140-0005**
**Population Management Objectives**

Population management objectives for statewide and regional populations for sage grouse are as follows:

(1) Objective 1 —Statewide: maintain or enhance sage-grouse numbers and distribution at the 2003 spring breeding population level, approximately 40,000 birds, until 2055.

(2) Objective 2 — Baker Resource Area: maintain or enhance sage-grouse numbers and distribution at the 2003 spring breeding population level, approximately 3,000 birds, until 2055.

(3) Objective 3 — Vale District BLM (not including Baker): maintain or enhance sage-grouse numbers and distribution at the 2003 spring breeding population level, approximately 16,000 birds, until 2055.

(4) Objective 4 — Burns District BLM: maintain or enhance sage-grouse numbers and distribution at the 2003 spring breeding population level, approximately 6,500 birds, until 2055.

(5) Objective 5 — Lakeview District BLM: maintain or enhance sage-grouse numbers and distribution at the 2003 spring breeding population level, approximately 12,000 birds, until 2055.

(6) Objective 6 — Prineville District BLM: restore sage-grouse numbers and distribution near the 1980 spring breeding population level, approximately 3,000 birds, until 2055.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 94-2005, f. & cert. ef. 8-19-05

**635-140-0010**
**Habitat Objectives**

Statewide and regional habitat objectives for sage-grouse are as follows:

(1) Objective 1 — Statewide: retain ≥70% of sage-grouse range as sagebrush habitat in advanced structural stages, sagebrush class 3, 4 or 5, with an emphasis on classes 4 and 5. The remaining 30% will include areas of juniper encroachment, non-sagebrush shrubland, and grassland that potentially can be rehabilitated or enhanced.

(2) Objective 2 — Maintain 100% of existing sagebrush habitats and enhance potential habitats that have been disturbed in the following regions. Existing conditions are:

(a) Baker Resource Area: 82% sagebrush and 18% disturbed habitats.

(b) Vale District (not including Baker): 73% sagebrush and 27% disturbed habitats.

(c) Burns District: 68% sagebrush and 32% disturbed habitats.

(d) Lakeview District: 72% sagebrush and 28% disturbed habitats.

(e) Prineville District: 47% sagebrush and 53% disturbed habitats.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 94-2005, f. & cert. ef. 8-19-05

**635-140-0025**
**Five-Year Review**

The Department will review the Plan every five years.

Stat. Auth.: ORS 496.012, 496.138, 496.146 & 496.162
Stats. Implemented: ORS 496.012, 496.138, 496.146 & 496.162
Hist.: DFW 94-2005, f. & cert. ef. 8-19-05

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**Adm. Order No.:** DFW 95-2005
**Filed with Sec. of State:** 8-19-2005

**Certified to be Effective:** 8-19-05
**Notice Publication Date:** 5-1-05
**Rules Amended:** 635-160-0000, 635-190-0000
**Subject:** Rules were amended to add an Appendix table to both the "Oregon Elk Management Plan" and the "Oregon Mule Deer Management Plan." The Appendix tables update the management objectives for each unit/area for mule deer and elk.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-160-0000**
**Elk Management Plan Content and Purpose**

The document entitled "Oregon Elk Management Plan" dated February 2003 is incorporated by reference into these rules. Copies of the plan are available through the Department. The plan provides program direction, identifies objectives, and outlines strategies to fulfill management, research, and habitat needs. Together with the rules establishing elk seasons, this plan establishes the framework and the implementation of the Department's elk program.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162 & 496.164
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162 & 496.164
Hist.: FWC 62-1992, f. & cert. ef. 7-30-92; FWC 13-1995, f. & cert. ef. 2-15-95; DFW 13-2003, f. & cert. ef. 2-14-03; DFW 95-2005, f. & cert. ef. 8-19-05

**635-190-0000**
**Mule Deer Management Plan Content and Purpose**

The document entitled "Oregon Mule Deer Management Plan" dated February 2003 is incorporated by reference into these rules. Copies of the plan are available through the Department. The plan provides program direction, identifies objectives, and outline strategies to fulfill management, research, and habitat needs. Together with the rules establishing deer seasons, this plan establishes the framework and the implementation of the Department's mule deer program.

Stat. Auth.: ORS 183 & 496
Stats. Implemented: ORS 183 & 496
Hist.: FWC 129-1990, f. & cert. ef. 12-24-90; DFW 13-2003, f. & cert. ef. 2-14-03; DFW 95-2005, f. & cert. ef. 8-19-05

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**Adm. Order No.:** DFW 96-2005(Temp)
**Filed with Sec. of State:** 8-22-2005
**Certified to be Effective:** 8-22-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-041-0075, 635-042-0031
**Rules Suspended:** 635-042-0031(T)
**Subject:** Amend rules to 1) extend the fall commercial salmon fishery in the Columbia River mainstem and 2) establish a fall Treaty Indian commercial salmon fishery. Modification is consistent with action taken by the Columbia River Compact.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-041-0075**
**Fall Salmon Season**

(1) Chinook salmon, coho salmon, steelhead, walleye, carp, and shad may be taken with gill net for commercial purposes from mainstem Columbia River waters in all of Zone 6.

(2) The open fishing periods are:

(a) 6:00 a.m. August 22 to 6:00 p.m. August 26, 2005;

(b) 6:00 a.m. August 29 to 6:00 p.m. September 2, 2005;

(c) 6:00 a.m. September 6 to 6:00 p.m. September 10, 2005.

(3) Through September 2, 2005 there is no mesh size restriction. For the fishing period beginning September 6, 2005, there is an 8-inch minimum mesh restriction.

(4) All standard dam and river mouth sanctuaries set forth in OAR 635-041-0045 are in effect, except Small Spring Creek sanctuary within a radius of 150 feet of the Spring Creek Hatchery fishway.

(5) Sturgeon may not be sold. However, sturgeon between 4–5 feet in length in The Dalles and John Day Pools and sturgeon between 45"–60" in the Bonneville Pool may be kept for subsistence purposes.

(6) Until further notice, sale of platform and hook-and-line caught fish will be allowed. Sales from the Big White Salmon River and Klickitat River will be allowed, only during those days and hours when these tributaries are open under lawfully enacted Yakama Nation Tribal subsistence fisheries.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: FWC 25-1979, f. & ef. 8-2-79; FWC 36-1979(Temp), f. & ef. 8-22-79; FWC 47-1979(Temp), f. & ef. 9-21-79; FWC 44-1980(Temp), f. & ef. 8-22-80; FWC 46-1980(Temp), f. & ef. 9-13-80; FWC 33-1981(Temp), f. & ef. 9-15-81; FWC 58-1982(Temp), f. & ef. 8-27-82; FWC 62-1982(Temp), f. & ef. 9-7-82; FWC 63-1982(Temp), f. & ef. 9-14-82; FWC 75-1982 (Temp), f. & ef. 10-29-82; FWC 36-1983, f. & ef. 8-18-83; FWC 49-1983(Temp), f. & ef. 9-26-83; FWC 51-1983(Temp), f. & ef. 9-30-83; FWC 55-1983(Temp), f. & ef. 10-4-83; FWC 46-1984, f. & ef. 8-30-84; FWC 55-1984(Temp), f. & ef. 9-10-84; FWC 58-1984(Temp), f. & ef. 9-17-84; FWC 61-1984 (Temp), f. & ef. 9-21-84; FWC 70-1984(Temp), f. & ef. 10-9-84; FWC 47-1985, f. & ef. 8-23-85; FWC 60-1985(Temp), f. & ef. 9-13-85; FWC 63-1985(Temp), f. & ef. 9-24-85; FWC 42-1986, f. & ef. 8-15-86; FWC 53-1986(Temp), f. & ef. 9-4-86; FWC 54-1986(Temp), f. & ef. 9-5-86; FWC 57-1986(Temp), f. & ef. 9-11-86; FWC 60-1986(Temp), f. & ef. 9-26-86; FWC 62-1986(Temp), f. & ef. 10-2-86; FWC 63-1987, f. & ef. 8-7-87; FWC 74-1987(Temp), f. & ef. 9-4-87; FWC 75-1987 (Temp), f. & ef. 9-1-87; FWC 78-1987(Temp), f. & ef. 9-15-87; FWC 80-1987(Temp), f. & ef. 9-18-87; FWC 87-1987(Temp), f. & ef. 10-9-87; FWC 89-1987(Temp), f. & ef. 10-12-87; FWC 67-1988, f. & cert. ef. 8-15-88; FWC 72-1988(Temp), f. & cert. ef. 8-19-88; FWC 77-1988(Temp), f. & cert. ef. 9-2-88; FWC 91-1988(Temp), f. & cert. ef. 9-16-88; FWC 95-1988 (Temp), f. 9-27-88, cert. ef. 9-28-88; FWC 54-1989(Temp), f. & cert. ef. 8-7-89; FWC 87-1989(Temp), f. & cert. ef. 9-1-89; FWC 95-1989(Temp), f. & cert. ef. 9-19-89; FWC 96-1989 (Temp), f. & cert. ef. 9-21-89; FWC 99-1989(Temp), f. & cert. ef. 9-27-89; FWC 100-1989(Temp), f. & cert. ef. 9-28-89; FWC 80-1990(Temp), f. 8-7-90, cert. ef. 8-8-90; FWC 90-1990, f. & cert. ef. 8-31-90; FWC 96-1990(Temp), f. 9-7-90, cert. ef. 9-10-90; FWC 98-1990(Temp), f. 9-14-90, cert. ef. 9-17-90; FWC 85-1991, f. 8-7-91, cert. ef. 8-12-91; FWC 96-1991, f. & cert. ef. 9-9-91; FWC 101-1991(Temp), f. & cert. ef. 9-10-91; FWC 103-1991(Temp), f. 9-17-91, cert. ef. 9-18-91; FWC 110-1991(Temp), f. & cert. ef. 9-27-91; FWC 73-1992(Temp), f. & cert. ef. 8-10-92; FWC 86-1992(Temp), f. 9-1-92, cert. ef. 9-2-92; FWC 87-1992(Temp), f. 9-4-92, cert. ef. 9-7-92; FWC 91-1992(Temp), f. 9-16-92, cert. ef. 9-17-92; FWC 96-1992(Temp), f. 9-22-92, cert. ef. 9-23-92; FWC 105-1992(Temp), f. 10-2-92, cert. ef. 10-5-92; FWC 107-1992 (Temp), f. & cert. ef. 10-9-92; FWC 47-1993, f. 8-6-93, cert. ef. 8-9-93; FWC 52-1993, f. & cert. ef. 8-30-93; FWC 57-1993(Temp), f. & cert. ef. 9-13-93; FWC 59-1993(Temp), f. 9-17-93, cert. ef. 9-20-93; FWC 61-1993(Temp), f. & cert. ef. 9-24-93; FWC 55-1994(Temp), f. 8-26-94, cert. ef. 8-29-94; FWC 61-1994(Temp), f. 9-7-94, cert. ef. 9-8-94; FWC 74-1994(Temp), f. & cert. ef. 10-12-94; FWC 68-1995(Temp), f. 8-25-95, cert. ef. 8-29-95; FWC 72-1995(Temp), f. & cert. ef. 9-1-95; FWC 75-1995(Temp), f. 9-12-95, cert. ef. 9-13-95; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1996(Temp), f. 8-29-96, cert. ef. 9-2-96; FWC 51-1996(Temp), f. 9-6-96, cert. ef. 9-9-96; FWC 53-1996(Temp), f. & cert. ef. 9-26-96; FWC 54-1996(Temp), f. & cert. ef. 9-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; FWC 52-1997(Temp), f. 8-29-97, cert. ef. 9-2-97, FWC 57(Temp), f. & cert. ef. 9-9-97; FWC 60-1997(Temp), f. 9-16-97, cert. ef. 9-17-97; DFW 68-1998(T), f. & cert. ef. 8-25-98 thru 9-25-98; DFW 76-1998(T), f. & cert. ef. 9-8-98 thru 9-25-98; DFW 77-1998(Temp), f. 9-14-98, cert. ef. 9-15-98 thru 9-25-98; DFW 79-1998(Temp), f. 9-21-98, cert. ef. 9-22-98 thru 9-25-98; DFW 80-1998(Temp), f. 9-23-98, cert. ef. 9-24-98 thru 9-25-98; DFW 59-1999(Temp), f. & cert. ef. 8-23-99 thru 9-11-99; DFW 62-1999(Temp), f. 9-2-99, cert. ef. 9-3-99 thru 9-11-99; DFW 65-1999(Temp), f. 9-14-99, cert. ef. 9-15-99 thru 9-17-99; DFW 69-1999(Temp), f. & cert. ef. 9-17-99 thru 9-18-99; DFW 72-1999(Temp), f. 9-21-99, cert. ef. 9-22-99 thru 10-22-99; DFW 74-1999(Temp), f. 9-28-99, cert. ef. 9-29-99 thru 10-22-99; Administrative correction 11-17-99; DFW 50-2000, f. 8-18-00, cert. ef. 8-21-00 thru 9-9-00; DFW 60-2000(Temp), f. 9-11-00, cert. ef. 9-12-00 thru 12-31-00; DFW 61-2000(Temp), f. 9-15-00, cert. ef. 9-19-00 thru 12-31-00; Administrative correction 6-19-01; DFW 75-2001(Temp), f. & cert. ef. 8-20-01 thru 9-8-01; DFW 87-2001(Temp), f. 9-10-01, cert. ef. 9-11-01 thru 9-15-01; DFW 91-2001(Temp), f. & cert. ef. 9-19-01 thru 12-31-01; DFW 94-2001(Temp), f. 9-26-01, cert. ef. 9-27-01 thru 12-31-01; DFW 100-2001(Temp), f. 10-16-01, cert. ef. 10-17-01 thru 12-31-01; DFW 89-2002(Temp), f. 8-16-02, cert. ef. 8-18-02 thru 12-31-02; DFW 98-2002(Temp), f. & cert. ef. 8-30-02 thru 12-31-02; DFW 102-2002(Temp), f. & cert. ef. 9-13-02 thru 12-31-02; DFW 104-2002(Temp), f. & cert. ef. 9-19-02 thru 12-31-02; DFW 113-2002(Temp), f. 10-14-02, cert. ef. 10-15-02 thru 12-31-02;. DFW 77-2003(Temp), f. & cert. ef. 8-13-03 thru 12-31-03; DFW 81-2003(Temp), f. 8-25-03, cert. ef. 8-26-03 thru 12-31-03; DFW 91-2003(Temp), f. 9-12-03 cert. ef. 9-16-03 thru 12-31-03; DFW 97-2003(Temp), f. 9-22-03, cert. ef. 9-24-03 thru 12-31-03; DFW 101-2003(Temp), f. 9-26-03, cert. ef. 10-1-03 thru 12-31-03; DFW 103-2003(Temp), f. 10-3-03, cert. ef. 10-8-03 thru 12-31-03; DFW 104-2003(Temp), f. 10-10-03, cert. ef. 10-11-03 thru 12-31-03; DFW 88-2004(Temp), f. & cert. ef. 8-23-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 99-2004(Temp), f. & cert. ef. 9-24-04 thru 12-31-04; DFW 104-2004(Temp), f. 10-12-04 cert. ef. 10-13-04 thru 12-31-04; DFW 110-2004(Temp), f. & cert. ef. 10-29-04 thru 12-31-04; Administrative correction, 2-18-05; DFW 96-2005(Temp), f. & cert. ef. 8-22-05 thru 12-31-05

**635-042-0031**
**Early Fall Salmon Season**

(1) Salmon and sturgeon may be taken for commercial purposes in the waters of the Columbia River, Zones 4-5, as identified in OAR 635-042-0001.

(2) The Lewis-A, Washougal and Sandy River sanctuaries are in effect.

(3) The open fishing period is 8:00 p.m. August 22 to 7:00 a.m. August 23, 2005;

(4) Gear is restricted to gill nets with a 9-inch minimum mesh size and 9-3/4-inch maximum mesh size.

(5) A maximum of five green or white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open. During the fishing period identified in (3), the weekly aggregate sturgeon limit applies to possession and sales in the Columbia River mainstem fishery, the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 496.118, 506.109 & 506.129
Stats. Implemented: ORS 506.119 & 507.030
Hist.: FWC 63-1987, f. & ef. 8-7-87; FWC 67-1988, f. & cert. ef. 8-15-88; FWC 68-1988(Temp), f. & cert. ef. 8-15-88; FWC 54-1989(Temp), f. & cert. ef. 8-7-89; FWC 56-1989(Temp), f. & cert. ef. 8-11-89; FWC 58-1989(Temp), f. & cert. ef. 8-14-89; FWC 80-1989(Temp), f. 8-28-89, cert. ef. 8-29-89; FWC 80-1990(Temp), f. 8-7-90, cert. ef. 8-8-90; FWC 85-1991, f. 8-7-91, cert. ef. 8-12-91; FWC 91-1991(Temp), f. & cert. ef. 8-29-91; FWC 73-1992(Temp), f. & cert. ef. 8-10-92; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 53-1996(Temp), f. & cert. ef. 9-16-96; FWC 49-1997, f. 8-20-97, cert. ef. 8-24-97; DFW 74-1998(Temp), f. & cert. ef. 8-25-98 thru 8-26-98; DFW 59-1999(Temp), f. & cert. ef. 8-23-99

thru 9-11-99; DFW 75-1999(Temp), f. 9-29-99, cert. ef. 9-30-99 thru 10-22-99; Administrative correction 11-17-99; DFW 50-2000(Temp), f. 8-18-00, cert. ef. 8-21-00 thru 9-9-00; DFW 52-2000(Temp), f. 8-23-00, cert. ef. 8-23-00 thru 8-24-00; Administrative correction 6-20-01; DFW 68-2001(Temp), f. 8-7-01, cert. ef. 8-8-01 thru 8-9-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 79-2001(Temp), f. & cert. ef. 8-22-01 thru 12-31-01; DFW 80-2001(Temp), f. & cert. ef. 8-24-01 thru 12-31-01; DFW 86-2001(Temp), f. & cert. ef. 9-4-01 thru 12-31-01; DFW 81-2002(Temp), f. 8-2-02, cert. ef. 8-4-02 thru 8-9-02; DFW 87-2002(Temp), f. & cert. ef. 8-9-02 thru 8-12-02; DFW 89-2002(Temp), f. 8-16-02, cert. ef. 8-18-02 thru 12-31-02; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 77-2003(Temp), f. & cert. ef. 8-13-03 thru 12-31-03; DFW 82-2003(Temp), f. & cert. ef. 8-25-03 thru 12-31-03; DFW 87-2003(Temp), f. & cert. ef. 8-27-03 thru 12-31-03; DFW 81-2004(Temp), f. & cert. ef. 8-12-04 thru 12-31-04; DFW: 82-2004(Temp), f. & cert. ef. 8-16-04 thru 12-31-04; DFW 86-2004 (Temp), f. 8-19-04 thru 12-31-04: DFW 88-2004(Temp), f. & cert. ef. 8-23-04 thru 12-31-04; Administrative correction, 2-18-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 88-2005(Temp), f. 8-11-05, cert. ef. 8-14-05 thru 12-31-05; DFW 90-2005(Temp), f. & cert. ef. 8-17-05 thru 12-31-05; DFW 96-2005(Temp), f. & cert. ef. 8-22-05 thru 12-31-05

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**Adm. Order No.:** DFW 97-2005(Temp)
**Filed with Sec. of State:** 8-23-2005
**Certified to be Effective:** 8-23-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-003-0077
**Rules Suspended:** 635-003-0077(T)
**Subject:** This rule will implement an inseason closure to the Oregon Ocean Commercial Troll Salmon season as adopted by the Pacific Fishery Management Council.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-003-0077**
**US-Canada Border to Cape Falcon**

(1) Vessels must land their fish within 24 hours of any closure. Vessels fishing north of Leadbetter Point, WA must land their fish within the area north of Leadbetter Point. Vessels fishing south of Leadbetter Point must land their fish within the area south Leadbetter Point except that Oregon permitted vessels may also land their fish in Garibaldi, Oregon. All vessels landing salmon into Oregon from any fishery between Leadbetter Point, WA and Cape Falcon, Oregon, must notify ODFW within one hour of delivery or prior to transport away from the port of landing by calling (541) 867-0300 extension 271. Notification shall include vessel name and number, number of salmon by species, port of landing and location of delivery, and estimated time of delivery.

(2) The commercial troll season, as described above in (1) is extended May 24, 2005 through May 26, 2005. For the seven day period May 20, 2005 through May 26, 2005 there is a 125 chinook landing and possession limit per vessel.

(3) The commercial troll season, as described above in (1) is closed effective 11:59 p.m., May 26, 2005.

(4) The commercial troll season, as described above in (1) is open effective 12:01 a.m., June 3, 2005 through 11:59 p.m., June 6, 2005. For the four day period there is a 60 chinook landing and possession limit per vessel.

(5) The commercial troll season, as described above in (1) is open effective 12:01 a.m., June 26, 2005 through 11:59 p.m., June 30, 2005. For the five day period there is a 30 chinook landing and possession limit per vessel.

(6) The commercial troll salmon fishery is closed to all troll salmon fishing effective 11:59 pm, August 23, 2005.

Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: ORS 506.129
Hist: DFW 6-2005, f. & cert. ef. 2-14-05; DFW 36-2005(Temp), f. & cert.ef. 5-4-05 thru 10-27-05; DFW 48-2005(Temp), f. 5-23-05, cert. ef. 5-24-05 thru 10-27-05; DFW 49-2005(Temp), f. 6-1-05, cert. ef. 6-3-05 thru 10-27-05; DFW 59-2005(Temp), f. 6-21-05, cert. ef. 6-26-05 thru 10-27-05; DFW 97-2005(Temp), f. & cert. ef. 8-23-05 thru 12-31-05

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**Adm. Order No.:** DFW 98-2005(Temp)
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 8-25-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-042-0031
**Rules Suspended:** 635-042-0031(T)
**Subject:** Amend rule to extend the fall commercial salmon fishery in the Columbia River mainstem. Modification is consistent with action taken by the Columbia River Compact.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-042-0031**
**Early Fall Salmon Season**

(1) Salmon and sturgeon may be taken for commercial purposes in the waters of the Columbia River, Zones 4-5, as identified in OAR 635-042-0001.

(2) The Lewis-A, Washougal and Sandy River sanctuaries are in effect.

(3) The open fishing periods are:

(a) 8:00 p.m. August 22 to 7:00 a.m. August 23, 2005.

(b) 8:00 p.m. August 25 to 7:00 a.m. August 26, 2005.

(4) Gear is restricted to gill nets with a 9-inch minimum mesh size and 9 1/2-inch maximum mesh size.

(5) A maximum of five green or white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open. During the fishing periods identified in (3), the weekly aggregate sturgeon limit applies to possession and sales in the Columbia River mainstem fishery, the Youngs Bay fishery and other open Select Area fisheries.

Stat. Auth.: ORS 496.118, 506.109 & 506.129
Stats. Implemented: ORS 506.119 & 507.030
Hist.: FWC 63-1987, f. & ef. 8-7-87; FWC 67-1988, f. & cert. ef. 8-15-88; FWC 68-1988(Temp), f. & cert. ef. 8-15-88; FWC 54-1989(Temp), f. & cert. ef. 8-7-89; FWC 56-1989(Temp), f. & cert. ef. 8-11-89; FWC 58-1989(Temp), f. & cert. ef. 8-14-89; FWC 80-1989(Temp), f. 8-28-89, cert. ef. 8-29-89; FWC 80-1990(Temp), f. 8-7-90, cert. ef. 8-8-90; FWC 85-1991, f. 8-7-91, cert. ef. 8-12-91; FWC 91-1991(Temp), f. & cert. ef. 8-29-91; FWC 73-1992(Temp), f. & cert. ef. 8-10-92; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 53-1996(Temp), f. & cert. ef. 9-16-96; FWC 49-1997, f. 8-20-97, cert. ef. 8-24-97; DFW 74-1998(Temp), f. & cert. ef. 8-25-98 thru 8-26-98; DFW 59-1999(Temp), f. & cert. ef. 8-23-99 thru 9-11-99; DFW 75-1999(Temp), f. 9-29-99, cert. ef. 9-30-99 thru 10-22-99; Administrative correction 11-17-99; DFW 50-2000(Temp), f. 8-18-00, cert. ef. 8-21-00 thru 9-9-00; DFW 52-2000(Temp), f. 8-23-00, cert. ef. 8-23-00 thru 8-24-00; Administrative correction 6-20-01; DFW 68-2001(Temp), f. 8-7-01, cert. ef. 8-8-01 thru 8-9-01; DFW 76-2001(Temp), f. & cert. ef. 8-20-01 thru 10-31-01; DFW 79-2001(Temp), f. & cert. ef. 8-22-01 thru 12-31-01; DFW 80-2001(Temp), f. & cert. ef. 8-24-01 thru 12-31-01; DFW 86-2001(Temp), f. & cert. ef. 9-4-01 thru 12-31-01; DFW 81-2002(Temp), f. 8-2-02, cert. ef. 8-4-02 thru 8-9-02; DFW 87-2002(Temp), f. & cert. ef. 8-9-02 thru 8-12-02; DFW 89-2002(Temp), f. 8-16-02, cert. ef. 8-18-02 thru 12-31-02; DFW 75-2003(Temp), f. & cert. ef. 8-1-03 thru 12-31-03; DFW 77-2003(Temp), f. & cert. ef. 8-13-03 thru 12-31-03; DFW 82-2003(Temp), f. & cert. ef. 8-25-03 thru 12-31-03; DFW 87-2003(Temp), f. & cert. ef. 8-27-03 thru 12-31-03; DFW 81-2004(Temp), f. & cert. ef. 8-12-04 thru 12-31-04; DFW: 82-2004(Temp), f. & cert. ef. 8-16-04 thru 12-31-04; DFW 86-2004 (Temp), f. 8-19-04 thru 12-31-04: DFW 88-2004(Temp), f. & cert. ef. 8-23-04 thru 12-31-04; Administrative correction, 2-18-05; DFW 85-2005(Temp), f. 8-1-05, cert. ef. 8-3-05 thru 12-31-05; DFW 88-2005(Temp), f. 8-11-05, cert. ef. 8-14-05 thru 12-31-05; DFW 90-2005(Temp), f. & cert. ef. 8-17-05 thru 12-31-05; DFW 96-2005(Temp), f. & cert. ef. 8-22-05 thru 12-31-05; DFW 98-2005(Temp), f. 8-24-05, cert. ef. 8-25-05 thru 12-31-05

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**Adm. Order No.:** DFW 99-2005(Temp)
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 8-26-05 thru 9-30-05
**Notice Publication Date:**
**Rules Amended:** 635-019-0090
**Subject:** Amend rule to close the McKay Reservoir to the retention of bass through the end of the season.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-019-0090**
**Inclusions and Modifications**

(1) The **2005 Oregon Sport Fishing Regulations** provide requirements for the Northeast 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 **2005 Oregon Sport Fishing Regulations**.

(2) Effective 11:59 p.m., August 26, 2005 and continuing through September 30, 2005, the McKay Reservoir is closed to the retention of bass.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146 & 506.119
Stats. Implemented: 496.162 & 506.129
Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 57-1994(Temp), f. 8-30-94, cert. ef. 10-1-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 70-1995, f. 8-29-95, cert. ef. 9-1-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 27-1996(Temp), f. 5-24-96, cert. ef. 5-25-96; FWC 57-1996(Temp), f. 9-27-96, cert. ef. 10-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 26-1997(Temp), f. 4-23-97, cert. ef. 5-17-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 13-1998(Temp), f. & cert. ef. 2-26-98 thru 4-15-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 5-1999(Temp), f. 2-5-99, cert. ef. 2-6-99 thru 2-19-99; DFW 8-1999(Temp), f. & cert. ef. 2-23-99 thru 4-15-99; DFW 37-1999(Temp), f. 5-24-99, cert. ef. 5-29-99 thru 6-5-99; DFW 43-1999(Temp), f. & cert. ef. 6-10-99 thru 6-13-99; DFW 45-1999(Temp), f. & cert. ef. 6-14-99 thru 6-20-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 17-2000(Temp), f. 4-10-00, cert. ef. 4-16-00 thru 6-30-00; DFW 64-2000(Temp), f. 9-21-00, cert. ef. 9-22-00 thru 3-20-01; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 5-2001(Temp), f. 2-22-01, cert. ef. 2-24-01 thru 4-15-01; DFW 39-2001(Temp) f. 5-23-01, cert. ef. 5-26-01 thru 7-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 45-2001(Temp), f. 6-1-01, cert. ef. 6-2-01 thru 7-31-01; DFW 49-2001(Temp), f. 6-19-01, cert. ef. 6-22-01 thru 7-31-01; DFW 70-2001, f. & cert. ef. 8-10-01; DFW 71-2001(Temp), f. 8-10-01, cert. ef. 9-1-01

thru 12-31-01; DFW 96-2001(Temp), f. 10-4-01, cert. ef. 12-1-01 thru 12-31-01; DFW 122-2001(Temp), f. & cert. ef. 12-31-01 thru 5-31-02; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 52-2002(Temp), f. 5-22-02, cert. ef. 5-26-02 thru 7-1-02; DFW 53-2002(Temp), f. 5-24-02, cert. ef. 5-26-02 thru 7-1-02; DFW 57-2002(Temp), f. & cert. ef. 5-30-02 thru 7-1-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 44-2003(Temp), f. 5-23-03, cert. ef. 5-28-03 thru 7-1-03; DFW 48-2003(Temp), f. & cert. ef. 6-5-03 thru 7-1-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 40-2004(Temp), f. 5-7-04, cert. ef. 5-13-04 thru 7-1-04; DFW 46-2004(Temp), f. 5-21-04, cert. ef. 5-22-04 thru 7-1-04; DFW 55-2004(Temp), f. 6-16-04, cert. ef. 6-19-04 thru 7-5-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 42-2005(Temp), f. & cert. ef. 5-13-05 thru 9-1-05; DFW 61-2005(Temp), f. 6-22-05, cert. ef. 6-25-05 thru 7-4-05; Administrative correction 7-20-05; DFW 99-2005(Temp), f. 8-24-05, cert. ef. 8-26-05 thru 9-30-05

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**Adm. Order No.:** DFW 100-2005(Temp)
**Filed with Sec. of State:** 8-30-2005
**Certified to be Effective:** 8-30-05 thru 12-31-05
**Notice Publication Date:**
**Rules Adopted:** 635-090-0195
**Subject:** This rule allows a special, fast-track review and approval process available to the Board for emergency seeding projects that address recent, wildfire-caused impacts to lands providing wildlife habitat.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-090-0195**
**Emergency Seeding**

(1) This section creates a special, fast-track review and approval process available to the Board for emergency seeding projects that address recent, wildfire-caused impacts to lands providing wildlife habitat. Notwithstanding any other rule, the Board may (at its discretion) process grant applications for such emergency projects using any or all of the special process elements provided by subsection (2) of this rule. However, the substantive standards provided in other rules shall still apply, with the addition of the special criteria specified in subsection (4) below.

(2) When processing an application for an emergency project, the Board may:

(a) Consult with the appropriate Regional Advisory Council in the most expeditious manner available (which may include fax, e-mail or telephone);

(b) Consider and vote on the application during a special meeting of the Board upon shorter notice than required for regular Board meetings; and

(c) Hold such a special Board meeting via telephone conference call.

(3) Any emergency grant application recommended by the Board through the special procedures provided by this rule shall be forwarded to the Director (rather than the Commission) for final funding decision. The Director shall act on such a recommendation within 7 working days of receipt.

(4) The Board shall apply the following special criteria to emergency grant applications, in addition to the general standards provided elsewhere in this division:

(a) The proposed project must be located entirely on private land;

(b) The project site must provide critical habitat for wildlife;

(c) The project must propose emergency seeding to benefit wildlife, and the seed mixture has been approved by the local ODFW district biologist;

(d) All equipment needed to complete the project is available; and

(e) The seeding can be completed in the timeframe required.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.232 & 496.242
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.232 & 496.242
Hist.: DFW 100-2005(Temp), f. & cert. ef. 8-30-05 thru 12-31-05

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**Adm. Order No.:** DFW 101-2005(Temp)
**Filed with Sec. of State:** 8-31-2005
**Certified to be Effective:** 9-2-05 thru 9-30-05
**Notice Publication Date:**
**Rules Amended:** 635-021-0090
**Subject:** Amend rule to allow increased harvest opportunity of game fish in Thief Valley Reservoir.
**Rules Coordinator:** Katie Thiel—(503) 947-6033

**635-021-0090**
**Inclusions and Modifications**

(1) The **2005 Oregon Sport Fishing Regulations** provide requirements for the Southeast 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 **2005 Oregon Sport Fishing Regulations**.

(2) Effective September 2, 2005, the Thief Valley Reservoir is open to angling for all game species.

(a) Harvest is allowed by hand, dip net or angling.

(b) There is no daily catch or possession limits.

(c) There are no minimum length requirements.

Stat. Auth.: ORS 183.325, 496.138 & 496.146
Stats. Implemented: ORS 496.162
Hist.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 76-1994(Temp), f. & cert. ef. 10-17-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 55-2001(Temp), f. & cert. ef. 6-29-01 thru 12-26-01; DFW 56-2001(Temp), f. & cert. ef. 6-29-01 thru 12-26-01; DFW 85-2001(Temp), f. & cert. ef. 8-30-01 thru 12-31-01; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 54-2002(Temp), f. 5-24-02, cert. ef. 6-15-02 thru 12-1-02; DFW 91-2002(Temp) f. 8-19-02,cert. ef 8-20-02 thru 11-1-0 2 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 93-2002(Temp), f. 8-22-02, cert. ef. 8-24-02 thru 12-31-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 80-2003(Temp), f. & cert. ef. 8-22-03 thru 9-30-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 101-2005(Temp), f. 8-31-05, cert. ef. 9-2-05 thru 9-30-05

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**Adm. Order No.:** DFW 102-2005(Temp)
**Filed with Sec. of State:** 9-1-2005
**Certified to be Effective:** 9-1-05 thru 2-10-06
**Notice Publication Date:**
**Rules Adopted:** 635-065-0771
**Subject:** Rules will be adopted to allow terminally ill children who are sponsored by a qualified organization be eligible for a free hunting tag.
**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-065-0771**
**Tags for Terminally Ill Children**

(1) “Organization” means a non-profit organization qualified under Internal Revenue Code section 501(c)(3) with the sole purpose of granting hunting adventures for children that have been diagnosed with a terminal illness by a licensed physician.

(2) “Qualified child” means a terminally ill child sponsored by an organization who provides to the Department supporting documentation demonstrating compliance with the prerequisites provided in this rule.

(3) Annually upon approval by the Director, the Department may issue no more than 25 big game tags free of charge to organizations for use by qualified children. The 25 tags will be distributed across deer, elk, and pronghorn antelope with no more than 10 tags to hunt either-sex deer, no more than 10 tags to hunt either-sex elk, and no more than five tags to hunt either-sex pronghorn antelope.

(a) Each organization is limited to five tags total for all species per year.

(b) An individual tag entitles the holder to only one deer, or one elk, or one pronghorn antelope.

(c) A qualified child may obtain only one tag pursuant to this rule.

(d) Tags issued under this rule may be used to hunt within any Oregon Wildlife Management Unit (as defined in OAR chapter 635 division 080), except specific area closures as identified in the current Oregon Big Game Regulations, Hart Mountain Antelope Refuge, or Starkey Experimental Forest enclosure.

(4) A qualified child must be between 12 and 17 years old at the time of the hunt, must comply with all requirements concerning minimum hunting age (ORS 497.350), concerning hunter education (ORS 497.360) and concerning hunting hours (OAR 635-065-0730) and must hold a valid Oregon hunting license.

(5) A qualified child may be either resident or non-resident.

(6) A qualified child must hunt in the company of an adult, and may use any legal weapon for hunting the species for which the tag is issued.

(7) For tags issued under this rule, open seasons are as follows:

(a) For deer and elk: September 1 through November 30, 2005.

(b) For pronghorn antelope: September 1 through September 30, 2005.

Stat. Auth.: ORS 496.012, 496.138, 496.146, 496.162, 497.350 & 497.360
Stats. Implemented: ORS 496.012, 496.138, 496.146, 496.162, 497.350 & 497.360
Hist.: DFW 102-2005(Temp), f. & cert. ef. 9-1-05 thru 2-10-06

**Adm. Order No.:** DFW 103-2005(Temp)
**Filed with Sec. of State:** 9-7-2005
**Certified to be Effective:** 9-9-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-013-0004
**Rules Suspended:** 635-013-0004(T)
**Subject:** Amend rule to prohibit chinook retention during the ocean recreational salmon fishery season from Leadbetter Point, WA to Cape Falcon, Oregon.
**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-013-0004**
**Inclusions and Modifications**

(1) OAR 635-013-0005 through OAR 635-013-0009 modify or are in addition to provisions contained in **Code of Federal Regulations, Title 50, Part 660, Subparts A and H**, and the **2005 Oregon Sport Fishing Regulations**.

(2) The **Code of Federal Regulations (CFR), Title 50, Part 660, Subparts A and H**, and the **2005 Oregon Sport Fishing Regulations** contain requirements for sport salmon angling in the Pacific Ocean off the Oregon coast. However, additional regulations may be adopted from time to time, and, to the extent of any inconsistency, they supersede the published federal regulations and the **2005 Oregon Sport Fishing Regulations**. This means that persons must consult not only the federal regulations and the published sport fishing regulations but also the Department's web page to determine all applicable sport fishing regulations.

(3) This rule contains requirements that modify sport salmon angling regulations off the Oregon coast. The following modifications are organized in sections that apply to the ocean sport salmon fishery in general and within management zones established by the Pacific Fishery Management Council and enacted by **Federal Regulations (CFR, Title 50, Part 660, Subparts A and H)**.

(4) Effective July 29, 2005, in the area from Leadbetter Point, WA, to Cape Falcon, OR, the salmon fishery is open seven days per week. The bag limit is two salmon per day. Minimum length requirements are 24-inches for chinook and 16-inches for coho. All retained coho must have a healed adipose fin-clip.

(5) Effective September 9, 2005, in the area from Leadbetter Point, WA, to Cape Falcon, OR, the salmon fishery is open seven days per week. The bag limit is two salmon per day. Retention of chinook is prohibited. The minimum length requirement is 16-inches for coho. All retained coho must have a healed adipose fin-clip.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146, 497.121 & 506.119
Stats. Implemented: ORS 496.004, 496.009, 496.162 & 506.129
Hist.: FWC 29-1989, f. 4-28-89, cert. ef. 5-1-89; FWC 31-1992, f. 4-29-92, cert. ef. 5-1-92; FWC 25-1994, f. & cert. ef. 5-2-94; FWC 34-1995, f. & cert. ef. 5-1-95; FWC 39-1995, f. 5-10-95, cert. ef. 5-12-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 72-1996, f. 12-21-96, cert. ef. 1-1-97; FWC 19-1997(Temp), f. 3-17-97, cert. ef. 4-15-97; FWC 30-1997, f. & cert. ef. 5-5-97; FWC 43-1997(Temp), f. 8-8-97, cert. ef. 8-10-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 59-1998(Temp), f. & cert. ef. 8-10-98 thru 8-21-98; DFW 66-1998(Temp), f. & cert. ef. 8-21-98 thru 9-24-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 20-1999(Temp), f. 3-29-99, cert. ef. 4-1-99 thru 4-30-99; DFW 31-1999, f. & cert. ef. 5-3-99; DFW 61-1999(Temp), f. 8-31-99, cert. ef. 9-3-99 thru 9-17-99; DFW 66-1999(Temp), f. & cert. ef. 9-17-99 thru 9-30-99; administrative correction 11-17-99; DFW 16-2000(Temp), f. 3-31-00, cert. ef. 4-1-00 thru 4-30-00; DFW 24-2000, f. 4-28-00, cert. ef. 5-1-00; DFW 47-2000(Temp), f. 8-10-00, cert. ef. 8-13-00 thru 9-30-00; DFW 83-2000(Temp), f 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 16-2001(Temp), f. 3-28-01, cert. ef. 4-1-01 thru 4-30-01; Administrative correction 6-20-01; DFW 59-2001(Temp), f. 7-18-01, cert. ef. 7-19-01 thru 10-31-01; DFW 20-2002(Temp), f. 3-19-02, cert. ef. 4-1-01 thru 4-30-02; DFW 75-2002(Temp), f. 7-19-02, cert. ef. 7-21-02 thru 12-31-02; DFW 80-2002(Temp), f. 7-31-02, cert. ef. 8-1-02 thru 12-31-02; DFW 85-2002(Temp), f. 8-8-02, cert. ef. 8-11-02 thru 12-31-02; DFW 99-2002(Temp) f. 8-30-02, cert. ef. 9-2-02 thru 12-31-02; DFW 100-2002(Temp), f. & cert. ef. 9-6-02 thru 12-31-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 18-2003(Temp) f. 2-28-03, cert. ef. 3-1-03 thru 4-30-03; DFW 35-2003, f. 4-30-03, cert. ef. 5-1-03; DFW 69-2003(Temp), f. 7-21-03, cert. ef. 7-25-03 thru 12-31-03; DFW 78-2003(Temp), f. 8-14-03, cert .ef. 8-20-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 75-2004(Temp), f. 7-20-04, cert. ef. 7-23-04 thru 12-31-04; DFW 80-2004(Temp), f. 8-12-04, cert. ef. 8-13-04 thru 12-31-04; DFW 93-2004(Temp), f. 9-2-04, cert. ef. 9-4-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 81-2005(Temp), f. 7-25-05, cert. ef. 7-29-05 thru 12-31-05; DFW 103-2005(Temp), f. 9-7-05, cert. ef. 9-9-05 thru 12-31-05

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**Adm. Order No.:** DFW 104-2005(Temp)
**Filed with Sec. of State:** 9-12-2005
**Certified to be Effective:** 9-12-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-041-0075
**Rules Suspended:** 635-041-0075(T)
**Subject:** Adopt rule to extend the fall commercial gillnet fishery and platform and hook-and-line, within Zone 6, for Treaty Indian fishers in the Columbia River. Allow the use of drift nets up to 800 feet in length. Implementation consistent with action taken September 9, 2005, by the Columbia River Compact.
**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-041-0075**
**Fall Salmon Season**

(1) Chinook salmon, coho salmon, steelhead, walleye, carp, and shad may be taken with gill net for commercial purposes from mainstem Columbia River waters in all of Zone 6.

(2) The open fishing periods are:

(a) 6:00 a.m. August 22 to 6:00 p.m. August 26, 2005;

(b) 6:00 a.m. August 29 to 6:00 p.m. September 2, 2005;

(c) 6:00 a.m. September 6 to 6:00 p.m. September 10, 2005.

(d) 6:00 a.m. September 12 to 6:00 p.m. September 16, 2005.

(3) Through September 2, 2005 there is no mesh size restriction. For the fishing periods beginning September 6, 2005, there is an 8-inch minimum mesh restriction.

(4) Nothwithstanding OAR 635-041-0050, the use of drift nets up to 800 feet in length are permitted during the fishery commencing September 12, 2005.

(5) All standard dam and river mouth sanctuaries set forth in OAR 635-041-0045 are in effect, except Small Spring Creek sanctuary within a radius of 150 feet of the Spring Creek Hatchery fishway.

(6) Sturgeon may not be sold. However, sturgeon between 4-5 feet in length in The Dalles and John Day Pools and sturgeon between 45"– 60" in the Bonneville Pool may be kept for subsistence purposes.

(7) Until further notice, sale of platform and hook-and-line caught fish will be allowed. Sales from the Big White Salmon River and Klickitat River will be allowed, only during those days and hours when these tributaries are open under lawfully enacted Yakama Nation Tribal subsistence fisheries.

Stat. Auth.: ORS 496.118 & 506.119
Stats. Implemented: ORS 506.109, 506.129 & 507.030
Hist.: FWC 25-1979, f. & ef. 8-2-79; FWC 36-1979(Temp), f. & ef. 8-22-79; FWC 47-1979(Temp), f. & ef. 9-21-79; FWC 44-1980(Temp), f. & ef. 8-22-80; FWC 46-1980(Temp), f. & ef. 9-13-80; FWC 33-1981(Temp), f. & ef. 9-15-81; FWC 58-1982(Temp), f. & ef. 8-27-82; FWC 62-1982(Temp), f. & ef. 9-7-82; FWC 63-1982(Temp), f. & ef. 9-14-82; FWC 75-1982 (Temp), f. & ef. 10-29-82; FWC 36-1983, f. & ef. 8-18-83; FWC 49-1983(Temp), f. & ef. 9-26-83; FWC 51-1983(Temp), f. & ef. 9-30-83; FWC 55-1983(Temp), f. & ef. 10-4-83; FWC 46-1984, f. & ef. 8-30-84; FWC 55-1984(Temp), f. & ef. 9-10-84; FWC 58-1984(Temp), f. & ef. 9-17-84; FWC 61-1984 (Temp), f. & ef. 9-21-84; FWC 70-1984(Temp), f. & ef. 10-9-84; FWC 47-1985, f. & ef. 8-23-85; FWC 60-1985(Temp), f. & ef. 9-13-85; FWC 63-1985(Temp), f. & ef. 9-24-85; FWC 42-1986, f. & ef. 8-15-86; FWC 53-1986(Temp), f. & ef. 9-4-86; FWC 54-1986(Temp), f. & ef. 9-5-86; FWC 57-1986(Temp), f. & ef. 9-11-86; FWC 60-1986(Temp), f. & ef. 9-26-86; FWC 62-1986(Temp), f. & ef. 10-2-86; FWC 63-1987, f. & ef. 8-7-87; FWC 74-1987(Temp), f. & ef. 9-4-87; FWC 75-1987 (Temp), f. & ef. 9-1-87; FWC 78-1987(Temp), f. & ef. 9-15-87; FWC 80-1987(Temp), f. & ef. 9-18-87; FWC 87-1987(Temp), f. & ef. 10-9-87; FWC 89-1987(Temp), f. & ef. 10-12-87; FWC 67-1988, f. & cert. ef. 8-15-88; FWC 72-1988(Temp), f. & cert. ef. 8-19-88; FWC 77-1988(Temp), f. & cert. ef. 9-2-88; FWC 91-1988(Temp), f. & cert. ef. 9-16-88; FWC 95-1988 (Temp), f. 9-27-88, cert. ef. 9-28-88; FWC 54-1989(Temp), f. & cert. ef. 8-7-89; FWC 87-1989(Temp), f. & cert. ef. 9-1-89; FWC 95-1989(Temp), f. & cert. ef. 9-19-89; FWC 96-1989 (Temp), f. & cert. ef. 9-21-89; FWC 99-1989(Temp), f. & cert. ef. 9-27-89; FWC 100-1989(Temp), f. & cert. ef. 9-28-89; FWC 80-1990(Temp), f. 8-7-90, cert. ef. 8-8-90; FWC 90-1990, f. & cert. ef. 8-31-90; FWC 96-1990(Temp), f. 9-7-90, cert. ef. 9-10-90; FWC 98-1990(Temp), f. 9-14-90, cert. ef. 9-17-90; FWC 85-1991, f. 8-7-91, cert. ef. 8-12-91; FWC 96-1991, f. & cert. ef. 9-9-91; FWC 101-1991(Temp), f. & cert. ef. 9-10-91; FWC 103-1991(Temp), f. 9-17-91, cert. ef. 9-18-91; FWC 110-1991(Temp), f. & cert. ef. 9-27-91; FWC 73-1992(Temp), f. & cert. ef. 8-10-92; FWC 86-1992(Temp), f. 9-1-92, cert. ef. 9-2-92; FWC 87-1992(Temp), f. 9-4-92, cert. ef. 9-7-92; FWC 91-1992(Temp), f. 9-16-92, cert. ef. 9-17-92; FWC 96-1992(Temp), f. 9-22-92, cert. ef. 9-23-92; FWC 105-1992(Temp), f. 10-2-92, cert. ef. 10-5-92; FWC 107-1992 (Temp), f. & cert. ef. 10-9-92; FWC 47-1993, f. 8-6-93, cert. ef. 8-9-93; FWC 52-1993, f. & cert. ef. 8-30-93; FWC 57-1993(Temp), f. & cert. ef. 9-13-93; FWC 59-1993(Temp), f. 9-17-93, cert. ef. 9-20-93; FWC 61-1993(Temp), f. & cert. ef. 9-24-93; FWC 55-1994(Temp), f. 8-26-94, cert. ef. 8-29-94; FWC 61-1994(Temp), f. 9-7-94, cert. ef. 9-8-94; FWC 74-1994(Temp), f. & cert. ef. 10-12-94; FWC 68-1995(Temp), f. 8-25-95, cert. ef. 8-29-95; FWC 72-1995(Temp), f. & cert. ef. 9-1-95; FWC 75-1995(Temp), f. 9-12-95, cert. ef. 9-13-95; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 48-1996(Temp), f. 8-29-96, cert. ef. 9-2-96; FWC 51-1996(Temp), f. 9-6-96, cert. ef. 9-9-96; FWC 53-1996(Temp), f. & cert. ef. 9-26-96; FWC 54-1996(Temp), f. & cert. ef. 9-23-96; FWC 48-1997, f. & cert. ef. 8-25-97; FWC 52-1997(Temp), f. 8-29-97, cert. ef. 9-2-97, FWC 57(Temp), f. & cert. ef. 9-9-97; FWC 60-1997(Temp), f. 9-16-97, cert. ef. 9-17-97; DFW 68-1998(T), f. & cert. ef. 8-25-98 thru 9-25-98; DFW 76-1998(T), f. & cert. ef. 9-8-98 thru 9-25-98; DFW 77-1998(Temp), f. 9-14-98, cert. ef. 9-15-98 thru 9-25-98; DFW 79-1998(Temp), f. 9-21-98, cert. ef. 9-22-98 thru 9-25-98; DFW 80-1998(Temp), f. 9-23-98, cert. ef. 9-24-98 thru 9-25-98; DFW 59-1999(Temp), f. & cert. ef. 8-23-99 thru 9-11-99; DFW 62-1999(Temp), f. 9-2-99, cert. ef. 9-3-99 thru 9-11-99; DFW 65-1999(Temp), f. 9-14-99, cert. ef. 9-15-99 thru 9-17-99; DFW 69-1999(Temp), f. & cert. ef. 9-17-99 thru 9-18-99; DFW 72-1999(Temp), f. 9-21-99, cert. ef. 9-22-99 thru 10-22-99; DFW 74-1999(Temp), f. 9-28-99, cert. ef. 9-29-99 thru 10-22-99; Administrative correction 11-17-99; DFW 50-2000, f. 8-18-00, cert. ef. 8-21-00 thru 9-9-00; DFW 60-2000(Temp), f. 9-11-00, cert. ef. 9-12-00 thru 12-31-00; DFW 61-2000(Temp), f. 9-15-00, cert. ef. 9-19-00 thru 12-31-00;

Administrative correction 6-19-01; DFW 75-2001(Temp), f. & cert. ef. 8-20-01 thru 9-8-01; DFW 87-2001(Temp), f. 9-10-01, cert. ef. 9-11-01 thru 9-15-01; DFW 91-2001(Temp), f. & cert. ef. 9-19-01 thru 12-31-01; DFW 94-2001(Temp), f. 9-26-01, cert. ef. 9-27-01 thru 12-31-01; DFW 100-2001(Temp), f. 10-16-01, cert. ef. 10-17-01 thru 12-31-01; DFW 89-2002(Temp), f. 8-16-02, cert. ef. 8-18-02 thru 12-31-02; DFW 98-2002(Temp), f. & cert. ef. 8-30-02 thru 12-31-02; DFW 102-2002(Temp), f. & cert. ef. 9-13-02 thru 12-31-02; DFW 104-2002(Temp), f. & cert. ef. 9-19-02 thru 12-31-02; DFW 113-2002(Temp), f. 10-14-02, cert. ef. 10-15-02 thru 12-31-02;. DFW 77-2003(Temp), f. & cert. ef. 8-13-03 thru 12-31-03; DFW 81-2003(Temp), f. 8-25-03, cert. ef. 8-26-03 thru 12-31-03; DFW 91-2003(Temp), f. 9-12-03 cert. ef. 9-16-03 thru 12-31-03; DFW 97-2003(Temp), f. 9-22-03, cert. ef. 9-24-03 thru 12-31-03; DFW 101-2003(Temp), f. 9-26-03, cert. ef. 10-1-03 thru 12-31-03; DFW 103-2003(Temp), f. 10-3-03, cert. ef. 10-8-03 thru 12-31-03; DFW 104-2003(Temp), f. 10-10-03, cert. ef. 10-11-03 thru 12-31-03; DFW 88-2004(Temp), f. & cert. ef. 8-23-04 thru 12-31-04; DFW 95-2004(Temp), f. 9-17-04, cert. ef. 9-19-04 thru 12-31-04; DFW 99-2004(Temp), f. & cert. ef. 9-24-04 thru 12-31-04; DFW 104-2004(Temp), f. 10-12-04 cert. ef. 10-13-04 thru 12-31-04; DFW 110-2004(Temp), f. & cert. ef. 10-29-04 thru 12-31-04; Administrative correction, 2-18-05; DFW 96-2005(Temp), f. & cert. ef. 8-22-05 thru 12-31-05; DFW 104-2005(Temp), f. & cert. ef. 9-12-05 thru 12-31-05

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**Adm. Order No.:** DFW 105-2005(Temp)
**Filed with Sec. of State:** 9-12-2005
**Certified to be Effective:** 10-1-05 thru 12-15-05
**Notice Publication Date:**
**Rules Amended:** 635-014-0090
**Subject:** Amend rule related to increased harvest opportunity, establishment of coho salmon seasons and bag limits for specific coastal lakes.
**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-014-0090**
**Inclusions and Modifications**

(1) The **2005 Oregon Sport Fishing Regulations** provide requirements for the Northwest 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 **2005 Oregon Sport Fishing Regulations**.

(2) Siltcoos Lake and Tahkenitch Lake is open to angling for coho salmon effective October 1, 2005 through December 15, 2005. The daily bag limit is one adult coho salmon and one jack coho salmon. The annual limit, in aggregate from both lakes, is five adult coho.

(a) The waters of Siltcoos Lake is defined as that area upstream from the Highway 101 Bridge and downstream of the railroad trestle on the Maple Creek arm and the Fivemile Road crossing on the Fiddle Creek arm.

(b) The waters of Tahkenitch Lake is defined as that area upstream from the Highway 101 Bridge and downstream of the railroad trestle on the Leitel Creek arm and ODFW Marker at the bridge on the 059 road off Douglas County road 49.

(3) All other specifications and restrictions as specified in the current 2005 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.: FWC 82-1993, f. 12-22-93, cert. ef. 1-1-94; FWC 21-1994(Temp), f. 4-22-94, cert. ef. 4-25-94; FWC 31-1994, f. 5-26-94, cert. ef. 6-20-94; FWC 65-1994(Temp), f. 9-15-94, cert. ef. 9-17-94; FWC 22-1995, f. 3-7-95, cert. ef. 3-10-95; FWC 28-1995(Temp), f. 3-31-95, cert. ef. 5-1-95; FWC 34-1995, f. & cert. ef. 5-1-95; FWC 39-1995, f. 5-10-95, cert. ef. 5-12-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 19-1996, f. & cert. ef. 5-16-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 29-1996, f. & cert. ef. 5-31-96; FWC 46-1996, f. & cert. ef. 8-23-96; FWC 55-1996(Temp), f. 9-25-96, cert. ef. 10-1-96; FWC 72-1996, f. 12-31-96, cert. ef. 1-1-97; FWC 73-1996(Temp), f. 12-31-96, cert. ef. 1-1-97; FWC 5-1997, f. & cert. ef. 2-4-97; FWC 30-1997, f. & cert. ef. 5-5-97; FWC 58-1997, f. 9-8-97, cert. ef. 10-1-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 12-1998(Temp), f. & cert. ef. 2-24-98 thru 4-24-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 69-1998, f. 8-28-98, cert. ef. 9-1-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 36-1999, f. & cert. ef. 5-20-99; DFW 96-1999, f. 12-27-99, cert. ef. 1-1-00; DFW 24-2000, f. 4-28-00, cert. ef. 5-1-00; DFW 83-2000(Temp), f. 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 28-2001, f. & cert. ef. 5-1-01; DFW 40-2001(Temp) f. & cert. ef. 5-24-01 thru 11-20-01; DFW 72-2001(Temp), f. 8-10-01, cert. ef. 8-16-01 thru 12-31-01; DFW 81-2001, f. & cert. ef. 8-29-01; DFW 85-2001(Temp), f. & cert. ef. 8-30-01 thru 12-31-01; DFW 90-2001(Temp), f. 9-14-01, cert. ef. 9-15-01 thru 12-31-01; DFW 123-2001, f. 12-31-01, cert. ef. 1-1-02; DFW 5-2002(Temp) f. 1-11-02 cert. ef. 1-12-02 thru 7-11-02; DFW 26-2002, f. & cert. ef. 3-21-02; DFW 37-2002, f. & cert. ef. 4-23-02; DFW 91-2002(Temp) f. 8-19-02, cert. ef 8-20-02 thru 11-1-02 (Suspended by DFW 101-2002(Temp), f. & cert. ef. 10-3-02 thru 11-1-02); DFW 118-2002(Temp), f, 10-22-02, cert. ef. 12-1-02 thru 3-31-03; DFW 120-2002(Temp), f. 10-24-02, cert. ef. 10-26-02 thru 3-31-03; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 18-2003(Temp) f. 2-28-03, cert. ef. 3-1-03 thru 4-30-03; DFW 38-2003(Temp), f. 5-7-03, cert. ef. 5-10-03 thru 10-31-03; DFW 51-2003(Temp), f. & cert. ef. 6-13-03 thru 10-31-03; DFW 90-2003(Temp), f. 9-12-03 cert. ef. 9-13-03 thru 12-31-03; DFW 108-2003(Temp), f. 10-28-03, cert. ef. 12-1-03 thru 3-31-04; DFW 123-2003(Temp), f. 12-10-03, cert. ef. 12-11-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 126-2003(Temp), f. 12-11-03, cert. ef. 1-1-04 thru 3-31-04; DFW 60-2004(Temp), f. 6-29-04, cert. ef 7-1-04 thru 7-15-04; DFW 90-2004(Temp), f. 8-30-04, cert. ef. 10-1-04 thru 12-31-04; DFW 103-2004(Temp), f. & cert, ef, 10-4-04 thru 12-31-04; DFW 108-2004(Temp), f. & cert. ef. 10-18-04 thru 12-31-04; DFW 111-2004(Temp), f. 11-16-04, cert. ef. 11-20-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 62-2005(Temp), f. 6-29-05, cert. ef. 7-1-05 thru 7-10-05; Administrative correction 7-20-05; DFW 105-2005(Temp), f. 9-12-05, cert. ef. 10-1-05 thru 12-15-05

**Adm. Order No.:** DFW 106-2005(Temp)
**Filed with Sec. of State:** 9-14-2005
**Certified to be Effective:** 9-17-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-013-0004
**Rules Suspended:** 635-013-0004(T)
**Subject:** Amend rule to permit chinook retention during the ocean recreational salmon fishery season from Leadbetter Point, WA to Cape Falcon, Oregon.
**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-013-0004**
**Inclusions and Modifications**

(1) OAR 635-013-0005 through 635-013-0009 modify or are in addition to provisions contained in **Code of Federal Regulations**, **Title 50**, **Part 660**, **Subparts A and H**, and the **2005 Oregon Sport Fishing Regulations**.

(2) **The Code of Federal Regulations (CFR)**, **Title 50**, **Part 660**, **Subparts A and H**, and the **2005 Oregon Sport Fishing Regulations** contain requirements for sport salmon angling in the Pacific Ocean off the Oregon coast. However, additional regulations may be adopted from time to time, and, to the extent of any inconsistency, they supersede the published federal regulations and the **2005 Oregon Sport Fishing Regulations**. This means that persons must consult not only the federal regulations and the published sport fishing regulations but also the Department's web page to determine all applicable sport fishing regulations.

(3) This rule contains requirements that modify sport salmon angling regulations off the Oregon coast. The following modifications are organized in sections that apply to the ocean sport salmon fishery in general and within management zones established by the Pacific Fishery Management Council and enacted by Federal Regulations (CFR, Title 50, Part 660, Subparts A and H).

(4) Effective September 17, 2005, in the area from Leadbetter Point, WA, to Cape Falcon, OR, the salmon fishery is open seven days per week. The bag limit is two salmon per day. Minimum length requirements are 24-inches for chinook and 16-inches for coho. All retained coho must have a healed adipose fin-clip.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.146, 497.121 & 506.119
Stats. Implemented: ORS 496.004, 496.009, 496.162 & 506.129
Hist.: FWC 29-1989, f. 4-28-89, cert. ef. 5-1-89; FWC 31-1992, f. 4-29-92, cert. ef. 5-1-92; FWC 25-1994, f. & cert. ef. 5-2-94; FWC 34-1995, f. & cert. ef. 5-1-95; FWC 39-1995, f. 5-10-95, cert. ef. 5-12-95; FWC 77-1995, f. 9-13-95, cert. ef. 1-1-96; FWC 20-1996, f. & cert. ef. 4-29-96; FWC 72-1996, f. 12-21-96, cert. ef. 1-1-97; FWC 19-1997(Temp), f. 3-17-97, cert. ef. 4-15-97; FWC 30-1997, f. & cert. ef. 5-5-97; FWC 43-1997(Temp), f. 8-8-97, cert. ef. 8-10-97; FWC 75-1997, f. 12-31-97, cert. ef. 1-1-98; DFW 34-1998, f. & cert. ef. 5-4-98; DFW 59-1998(Temp), f. & cert. ef. 8-10-98 thru 8-21-98; DFW 66-1998(Temp), f. & cert. ef. 8-21-98 thru 9-24-98; DFW 100-1998, f. 12-23-98, cert. ef. 1-1-99; DFW 20-1999(Temp), f. 3-29-99, cert. ef. 4-1-99 thru 4-30-99; DFW 31-1999, f. & cert. ef. 5-3-99; DFW 61-1999(Temp), f. 8-31-99, cert. ef. 9-3-99 thru 9-17-99; DFW 66-1999(Temp), f. & cert. ef. 9-17-99 thru 9-30-99; administrative correction 11-17-99; DFW 16-2000(Temp), f. 3-31-00, cert. ef. 4-1-00 thru 4-30-00; DFW 24-2000, f. 4-28-00, cert. ef. 5-1-00; DFW 47-2000(Temp), f. 8-10-00, cert. ef. 8-13-00 thru 9-30-00; DFW 83-2000(Temp), f 12-28-00, cert. ef. 1-1-01 thru 1-31-01; DFW 1-2001, f. 1-25-01, cert. ef. 2-1-01; DFW 16-2001(Temp), f. 3-28-01, cert. ef. 4-1-01 thru 4-30-01; Administrative correction 6-20-01; DFW 59-2001(Temp), f. 7-18-01, cert. ef. 7-19-01 thru 10-31-01; DFW 20-2002(Temp), f. 3-19-02, cert. ef. 4-1-01 thru 4-30-02; DFW 75-2002(Temp), f. 7-19-02, cert. ef. 7-21-02 thru 12-31-02; DFW 80-2002(Temp), f. 7-31-02, cert. ef. 8-1-02 thru 12-31-02; DFW 85-2002(Temp), f. 8-8-02, cert. ef. 8-11-02 thru 12-31-02; DFW 99-2002(Temp) f. 8-30-02, cert. ef. 9-2-02 thru 12-31-02; DFW 100-2002(Temp), f. & cert. ef. 9-6-02 thru 12-31-02; DFW 130-2002, f. 11-21-02, cert. ef. 1-1-03; DFW 18-2003(Temp) f. 2-28-03, cert. ef. 3-1-03 thru 4-30-03; DFW 35-2003, f. 4-30-03, cert. ef. 5-1-03; DFW 69-2003(Temp), f. 7-21-03, cert. ef. 7-25-03 thru 12-31-03; DFW 78-2003(Temp), f. 8-14-03, cert .ef. 8-20-03 thru 12-31-03; DFW 125-2003, f. 12-11-03, cert. ef. 1-1-04; DFW 75-2004(Temp), f. 7-20-04, cert. ef. 7-23-04 thru 12-31-04; DFW 80-2004(Temp), f. 8-12-04, cert. ef. 8-13-04 thru 12-31-04; DFW 93-2004(Temp), f. 9-2-04, cert. ef. 9-4-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 81-2005(Temp), f. 7-25-05, cert. ef. 7-29-05 thru 12-31-05; DFW 103-2005(Temp), f. 9-7-05, cert. ef. 9-9-05 thru 12-31-05; DFW 106-2005(Temp), f. 9-14-05, cert. ef. 9-17-05 thru 12-31-05

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**Adm. Order No.:** DFW 107-2005(Temp)
**Filed with Sec. of State:** 9-14-2005
**Certified to be Effective:** 9-15-05 thru 10-31-05
**Notice Publication Date:**
**Rules Amended:** 635-039-0085
**Rules Suspended:** 635-039-0085(T)
**Subject:** Amend rules to reopen the 2005 recreational fishery for Pacific halibut as implemented by the International Pacific Halibut

Commission for the area between Cape Falcon and Humbug Mountain.

**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-039-0085**
**Halibut Seasons**

(1) The Pacific halibut sport fishery in Oregon is regulated by the federal government and the International Pacific Halibut Commission (IPHC). OAR chapter 635, division 039 incorporates into Oregon Administrative Rules, by reference, modifications or additions to provisions determined by the Commission and to the extent they are consistent with Title 50 of the **Code of Federal Regulations**, **Part 300**, **Subpart E** (**61FR35550**, **July 5**, **1996**); **Volume 70**, **Number 37**, **dated February 25**, **2005**; **Federal Regulations**, **Vol. 70**, **No. 74**, **dated April 19**, **2005** and the annual **Pacific Halibut Fishery Regulations** to determine regulations applicable to this fishery.

(2) Effective September 15, 2005, the Columbia River sub-area (Cape Falcon, OR to Leadbetter Pt., WA) is open seven days per week to the retention of Pacific halibut.

(3) The sport fishery between Cape Falcon and Humbug Mountain is open weekends, Friday through Sunday, effective August 12, 2005, to the retention of Pacific halibut.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 496.138, 496.162, 506.036, 506.109, 506.119, 506.129
Stats. Implemented: ORS 496.162 ,506.129
Hist.: DFW 56-2005, f. 6-21-05, cert. ef. 7-1-05; DFW 89-2005(Temp), f. & cert. ef. 8-12-05 thru 12-12-05; DFW 107-2005(Temp), f. 9-14-05, cert. ef. 9-15-05 thru 10-31-05

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**Adm. Order No.:** DFW 108-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 9-17-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 635-023-0130
**Rules Suspended:** 635-023-0130(T)
**Subject:** Amend rule to close the Columbia River to the retention of chinook salmon from the Tongue Point/Rocky Point line upstream to Bonneville Dam. Revision consistent with action taken at the September 14, 2005 Joint State Hearing.
**Rules Coordinator:** Marci Wightman—(503) 947-6034

**635-023-0130**
**Fall Sport Fishery**

(1) Notwithstanding, all other specifications and restrictions as outlined in the current **2005 Oregon Sport Fishing Regulations**, the following conditions apply:

(2) Effective August 1 through December 31, 2005, in the mainstem Columbia River from a north-south line through Buoy 10 upstream to a line projected from Rocky Point on the Washington bank through Red Buoy 44 to the navigation light at Tongue Point on the Oregon bank the bag limit is two salmon per day of which only one may be a chinook.

(3) The mainstem Columbia River from a line projected from Rocky Point on the Washington bank through Red Buoy 44 to the navigation light at Tongue Point on the Oregon bank upstream to Bonneville Dam is closed to the retention of chinook salmon effective 11:59 p.m., September 17, 2005.

(4) Eagle Creek upstream to the mainline railroad bridge is open for adipose fin-clipped coho salmon effective August 1 through December 31, 2005. All non-adipose fin-clipped coho salmon must be released immediately unharmed.

(5) Herman Creek upstream to the main line railroad bridge is open for adipose fin-clipped coho effective August 1 through August 15, 2005, and again from December 1 through December 31, 2005. The area west of the peninsula up to the Lower Herman Creek Pond structure is open for adipose fin-clipped coho August 1 through December 31, 2005. All non-adipose fin-clipped coho salmon must be released immediately unharmed.

[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 32-2004, f. 4-22-04, cert. ef. 5-1-04; DFW 92-2004(Temp), f. 9-2-04 cert. ef. 9-6-04 thru 12-31-04; DFW 96-2004(Temp), f. 9-20-04, cert. ef. 9-30-04 thru 12-31-04; DFW 117-2004, f. 12-13-04, cert. ef. 1-1-05; DFW 25-2005, f. & cert. ef. 4-15-05; DFW 84-2005(Temp), f. & cert. ef. 8-1-05 thru 12-31-05; DFW 108-2005(Temp), f. 9-15-05, cert. ef. 9-17-05 thru 12-31-05

## Department of Human Services, Child Welfare Programs Chapter 413

**Adm. Order No.:** CWP 10-2005
**Filed with Sec. of State:** 8-26-2005
**Certified to be Effective:** 8-27-05
**Notice Publication Date:** 8-1-05
**Rules Repealed:** 413-330-0070
**Subject:** Rule 413-330-0070 was adopted to implement contractor selection rules for the State Office for Services to Families and Children. This Office was incorporated into the Office of Children, Adults and Families (CAF) subsequent to the 2001 Department reorganization. The repeal of rule 413-330-0070 is necessary to bring Department contracting rules and procedures into compliance with Oregon Law and with DAS and Department contracting rules and procedures.
**Rules Coordinator:** Pat Bougher—(503) 945-5844

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**Adm. Order No.:** CWP 11-2005(Temp)
**Filed with Sec. of State:** 9-1-2005
**Certified to be Effective:** 9-1-05 thru 12-31-05
**Notice Publication Date:**
**Rules Suspended:** 413-080-0100, 413-080-0110, 413-080-0120, 413-080-0130, 413-080-0140, 413-080-0150
**Subject:** The current rule allows for the placement of children in relative homes which are not certified. This is in conflict with another administrative rule, policy and practice. Children in state custody need to be placed in certified homes.
**Rules Coordinator:** Annette Tesch—(503) 945-6067

**413-080-0100**
**Purpose**

These administrative rules describe family foster care services and define the criteria for appropriate foster care placements. These rules are in addition to OAR 413-030-0200 through 413-030-0220 which define the eligibility criteria for placement of a child in any kind of substitute care, including family foster care.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**413-080-0110**
**Program Description**

Family foster care services provide substitute family care for a child when the child's own family cannot provide care, or when adoption is either not in the best interest of the child or not yet possible.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**413-080-0120**
**Program Components**

(1) The child will receive care in a family home that has met the standards for certification as a foster home set forth in the administrative rules 413-200-0100 through 413-200-0230.

(2) Social services, including treatment and supportive services when appropriate, will be provided by SOSCF per OAR 413-040-0010.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**413-080-0130**
**Children for Whom Family Foster Care is Appropriate**

(1) Children with normal developmental needs and some children with special needs or problems are appropriate for family foster care. Family foster care should be utilized for children who can be maintained in a regular family setting.

(2) Family foster care may be used for a child who is unable to fit into regular family living, but can benefit from family life that has been adapted to the child's needs. Placement of such a child in family foster care is dependent upon locating foster parents who have the skill and stamina to

care for the child. Children placed in foster care with the following behaviors or attitudes shall have a written care plan, or clear guidelines of care, provided to foster parents. Such children include, but are not limited to:

(a) A child with severe health impairments or developmental disabilities requiring specialized medical and physical care who can benefit from family life;

(b) Children with diagnosed impairments who can receive day or outpatient treatment;

(c) Youth with emotional/behavioral problems who need care following residential treatment and are able to live in the community with special help;

(d) A teen mother who requires both parental guidance for herself and assistance with learning to parent her child;

(e) Delinquent children in the custody of SOSCF who can benefit from close family supervision;

(f) A child whose emotional/behavioral problems are so disturbing that they require extraordinary support, so that a family or community is unable to cope with the behavior;

(g) A child or adolescent who cannot accept parental care and guidance;

(h) A child who requires a regulated environment integrated with social treatment services and training.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**413-080-0140**
**Types of Family Foster Care**

(1) SOSCF has four types of family foster care services. Each varies in the type of child served, and in the expectations of the child, the child's parents and/or family and the foster parents. The foster care service types are:

(a) "Family Shelter Care" provided to a child who is in need of protection due to a crisis in the child's own home because of abuse or neglect, or for a child who is in SOSCF's legal custody and in need of care including, but not limited to, the following reasons: another placement failed, the child ran away, respite care;

(b) "Regular Foster Care" provided on a planned basis for a child in the legal custody of SOSCF who is not related to the foster parents;

(c) "Relative Foster Care" provided to a child in SOSCF's legal custody by a relative. SOSCF payment of foster care to a relative is limited to children who are eligible for federally matched foster care (Title IV-E/ADC-FC; (see policy I-E.6.1), or an Indian child in a relative placement. Relatives who do not receive foster care payments are not required to be certified as a foster home, but they must meet the requirements outlined in OAR 413-200-0100 through 413-200-0230;

(d) "Family Group Home Care" provided by foster parents who have been selected and contracted with SOSCF to provide a therapeutic group living situation for four or more youth. Services provided include individual and group counseling, as well as an enriched family living environment (see policy I-E.4.2.1).

(2) Family foster care may be either a reimbursed or non-reimbursed service. Non-reimbursed care, medical care only, and reimbursed care may be appropriate in the following situations:

(a) Reimbursed Care. Generally foster care is a reimbursed service and the rate is one of SOSCF's standardized reimbursement rates (see policy I-E.5.1.1). Rates that are higher than the standard rates are individually determined following the rules for special rates (see policy I-E.5.1.2). A rate that is less than the standard rate may be paid for a child in an adoptive placement or in any other foster care placement if the foster parents agree to the lower rate;

(b) Medical Services Only. Children who are appropriate for medical services only are:

(A) A child in a legal risk placement where the foster parents have indicated they do not wish to receive a foster care maintenance payment;

(B) A child in a supervised adoptive placement;

(C) An older youth who is nearly self-supporting; or

(D) A child who is temporarily away from the foster home due to hospitalization, trial home visit or runaway.

(c) Non-reimbursed Foster Care/Non-reimbursed Relative Foster Care. The foster parents of children in non-reimbursed foster care receive no compensation from SOSCF for the child's care, and the child does not receive Medicaid services based on the child's eligibility for foster care. The child's expenses are either covered by the foster parents own resources, by a public assistance program or by the child's own resources.

Stat. Auth.: HB 2004
Stats. Implemented: ORS 418.470
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**413-080-0150**
**Duration of Foster Care**

Oregon Statutes and Public Law 96-272 require that SOSCF develop and implement a permanent plan for each child that eliminates the need for legal custody to SOSCF and extended placement in foster care. A child is eligible for foster care until the child can be safely returned to the parent or legal guardian, or until the child is placed in an adoptive home according to SOSCF policy I-F.2 "Determining the Adoptability of a Child," or an alternate permanent plan is developed.

Stat. Auth.: HB 2004
Stats. Implemented: PL 96-272
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

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**Adm. Order No.:** CWP 12-2005(Temp)
**Filed with Sec. of State:** 9-12-2005
**Certified to be Effective:** 9-12-05 thru 12-31-05
**Notice Publication Date:**
**Rules Suspended:** 413-050-0100, 413-050-0110, 413-050-0120, 413-050-0130, 413-050-0140
**Subject:** These Family Resource Worker Services rules (policy #I-C.2) are being suspended due to the discontinuance of funding as recommended by the Department and approved by the 2005 Legislature.
**Rules Coordinator:** Annette Tesch—(503) 945-6067

**413-050-0100**
**Purpose**

These rules define and describe family resource worker (FRW) services; set forth the methods by which they are provided; and define the general limitations and requirements.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 12-2005(Temp), f. & cert. ef. 9-12-05 thru 12-31-05

**413-050-0110**
**Services Family Resource Workers Provide**

The major responsibility of the family resource worker is to provide an intensive support to the social service effort in order to improve the parents' homemaking skills and child care knowledge and practices, and to sustain the household functioning at a time of crisis. These services shall include:

(1) Services Related to Parent Functioning:

(a) Teaching and demonstrating the basic physical and emotional care of children;

(b) Teaching and demonstrating practical ways to care for children with special physical needs;

(c) Teaching aspects of family hygiene and nutrition;

(d) Reinforcing the instruction and training given to parents by parent trainers when families are referred for both homemaker service and parent training.

(2) Services Related to Personal, Social, and Emotional Needs of the Family:

(a) Providing appropriate emotional support to parents;

(b) Carrying out special assignments with the service worker related to other therapeutic interventions with parents or child.

(3) Service Related to Evaluation and Diagnosis of Family Strengths, and Issues of Concern:

(a) Assisting the service worker in identifying parenting, emotional or developmental strengths and concerns;

(b) Reporting to the service worker indications of treatment progress in areas of parenting, emotional growth, social maturity, and general family functioning.

(4) Services Related to Home Management. Family resource worker service is not interchangeable with housekeeper service. The family resource worker is not a provider of household tasks but a teacher of those functions. This service includes:

(a) Managing time and organizing the home;

(b) Economizing, budgeting and buying;

(c) Housekeeping and related chores.

(5) Individual Care Services. The family resource worker provides individual care only when they are trained to provide the skills required and

when such skills are needed on a time limited basis until other arrangements can be made.

(a) Caring for children and their environment when the parent is temporarily disabled and special skills are required;

(b) Providing (non-nursing) support for medical services to a parent;

(c) Performing home management functions when the parent(s) is/are unable.

(6) Services Family Resource Workers Do Not Provide. A family resource worker does not give nursing care, medical treatments, or administer oral or injectable medications. Also, general housekeeping and/or babysitting functions are by themselves considered an inappropriate use of a family resource worker's time.

(7) How Service is Provided. The service is provided in one of two ways:

(a) Through contracting with a family resource worker service agency (FRW); or

(b) Through using SOSCF's own staff.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 12-2005(Temp), f. & cert. ef. 9-12-05 thru 12-31-05

**413-050-0120**
**Eligibility**

(1) Criteria. Family resource worker service may be provided only to those families receiving SOSCF services, including foster parents, for whom family resource worker service is appropriate.

(2) Family Conditions Which Make Family Resource Worker Service Appropriate:

(a) When the parent or parents in the home are unable to provide adequate care for children because of physical or mental illness, physical handicaps or other disabilities;

(b) When there are indications of neglect and it is anticipated that with consistent help in parenting, placement of the children may be averted;

(c) When the parent or parents are inexperienced or of limited intelligence, and need training and demonstration of child care, nutrition, budgeting and housekeeping skills;

(d) When a parent requires relief from other duties and care of the other children in the family as a result of the ill or handicapping condition of a child requiring specialized medical treatment and/or special care;

(e) When foster children need emergency care because of a child's illness or because a foster parent is ill and needs assistance with the care of children and household management;

(f) When a child(ren) can be returned home from substitute care with the support of a family resource worker in the child's home;

(g) When youth need home management training upon entering the SOSCF independent living program.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 12-2005(Temp), f. & cert. ef. 9-12-05 thru 12-31-05

**413-050-0130**
**Service Priorities**

(1) Priority shall be given to families in which the service is in support of time-limited objectives to improve family functioning or maintain a family in a crisis. Normally, the service is not intended to provide long-term maintenance for a family.

(2) Incoming cases will be prioritized based on the following:

(a) Priority 1: Children who are at imminent risk of abuse or neglect. This includes any child at risk of neglect or of physical, emotional, or sexual abuse in his/her own home as substantiated by specific, reliable information which generates concern for the child's immediate safety;

(b) Priority 2: Children who are at risk of out of home placement, replacement or whose return home is imminent. This includes:

(A) Any child in his/her own home who is at risk of out-of-home placement due to conditions such as parental illness of a catastrophic nature, incarcerated parents, physically or mentally disabled child, physically disabled parents, intellectually limited parents, or parents needing assistance in coping with the child's behavior;

(B) Any child currently in foster care whose placement is jeopardized by a temporary disability, dysfunction or crisis in the substitute care situation;

(C) Any child whose return home from substitute care could be affected with the help of a family resource worker.

(c) Priority 3: Children who are not at imminent risk of abuse, neglect, out-of-home placement or replacement. This includes any child in a family which provides minimally adequate parenting and which periodically falls below community standards;

(d) Priority 4: Children in a family who meet appropriate conditions for provisions of family resource worker services, but demonstrate none of the needs described in the preceding priorities for service.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 12-2005(Temp), f. & cert. ef. 9-12-05 thru 12-31-05

**413-050-0140**
**Families Inappropriate for Referral**

Parents who have demonstrated the inability to change or to learn new behaviors by virtue of their long-term conduct or clinically diagnosed condition. Exceptions can be made in permanent planning cases when determined appropriate for service.

Stat. Auth.: HB 2004
Stats. Implemented: HB 2004
Hist.: SCF 6-1995, f. 12-22-95, cert. ef. 12-29-95; Suspended by CWP 12-2005(Temp), f. & cert. ef. 9-12-05 thru 12-31-05

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**Adm. Order No.:** CWP 13-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 9-15-05 thru 3-1-06
**Notice Publication Date:**
**Rules Amended:** 413-015-0505, 413-015-0510, 413-015-0511, 413-015-0512, 413-015-0513, 413-015-0514
**Subject:** Amending these Child Safety Assessment and Child Safety Planning rules adds that a review of a safety plan will include contact with treatment providers or staff from other agencies who are involved with any family member included in the safety plan. This must include all treatment providers or other agencies' staff who are currently working with these family members or have worked with them in the last 12 months.

Sets time lines for completing the safety plan review at critical junctures, for documenting it and for obtaining supervisory review and approval of the review and of any changes made to the safety plan.

Establishes procedures and time lines for supervisory review and approval of the child safety plan before a child is returned home.

The Initial Safety Assessments and Time Frames (413-015-0505) and Initial Safety Plan (413-015-0510) sections of the rule are being amended to clarify the intent of the existing rule.
**Rules Coordinator:** Annette Tesch—(503) 945-6067

**413-015-0505**
**Initial Safety Assessments and Time Frames**

(1) To complete a safety assessment, the CPS worker must:

(a) Make efforts to contact the child at home, school, day care, or any other place the worker believes the child may be found. If the worker is unsuccessful, the worker must document in the assessment activities section of the GAP all attempts made to contact the child and the dates of those attempted contacts.

(b) Have face-to-face contact with the child who is the subject of the referral.

(c) Have face-to-face contact with the primary parent or caregiver. If it is not possible to make contact, document why contact was not made.

(d) Determine if other children in the home are safe.

(e) Utilize the GAP and interviewing guidelines set out in OAR 413-015-0700 to 413-015-0740 to:

(A) Identify safety threats;

(B) Assess risk influences; and

(C) Assess parents' or caregivers' protective capacity.

(2) Except as provided in section (3) of this rule, the CPS worker must complete a safety assessment within the following time lines:

(a) Immediate Response: The CPS worker must complete a safety assessment within 24 hours of the time the report alleging child abuse is received by the Department.

(b) Response Required: The CPS worker must make a face-to-face contact with the child within five days of the day the report alleging child abuse is received by the Department and must complete the safety assessment without undue delay after that face-to-face contact.

(3) Exceptions:

(a) Any exception to the time lines given in section (2) of this rule requires CPS supervisor approval, written justification, and an explanation of how the child's safety needs have been considered.

(b) If the screener was granted an extension to complete the screening process, the CPS supervisor may adjust the safety assessment and CPS assessment time lines as follows:

(A) Immediate Response: The CPS worker must complete a safety assessment within 24 hours of the end date of the last screening extension or the date the CPS assessment was assigned, whichever is earlier.

(B) Response Required: The CPS worker must complete a safety assessment with five days of the end date of the last screening extension or the date the CPS assessment was assigned, whichever is earlier.

(4) Documentation requirements. The CPS worker must document, using the GAP:

(a) The initial safety assessment within five working days following face-to-face contact with a child; and

(b) The initial safety plan within the CPS assessment time frames (see OAR 413-015-0400(5)).

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 14-2004, f. 7-30-04, cert. ef. 8-1-04; CWP 17-2004, f. & cert. ef. 11-1-04; CWP 4-2005, f. & cert. ef. 2-1-05; CWP 13-2005(Temp), f. & cert. ef. 9-15-05 thru 3-1-06

**413-015-0510**
**Initial Safety Plan**

(1) Safety Plan. The CPS worker must develop and document a safety plan when a current safety threat has been identified as a result of a child safety assessment and a case is being opened. If there is adequate parental or caregiver protective capacity to mitigate the safety threat, then the documentation occurs in the assessment activities section of the GAP.

(2) The CPS worker must develop the safety plan with family participation whenever possible.

(3) The CPS worker must utilize the GAP to consider safety threats, risk influences, and parent's or caregiver's protective capacity in developing the safety plan.

(4) If the CPS worker knows or has reason to know the case involves an Indian child, the CPS worker must involve the Indian child's tribe when developing the safety plan unless the tribe declines to participate.

(5) The safety plan must contain one or both of the following elements depending on the individual safety needs of children in the family:

(a) An in-home safety plan. An in-home safety plan must be developed when the protective capacity of the parent or caregiver can be enhanced or supported to create safety for the children.

(b) An out-of-home safety plan. An out-of-home safety plan must be developed if reasonable efforts or active efforts (if applicable) have been made to prevent the removal of the child from the home and:

(A) Existing protective capacity of the parent or caregiver cannot be enhanced or supported to provide for the child's safety; or

(B) There is no parent or caregiver to provide for the child's safety needs.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 25-2003, f. & cert. ef. 7-1-03; CWP 14-2004, f. 7-30-04, cert. ef. 8-1-04; CWP 17-2004, f. & cert. ef. 11-1-04; CWP 13-2005(Temp), f. & cert. ef. 9-15-05 thru 3-1-06

**413-015-0511**
**Review of Safety Plan**

(1) The assigned worker must complete the following activities at the critical case junctures and within the time frames described in section (2):

(a) Review child safety;

(b) Review the child safety plan;

(c) Review changes to the child safety plan; and

(d) Make the following contacts:

(A) Face-to-face contact with the child;

(B) Face-to-fact contact with the custodial parent or caregiver;

(C) Contact those persons who are providing services or monitoring behaviors related to identified safety threats and either currently work with a parent or child identified in the safety plan or who have worked with such parent or child since the last safety plan review. Examples of persons who should be contacted as provided in this section are persons who provide parent training, substance abuse treatment, batterer intervention treatment, probation supervision or parole supervision.

(2) The review and contact required by section (1) must be completed by the assigned worker at the following critical case junctures:

(a) Upon completion of the CPS assessment — see OAR 413-015-0400 and 413-015-0405 for requirements for the review.

(b) Following transfer of a case to another worker — Review and contact must be completed by the receiving worker within seven calendar days immediately following the transfer.

(c) Prior to a change from supervised to unsupervised visitation — Review and contact must be completed within seven calendar days immediately prior to the change.

(d) Prior to a change in placement — Review and contact must be completed within seven calendar days immediately prior to the change.

(e) Upon a child's return home — Review and contact must be completed within three calendar days immediately following return.

(f) After a significant change in family circumstances or constellation — A significant change includes a new live-in companion or house mate, new baby, change in employment status, divorce, substance abuse relapse, mental health incident, missed medical appointment by the caregiver for a vulnerable baby, or a change in the protective capacity of a parent or caregiver. Review and contact based upon a significant change in family circumstances or constellation must be completed as follows:

(A) If the child is at home, within seven calendar days after identification of the change.

(B) If the child is in substitute care, within 30 calendar days after identification of the change.

(g) Prior to recommending dismissal of juvenile court jurisdiction — Review and contact must be completed within seven calendar days immediately prior to making a recommendation that the juvenile court dismiss jurisdiction.

(h) Prior to closure of the case — Review and contact must be completed within seven calendar days immediately prior to the closure.

(3) Child safety and the safety plan must also be reviewed anytime the child welfare caseworker has face-to-face contact with the child, including a mandatory 30-day visitation, which is governed by Child Welfare policy "Caseworker Contact with Children, Parents, and Caregivers," Policy I-B.1, OAR 413-080-0040 to 413-080-0060).

(4) The review and contact described in sections (1) and (2) of this rule must be documented in the FACIS safety plan screen within 14 calendar days after the completion of the review.

(5) The supervisor must review child safety and approve the child safety plan, including changes made to the plan, not later than the time of the documentation required by section (4) of this rule.

(6) In addition to the review and contact requirements described in this rule, child safety and the safety plan will be discussed:

(a) At each TDM, FDM, or other family meeting;

(b) At a high-risk staffing;

(c) When the case is reviewed by a Citizen Review Board; and

(d) During a juvenile court proceeding.

(7) Child's return home.

(a) Except as provided in subsection (7)(c) of this rule, a supervisor must review child safety and approve the current safety plan within seven calendar days immediately prior to the return of a child to the child's parent's home. The supervisor must--

(A) Review the identified safety threats and abusive behavior that caused the child to be placed in out-of-home care and confirm that the safety threats and abusive behaviors have been addressed;

(B) Confirm that persons providing services or monitoring behaviors related to identified safety threats that are either currently working with a parent or child identified in the safety plan or who have worked with a parent or child since the last safety plan review have been involved in the process that resulted in the decision to return a child to the child's parent's home. Examples of the persons who should be involved in the decision making process include persons who provide parent training, substance abuse treatment, batterer intervention treatment, probation supervision or parole supervision.

(C) Confirm that information from other community partners or involved agencies has been gathered, documented and considered by the caseworker as part of the decision making process.

(D) Review the current safety plans, service agreements, and most recent court orders to ensure that parents have successfully completed required services and demonstrated changes in parental behavior and home environment.

(E) Review all evaluation and treatment documents to assure that treatment recommendations have been followed, needed reports have been received and reviewed, and that there is documented change in parental protective capacity related to child safety concerns.

(F) Discuss with the caseworker the current home environment and confirm that there is documentation as to when the caseworker last visited the family to which the child is being returned. If the caseworker noted any

concerns, the supervisor must assure that there is documentation as to how the worker confirmed that the concerns have been addressed and resolved. There must also be documentation of all persons residing in the home. CPS record and criminal records checks must be obtained on all household members and reviewed.

(G) Assure that the plan for in-home supervision is appropriate and specific as to how the supervision will be executed.

(H) Document the supervisor's review and findings required by section (7) in the FACIS safety plan screen prior to the child's return home.

(b) In the event a court orders the return of a child to the child's parent's home before the supervisory review can be completed as described in section (7) of this rule, the review and documentation of the review must occur as soon as practicable, but no later than seven calendar days following the court order. In all other respects, the review must meet the requirements of subsection (7)(a).

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 17-2004, f. & cert. ef. 11-1-04; CWP 4-2005, f. & cert. ef. 2-1-05; CWP 13-2005(Temp), f. & cert. ef. 9-15-05 thru 3-1-06

**413-015-0512**
**Mandatory Reporting of New Safety Threats**

When a new or unaddressed safety threat is reported on an existing child welfare case, the following must occur:

(1) The child welfare worker who has information that indicates a new or unaddressed safety threat must make a CPS report to a screener.

(2) The screener will consult with a CPS supervisor to determine the Department's response in accordance with OAR 413-015-0200 to 413-015-0225.

(3) When the referral is assigned for a CPS assessment, the CPS worker must complete a safety assessment in accordance with OAR 413-015-0505, "Initial Safety Assessments and Time Frames," and OAR 413-015-0400 to 413-015-0410.

(4) If a new safety threat is identified, a new safety plan must be developed or the current plan revised in accordance with OAR 413-015-0510, "Initial Safety Plan."

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 17-2004, f. & cert. ef. 11-1-04; CWP 13-2005(Temp), f. & cert. ef. 9-15-05 thru 3-1-06

**413-015-0513**
**Closing a Safety Plan**

(1) The caseworker will close the safety plan when a case is being closed and services are no longer being provided because:

(a) The child is returned to the home of the child's parents and:

(A) The identified safety threats have been eliminated; or

(B) The parent's or caregiver's protective capacity can manage the identified safety threats; or

(b) A permanent plan, such as adoption or legal guardianship, has been established and return to a parent is no longer the plan.

(2) A family decision meeting will be held to determine whether identified safety threats have been addressed so that the safety plan can be closed. If a family decision meeting is not held as described in this section, supervisory approval and supporting documentation is required to explain why the meeting was not held.

(3) A supervisor must approve the closure of a safety plan. Before approving the closure, the supervisor must determine that closure is appropriate because one of the circumstances described in (1) applies, a family decision meeting has been held or there is documentation explaining why a meeting was not held and current safety threats have been addressed.

Stat. Auth.: ORS 418.005
Stats. Implemented: ORS 418.005
Hist.: CWP 17-2004, f. & cert. ef. 11-1-04; CWP 13-2005(Temp), f. & cert. ef. 9-15-05 thru 3-1-06

**413-015-0514**
**Use of Team Decision Meetings (TDMs)**

(1) A TDM is used by DHS staff to gather information for making a child placement decision. Except as provided in section (3) of this rule, a TDM must be held:

(a) When a child is about to be or has been initially placed in substitute care:

(A) Prior to placement of the child;

(B) Within 24 hours of an emergency placement; or

(C) On the next working day after a placement occurs during an evening, holiday, or weekend.

(b) Before the child is returned to the home of the parent.

(2) The following requirements apply to the use of TDMs:

(a) The DHS staff retains final responsibility for assessing child safety and approving the safety plan.

(b) Each TDM must include a review of the identified safety threats and the safety plan.

(c) A supervisor or a staff person other than the caseworker, designated by a supervisor, must attend a TDM held to determine the initial placement for a child.

(3) If a TDM is not held as required by section (1) of this rule, supervisory approval and supporting documentation are required to explain why the TDM was not held.

(4) A supervisor must review the identified safety threats and abusive behavior and confirm that the safety threats and abusive behaviors have been addressed in the safety plan developed in a TDM and approve the safety plan before a placement is made or a child is returned home. Supervisory approval of the plan must be documented on the TDM notes.

Stat. Auth.: 418.005
Stats. Implemented: 418.005
Hist.: CWP 17-2004, f. & cert. ef. 11-1-04; CWP 13-2005(Temp), f. & cert. ef. 9-15-05 thru 3-1-06

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

**Adm. Order No.:** OMAP 38-2005
**Filed with Sec. of State:** 8-26-2005
**Certified to be Effective:** 8-27-05
**Notice Publication Date:** 8-1-05
**Rules Repealed:** 410-003-0000, 410-003-0001, 410-003-0002, 410-003-0003
**Subject:** Rules 410-003-0000, 410-003-0001, 410-003-0002 and 410-003-0003 were adopted to establish contracting practices for businesses functioning as public bodies. The repeal of these rules is an administrative consistency measure due to the fact these rules expired December 31, 1978, yet remain in the public rules for Chapter 410.
**Rules Coordinator:** Pat Bougher—(503) 945-5844

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**Adm. Order No.:** OMAP 39-2005
**Filed with Sec. of State:** 9-2-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Adopted:** 410-120-0025, 410-120-1395, 410-120-1397, 410-120-1505, 410-120-1510, 410-120-1855
**Rules Amended:** 410-120-0000, 410-120-0250, 410-120-1140, 410-120-1160, 410-120-1180, 410-120-1195, 410-120-1200, 410-120-1210, 410-120-1230, 410-120-1260, 410-120-1280, 410-120-1300, 410-120-1320, 410-120-1340, 410-120-1350, 410-120-1360, 410-120-1380, 410-120-1385, 410-120-1390, 410-120-1400, 410-120-1460, 410-120-1560, 410-120-1570, 410-120-1580, 410-120-1600, 410-120-1680, 410-120-1700, 410-120-1860, 410-120-1865, 410-120-1870, 410-120-1875, 410-120-1880, 410-120-1920, 410-120-1940, 410-120-1960, 410-120-1980
**Rules Repealed:** 410-120-1290, 410-120-1420, 410-120-1440, 410-120-1480, 410-120-1500, 410-120-1520, 410-120-1540, 410-120-1565, 410-120-1640, 410-120-1660, 410-120-1685, 410-120-1720, 410-120-1820
**Subject:** The General Rules program administrative rules govern the Office of Medical Assistance Programs' payment for services rendered to clients. Nearly all 410-120 rules are affected by this filing. The following is a short description of the permanent amendments:

**Adoptions:** 410-120-0025: administration framework for the medical assistance programs and interrelationships between managed care contractors, their participating providers and OMAP's fee-for-service providers. 410-120-1395: program integrity activities related to medical assistance programs. 410-120-1397: overpayment recovery, recoupment activities and added text from other repealed rules. 410-120-1505: program audit parameters, requirements and processes and text from repealed rule. 410-120-1510: federal regu-

lations governing fraud and abuse. 410-120-1855: OMAP clients' rights and responsibilities.

**Amendments:** 410-120-0000: to add numerous definitions and clarify emergency transportation; 410-120-1160: provider responsibility for compliance with OMAP rules, and Office of Mental Health and Addiction Services (OMHAS) responsibility for alcohol and drug inpatient hospital services; 410-120-1200: exclusion of clinical trials and demonstration projects and exceptions to exclusion of DHS' waivered Home and Community Based personal care services; 410-120-1260: enrollment responsibilities as a result of the National Provider Identification (NPI) and Electronic Data Interchange (EDI) rules required by Health Insurance Portability and Accountability Act (HIPAA); 410-120-1280: billing practices affected by NPI and EDI requirements; 410-120-1320: payment authorization in relationship to client's benefit package; 410-120-1340: payment practices affected by NPI and EDI requirements, and medical assistance programs applicable rate setting; 410-120-1380: to include contractual requirements applicable to OMAP enrolled providers; 410-120-1460: OMAP's ability to immediately suspend an enrolled provider's billing where public harm or inappropriate expenditure dictates, and add text from repealed rules; 410-120-1400, 410-120-1560 and 410-120-1600: to add text from repealed rules. Most rules will be amended to take care of necessary housekeeping corrections.

**Repeals:** Most text still exists in other rules.

**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-120-0000**
**Acronyms and Definitions**

(1) AAA — Area Agency on Aging.

(2) Abuse — Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Office of Medical Assistance Programs (OMAP), or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to OMAP.

(3) Acupuncturist — A person licensed to practice acupuncture by the relevant State Licensing Board.

(4) Acupuncture Services — Services provided by a licensed Acupuncturist within the scope of practice as defined under state law.

(5) Acute — A condition, diagnosis or illness with a sudden onset and which is of short duration.

(6) Acquisition Cost — Unless specified otherwise in individual program administrative rules, the net invoice price of the item, supply or equipment, plus any shipping and/or postage for the item.

(7) Adequate Record Keeping — Documentation that supports the level of service billed. See 410-120-1360, Requirements for Financial, Clinical, and Other Records, and the individual Provider rules.

(8) Administrative Medical Examinations and Reports — Examinations, evaluations, and reports, including copies of medical records, requested on the OMAP 729 form through the local Department of Human Services (DHS) branch office or requested or approved by OMAP to establish Client eligibility for a medical assistance program or for casework planning.

(9) All Inclusive Rate — The nursing facility rate established for a facility. This rate includes all services, supplies, drugs and equipment as described in OAR 411-070-0085, and in the Pharmaceutical Services and the Home Enteral/Parenteral Nutrition and IV Services Provider rules, except as specified in OAR 410-120-1340, Payment.

(10) Allied Agency — Local and regional governmental agencies and regional authorities that contract with DHS to provide the delivery of services to covered individual. (e.g., local mental health authority, community mental health program, Oregon Youth Authority, Department of Corrections, local health departments, schools, education service districts, developmental disability service programs, area agencies on aging, federally recognized American Indian tribes).

(11) Ambulance — A specially equipped and licensed vehicle for transporting sick or injured persons which meets the licensing standards of DHS or the licensing standards of the state in which the Provider is located.

(12) Ambulatory Surgical Center (ASC) — A facility licensed as an ASC by DHS.

(13) American Indian/Alaska Native (AI/AN) — A member of a federally recognized Indian tribe, band or group, an Eskimo or Aleut or other Alaska native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601, or a person who is considered by the Secretary of the Interior to be an Indian for any purpose.

(14) American Indian/Alaska Native clinic — Clinics recognized under Indian Health Services (IHS) law or by the Memorandum of Agreement between IHS and the Centers for Medicare and Medicaid (CMS).

(15) Ancillary Services — Services supportive of or necessary to the provision of a primary service (e.g., anesthesiology is an ancillary service necessary for a surgical procedure).

(16) Anesthesia Services — Administration of anesthetic agents to cause loss of sensation to the body or body part.

(17) Atypical Provider — Entity able to enroll as a Billing Provider or performing Provider for medical assistance programs related non-health care services but which does not meet the definition of health care Provider for National Provider Identification (NPI) purposes.

(18) Audiologist — A person licensed to practice audiology by the State Board of Examiners for Speech Pathology and Audiology.

(19) Audiology — The application of principles, methods and procedures of measurement, testing, appraisal, prediction, consultation, counseling and instruction related to hearing and hearing impairment for the purpose of modifying communicative disorders involving speech, language, auditory function, including auditory training, speech reading and hearing aid evaluation, or other behavior related to hearing impairment.

(20) Automated Information System (AIS) — A computer system that provides information on Clients' current eligibility status from the Office of Medical Assistance Programs (OMAP) by computerized phone or Web-based response.

(21) Benefit Package — The package of covered health care services for which the Client is eligible.

(22) Billing Agent or Billing Service — Third party or organization that contracts with a Provider to perform designated services in order to facilitate an EDI transaction on behalf of the Provider.

(23) Billing Provider (BP) — A person, agent, business, corporation, clinic, group, institution, or other entity who submits claims to and/or receives payment from OMAP on behalf of a performing Provider and has been delegated the authority to obligate or act on behalf of the performing Provider.

(24) Buying Up — The practice of obtaining Client payment in addition to the OMAP or managed care plan payment to obtain a non-covered service or item. (See 410-120-1350 Buying Up)

(25) By Report (BR) — Services designated, as BR require operative or clinical and other pertinent information to be submitted with the billing as a basis for payment determination. This information must include an adequate description of the nature, and extent of need for the procedure. Information such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care will facilitate evaluation.

(26) Children, Adults and Families (CAF) — An office within DHS, responsible for administering self-sufficiency and child-protective programs;

(27) Children's Health Insurance Program (CHIP) — A federal and state funded portion of the Oregon Health Plan established by Title XXI of the Social Security Act and administered by OMAP.

(28) Chiropractor — A person licensed to practice chiropractic by the relevant State Licensing Board.

(29) Chiropractic Services — Services provided by a licensed Chiropractor within the scope of practice, as defined under State law and Federal regulation.

(30) Citizen/Alien-Waived Emergency Medical (CAWEM) — Aliens granted lawful temporary resident status, or lawful permanent resident status under the Immigration and Nationality Act, are eligible only for emergency services and limited service for pregnant women. Emergency Services for CAWEM are defined in OAR 410-120-1200 (3)(e).

(31) Claimant — a person who has requested a hearing.

(32) Client — A person who is currently receiving medical assistance (also known as a Recipient).

(33) Clinical Social Worker — A person licensed to practice clinical social work pursuant to State law.

(34) Contiguous Area — The area up to 75 miles outside the border of the State of Oregon.

(35) Contiguous Area Provider — A Provider practicing in a contiguous area.

(36) Copayments — The portion of a claim or medical, dental or pharmaceutical expense that a Client must pay out of their own pocket to a Provider or a facility for each service. It is usually a fixed amount that is paid at the time service is rendered. (See 410-120-1230 Client Copayment)

(37) Cost Effective — The lowest cost health care service or item that, in the judgment of OMAP staff or its contracted agencies, meets the medical needs of the Client.

(38) Current Dental Terminology (CDT) — A listing of descriptive terms identifying dental procedure codes used by the American Dental Association.

(39) Current Procedural Terminology (CPT) — The Physicians' Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health care Providers.

(40) Date of Receipt of a Claim — The date on which OMAP receives a claim, as indicated by the Internal Control Number (ICN) assigned to a claim. Date of Receipt is shown as the Julian date in the 5th through 7th position of the ICN.

(41) Date of Service — The date on which the Client receives medical services or items, unless otherwise specified in the appropriate Provider rules. For items that are mailed or shipped by the Provider, the date of service is the date on which the order was received, the date on which the item was fabricated, or the date on which the item was mailed or shipped.

(42) Dental Emergency Services — Dental Services provided for severe tooth pain, unusual swelling of the face or gums, or an avulsed tooth.

(43) Dental Services — Services provided within the scope of practice as defined under State law by or under the supervision of a Dentist.

(44) Dentist — A person licensed to practice dentistry pursuant to State law of the state in which he/she practices dentistry, or a person licensed to practice dentistry pursuant to Federal law for the purpose of practicing dentistry as an employee of the Federal government.

(45) Denturist — A person licensed to practice denture technology pursuant to State law.

(46) Denturist Services — Services provided, within the scope of practice as defined under State law, by or under the personal supervision of a denturist.

(47) Dental Hygienist — A person licensed to practice hygiene under the direction of a licensed professional within the scope of practice pursuant to State law.

(48) Dental Hygienist with Limited Access Certification (LAC) — A person licensed to practice dental hygiene with LAC pursuant to State law.

(49) Department — DHS or its Office of Medical Assistance Programs.

(50) Department of Human Services (DHS) — The Oregon Department of Human Services or any of its programs or offices.

(51) Department Representative — A person who represents the Department in a hearing and presents the Department's position.

(52) Diagnosis Code — As identified in the ICD-CM, the primary diagnosis code is shown in all billing claims, unless specifically excluded in individual Provider rule(s). Where they exist, diagnosis codes shall be shown to the degree of specificity outlined in OAR 410-120-1280, Billing.

(53) Diagnosis Related Group (DRG) — A system of classification of diagnoses and procedures based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM).

(54) Durable Medical Equipment (DME) and Medical Supplies — Equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose. Examples include wheelchairs, respirators, crutches and custom built orthopedic braces. Medical supplies are non-reusable items used in the treatment of illness or injury. Examples of medical supplies include diapers, syringes, gauze bandages and tubing.

(55) Electronic Data Interchange (EDI) – The exchange of business documents from application to application in a federally mandated format or, if no federal standard has been promulgated, such other format as Oregon DHS will designate.

(56) EDI Submitter — The entity that establishes an electronic connection with Oregon DHS to submit or receive an electronic data transaction on behalf of a Provider.

(57) Electronic Eligibility Verification Service (EEVS) — Vendors of medical assistance eligibility information that have met the legal and technical specifications of OMAP in order to offer eligibility information to enrolled Providers of OMAP.

(58) Emergency Department — The part of a licensed hospital facility open 24 hours a day to provide care for anyone in need of emergency treatment.

(59) Emergency Medical Services — (This definition does not apply to Clients with CAWEM benefit package. CAWEM emergency services are governed by OAR 410-120-1210 (3)(e)(B)). The health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of both the woman and her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. If an emergency medical condition is found to exist, emergency medical services necessary to stabilize the condition must be provided. This includes all treatment that may be necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the Client or transfer of the Client to another facility.

(60) Emergency Transportation — Transportation necessary when a sudden, unexpected Emergency Medical Service creates a medical crisis requiring a skilled medical professional such as an Emergency Medical Technician (EMT) and immediate transport to a site, usually a hospital, where appropriate emergency medical service is available.

(61) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT; also Medicheck) — The Title XIX program of Early and Periodic Screening, Diagnosis and Treatment Services for eligible Clients under age 21. It is a comprehensive child health program to assure the availability and accessibility of required medically appropriate health care services and to help OMAP Clients and their parents or guardians effectively use them.

(62) False Claim — A claim that a Provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and such inaccurate or misleading information would result, or has resulted, in an overpayment.

(63) Family Planning — Services for Clients of child bearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(64) Federally Qualified Health Center (FQHC) — A federal designation for a medical entity which receives grants under Section 329, 330, or 340 of the Public Health Service Act; or a facility designated as a FQHC by the Centers for Medicare and Medicaid Services (CMS) upon recommendation of the U.S. Public Health Service.

(65) Fee-for-Service Provider — A medical Provider who is not reimbursed under the terms of an OMAP contract with a Prepaid Health Plan (PHP), also referred to as a managed care organization (MCO). A medical Provider participating in a PHP may be considered a Fee-for-Service Provider when treating Clients who are not enrolled in a PHP.

(66) Fraud — An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(67) General Assistance (GA) — Medical Assistance administered and funded 100% with State of Oregon funds through the Oregon Health Plan.

(68) Healthcare Common Procedure Coding System (HCPCS) — A method for reporting health care professional services, procedures, and supplies. HCPCS consists of the Level l — American Medical Association's Physician's Current Procedural Terminology (CPT), Level II — National codes, and Level III — Local codes. OMAP uses HCPCS codes; however, OMAP uses Current Dental Terminology (CDT) codes for the reporting of dental care services and procedures.

(69) Health Maintenance Organization (HMO) — A public or private health care organization which is a federally qualified HMO under Section 1310 of the U.S. Public Health Services Act. HMOs provide health care services on a capitated, contractual basis.

(70) Hearing Aid Dealer — A person licensed by the Board of Hearing Aid Dealers to sell, lease or rent hearing aids in conjunction with the evaluation or measurement of human hearing and the recommendation, selection, or adaptation of hearing aids.

(71) Home Enteral Nutrition — Services provided in the Client's place of residence to an individual who requires nutrition supplied by tube into the gastrointestinal tract, as described in the Home Enteral/Parenteral Nutrition and IV Services Provider rules.

(72) Home Health Agency — A public or private agency or organization which has been certified by Medicare as a Medicare Home Health Agency and which is licensed by DHS as a Home Health Agency in

Oregon, and meets the capitalization requirements as outlined in the Balanced Budget Act (BBA) of 1997.

(73) Home Health Services — Part-time or intermittent skilled nursing services, other therapeutic services (physical therapy, occupational therapy, speech therapy), and home health aide services made available on a visiting basis in a place of residence used as the Client's home.

(74) Home Intravenous (IV) Services — Services provided in the Client's place of residence to an individual who requires that medication (antibiotics, analgesics, chemotherapy, hydrational fluids, or other intravenous medications) be administered intravenously as described in the Home Enteral/Parenteral Nutrition and IV Services rules.

(75) Home Parenteral Nutrition — Services provided in the Client's residence to an individual who is unable to absorb nutrients via the gastrointestinal tract, or for other medical reasons, requires nutrition be supplied parenterally as described in the Home Enteral/Parenteral Nutrition and IV Services rules.

(76) Hospice — a public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare, accredited by the Oregon Hospice Association, and is listed in the Hospice Program Registry.

(77) Hospital — A facility licensed by the Office of Public Health Systems as a general hospital which meets requirements for participation in the OHP under Title XVIII of the Social Security Act. Facilities licensed as Special Inpatient Care Facilities under the Office of Public Health System's definition of hospital are not considered hospitals by OMAP for reimbursement purposes; however, effective April 1, 2000, OMAP will reimburse a Special Inpatient Care Facility if the Centers for Medicare and Medicaid has certified the facility for participation in the Medicare Program as a Hospital. Out-of-state hospitals will be considered Hospitals for reimbursement purposes if they are licensed as an acute care or general hospital by the appropriate licensing authority within that state, and if they are enrolled as a Provider of hospital services with the Medicaid agency within that state.

(78) Hospital-Based Professional Services — Professional services provided by licensed practitioners or staff based on a contractual or employee/employer relationship and reported as a cost on the Hospital Statement of Reasonable Cost report for Medicare and the Calculation of Reasonable Cost (OMAP 42) report for the Office of Medical Assistance Programs.

(79) Hospital Laboratory — A Laboratory providing professional technical Laboratory Services as outlined under Laboratory Services, in a Hospital setting, as either an Inpatient or Outpatient Hospital service whose costs are reported on the Hospital's cost report to Medicare and to OMAP.

(80) ICD-9-CM — The ninth revision of the International Classification of Diseases Clinical Modification, including volumes 1, 2, and 3, as revised annually.

(81) Indian Health Program — Any Indian Health Service facility, any Federally recognized Tribe or Tribal organization, or any Federally Qualified Health Clinic (FQHC) with a 638 designation.

(82) Individual Adjustment Request — Form OMAP 1036 used to resolve an incorrect payment on a previously paid claim, including underpayments or overpayments.

(83) Inpatient — a hospital patient who is not an Outpatient.

(84) Inpatient Hospital Services — Services that are furnished in a Hospital for the care and treatment of an inpatient. (See Hospital Services rules for Inpatient covered services.)

(85) Institutional Level of Income Standards (ILIS) — Three times the amount SSI pays monthly to a person who has no other income and who is living alone in the community. This is the standard used for Medicaid eligible individuals to calculate eligibility for long-term nursing care in a Nursing Facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and individuals on ICF/MR waivers or eligibility for services under Seniors and People with Disabilities' Home and Community Based Waiver.

(86) Institutionalized — A patient admitted to a Nursing Facility or Hospital for the purpose of receiving nursing and/or hospital care for a period of 30 days or more.

(87) Laboratory — A facility licensed under ORS 438 and certified by the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services, DHHS, as qualified to participate under Medicare, to provide Laboratory Services within or a part from a hospital. An entity is considered a Laboratory if materials are derived from the human body for the purpose of providing information for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of, human beings. If an entity performs even one Laboratory test, including waived tests for these purposes, it is considered under the Clinical Laboratory Improvement Act (CLIA), to be a Laboratory.

(88) Laboratory Services — Those professional and technical diagnostic analyses of blood, urine, and tissue ordered by a physician or other licensed practitioner of the healing arts within his/her scope of practice as defined under State law and provided to a patient by or under the direction of a Physician or appropriate licensed practitioner in an office or similar facility, Hospital, or independent Laboratory.

(89) Licensed Direct Entry Midwife — A practitioner licensed by the Oregon Health Division as a Licensed Direct Entry Midwife.

(90) Liability Insurance — Insurance that provides payment based on legal liability for injuries or illness. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowner's liability insurance, malpractice insurance, product liability insurance, Worker's Compensation, and general casualty insurance. It also includes payments under state wrongful death statutes that provide payment for medical damages.

(91) Managed Care Organization (MCO) – Contracted health delivery system providing capitated or prepaid health services, also known as a Prepaid Health Plan (PHP). An MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law. An MCO may be a Chemical Dependency Organization (CDO), Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Mental Health Organization (MHO), or Physician Care Organization (PCO).

(92) Maternity Case Management — A program available to pregnant Clients. The purpose of Maternity Case Management is to extend prenatal services to include non-medical services, which address social, economic and nutritional factors. For more information refer to the Medical-Surgical Services rules.

(93) Medicaid — A federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act, as amended, administered in Oregon by the Department of Human Services.

(94) Medical Assistance Eligibility Confirmation — Verification through the Automated Information System (AIS), an authorized DHS representative, an authorized electronic eligibility vendor (EEVS) or through presentation of a valid Medical Care Identification that a Client has an open assistance case, which includes medical benefits.

(95) Medical Services — Care and treatment provided by a licensed medical Provider directed at preventing, diagnosing, treating or correcting a medical problem.

(96) Medical Transportation — Transportation to or from covered Medical Services.

(97) Medically Appropriate — Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an Oregon Health Plan Client or a Provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies which can be safely provided to an OMAP Client or PCM Member in the PHP's or Primary Care Manager's judgment.

(98) Medicare — A federally administered program offering health insurance benefits for persons aged 65 or older and certain other aged or disabled persons. This program includes:

(a) Hospital Insurance (Part A) for inpatient services in a Hospital or skilled Nursing Facility, home health care, and Hospice care; and

(b) Medical Insurance (Part B) for physicians' services, outpatient hospital services, home health care, end-stage renal dialysis, and other Medical Services and supplies.

(99) Medicheck for Children and Teens — See Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

(100) National Provider Identification – Federally directed Provider number mandated for use on HIPAA covered transactions; individuals, Provider Organizations and Subparts of Provider Organizations that meet the definition of health care Provider (45 CFR 160.103) and who conduct HIPAA covered transactions electronically are eligible to apply for an NPI; Medicare covered entities are required to apply for an NPI.

(101) Naturopath — A person licensed to practice naturopathy pursuant to State law.

(102) Naturopathic Services — Services provided within the scope of practice as defined under State law.

(103) Non Covered Services — Services or items for which OMAP is not responsible for payment. Non-covered services are identified in:

(a) OAR 410-120-1200, Medical Assistance Benefits: Excluded Services and Limitations; and

(b) 410-120-1210, Benefit packages;

(c) 410-141-0480, Benefit Package of Covered Services;

(d) 410-141-0520, Prioritized List of Health Services; and

(e) The individual OMAP Provider rules.

(104) Nurse Anesthetist, C.R.N.A. — A registered nurse licensed in the State of Oregon who is currently certified by the American Association of Nurse Anesthetists Council on Certification.

(105) Nurse Practitioner — A person licensed as a registered nurse and certified by the Board of Nursing to practice as a nurse practitioner pursuant to State law.

(106) Nurse Practitioner Services — Services provided within the scope of practice of a Nurse Practitioner as defined under State law and by rules of the Board of Nursing.

(107) Nursing Facility — A facility licensed and certified by the DHS Seniors and People with Disabilities as defined in 411-070-0005.

(108) Nursing Services — Health care services provided to a patient by a registered professional nurse or a licensed practical nurse under the direction of a licensed professional within the scope of practice as defined by State law.

(109) Nutritional Counseling — Counseling which takes place as part of the treatment of a person with a specific condition, deficiency or disease such as diabetes, hypercholesterolemia, or phenylketonuria.

(110) Occupational Therapist — A person licensed by the State Board of Examiners for Occupational Therapy.

(111) Occupational Therapy — The functional evaluation and treatment of individuals whose ability to adapt or cope with the task of living is threatened or impaired by developmental deficiencies, physical injury or illness, aging process, or psychological disability; the treatment utilizes task-oriented activities to prevent or correct physical and emotional difficulties or minimize the disabling effect of these deficiencies on the life of the individual.

(112) Office of Medical Assistance Programs (OMAP) — An Office within DHS; OMAP is responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan (OHP) Medicaid demonstration, the State Children's Health Insurance Program (SCHIP -Title XXI), and several other programs

(113) Office of Mental Health and Addiction Services (OMHAS) — An Office within the Oregon Department of Human Services administering mental health and addiction programs and services.

(114) Optometric Services — Services provided, within the scope of practice of optometrists as defined under State law.

(115) Optometrist — A person licensed to practice optometry pursuant to State law.

(116) Oregon Medical Professional Review Organization (OMPRO) — OMPRO is the Oregon Professional Review Organization for Medicare and contracts with OMAP to provide Hospital utilization review and other services for the medical assistance programs. A Professional Review Organization is an organization established under federal law by the Department of Health and Human Services for the purpose of utilization review and quality assurance.

(117) Oregon Youth Authority (OYA) — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(118) Out-of-State Providers — Any Provider located outside the borders of Oregon:

(a) Contiguous area Providers are those located no more than 75 miles from the border of Oregon;

(b) Non-contiguous area Providers are those located more than 75 miles from the borders of Oregon.

(119) Outpatient — a Hospital patient who:

(a) Is treated and released the same day or is admitted to the Hospital and discharged before midnight and is not listed on the following day's census, excluding a patient who:

(A) Is admitted and transferred to another acute care Hospital on the same day;

(B) Expires on the day of admission; or

(C) Is born in the Hospital.

(b) Is admitted for ambulatory surgery, to a birthing center, a treatment or observation room, or a short-term stay bed;

(c) Receives observation services provided by a Hospital, including the use of a bed and periodic monitoring by Hospital nursing or other staff for the purpose of evaluation of a patient's medical condition for a maximum of 48 hours; or

(d) Receives routine preparation services and recovery for diagnostic services provided in a Hospital Outpatient department.

(120) Outpatient Hospital Services — Services that are furnished in a Hospital for the care and treatment of an Outpatient. (See Hospital rules for Outpatient covered services).

(121) Overdue Claim — A valid claim that is not paid within 45 days of the date it was received.

(122) Overpayment — Payment(s) made by OMAP to a Provider in excess of the correct OMAP payment amount for a service. Overpayments are subject to repayment to OMAP.

(123) Overuse — Use of medical goods or services at levels determined by OMAP medical staff and/or medical consultants to be medically unnecessary or potentially harmful.

(124) Panel — The Hearing Officer Panel established by section 3, chapter 849, Oregon Laws 1999.

(125) Payment Authorization — Authorization granted by the responsible DHS agency, office or organization for payment prior or subsequent to the delivery of services, as described in these General Rules and the appropriate program rules. See the individual program rules for services requiring authorization.

(126) Pharmaceutical Services — Services provided by a Pharmacist, including medications dispensed in a pharmacy upon an order of a licensed practitioner prescribing within his/her scope of practice.

(127) Pharmacist — A person licensed to practice pharmacy pursuant to state law.

(128) Physical Capacity Evaluation — An objective, directly observed measurement of a person's ability to perform a variety of physical tasks combined with subjective analysis of abilities of the person.

(129) Physical Therapist — A person licensed by the relevant State licensing authority to practice physical therapy.

(130) Physical Therapy — Treatment comprising exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental disability, or the performance of tests as an aid to the assessment, diagnosis or treatment of a human being. Physical Therapy shall not include radiology or electrosurgery.

(131) Physician — A person licensed to practice medicine pursuant to state law of the state in which he/she practices medicine, or a person licensed to practice medicine pursuant to federal law for the purpose of practicing medicine under a contract with the federal government.

(132) Physician Assistant — A person licensed as a Physician Assistant in accordance with ORS 677. Physician Assistants provide Medical Services under the direction and supervision of an Oregon licensed physician according to a practice description approved by the Board of Medical Examiners.

(133) Physician Services — Services provided, within the scope of practice as defined under state law, by or under the personal supervision of a physician.

(134) Podiatric Services — Services provided within the scope of practice of podiatrists as defined under state law.

(135) Podiatrist — A person licensed to practice podiatric medicine pursuant to state law.

(136) Post-Payment Review — Review of billings and/or other medical information for accuracy, medical appropriateness, level of service or for other reasons subsequent to payment of the claim.

(137) Practitioner — A person licensed pursuant to state law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(138) Premium Sponsorship — Premium donations made for the benefit of one or more specified Office of Medical Assistance Programs (OMAP) Clients (See 410-120-1390).

(139) Prepaid Health Plan (PHP) – A managed health, dental, chemical dependency, or mental health organization that contracts with OMAP and/or OMHAS on a case managed, prepaid, capitated basis under the Oregon Health Plan. PHP's may be a Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO), or Physician Care Organization (PCO)

(140) Primary Care Physician — A Physician who has responsibility for supervising, coordinating and providing initial and primary care to

patients, initiating referrals for consultations and specialist care, and maintaining the continuity of patient care.

(141) Primary Care Provider (PCP) — Any enrolled medical assistance Provider who has responsibility for supervising, coordinating, and providing initial and primary care within their scope of practice for identified Clients. PCPs initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of Medically Appropriate Client care.

(142) Prior Authorization (PA) — Payment Authorization for specified medical services or items given by OMAP staff, or its contracted agencies prior to provision of the service. A Physician referral is not a Prior Authorization.

(143) Prioritized List of Health Services — Also referred to as the Prioritized List, the Oregon Health Services Commission's (HSC) listing of health services with "expanded definitions" of Ancillary Services and Preventive Services and the HSC's practice guidelines, as presented to the Oregon Legislative Assembly. The Prioritized List is generated and maintained by HSC. The Prioritized List governs medical assistance programs' health services and benefit packages pursuant to these General Rules (OAR 410-120-0000 et seq. and OAR 410-141-0480 through 410-141-0520).

(144) Private Duty Nursing Services — Nursing services provided within the scope of license by a registered nurse or a licensed practical nurse, under the general direction of the patient's Physician to an individual who is not in a health care facility.

(145) Provider — An individual, facility, institution, corporate entity, or other organization which supplies health care services or items, also termed a performing Provider, or bills, obligates and receives reimbursement on behalf of a performing Provider of services, also termed a Billing Provider. The term Provider refers to both Performing Providers and Billing Providers unless otherwise specified.

(146) Provider Organization — a group practice, facility, or organization that is:

(a) An employer of a Provider, if the Provider is required as a condition of employment to turn over fees to the employer; or

(b) The facility in which the service is provided, if the Provider has a contract under which the facility submits claims; or

(c) A foundation, plan, or similar organization operating an organized health care delivery system, if the Provider has a contract under which the organization submits the claim; and

(d) Such group practice, facility, or organization is enrolled with DHS, and payments are made to the group practice, facility or organization.

(e) If such entity solely submits billings on behalf of Providers and payments are made to each Provider, then the entity is an agent.

(See Subparts of Provider Organization)

(147) Public Health Clinic — A clinic operated by county government.

(148) Public Rates — The charge for services and items that Providers, including Hospitals and Nursing Facilities, made to the general public for the same service on the same date as that provided to OMAP Clients.

(149) Qualified Medicare Beneficiary (QMB) — A Medicare beneficiary, as defined by the Social Security Act and its amendments.

(150) Qualified Medicare and Medicaid Beneficiary (QMM) — A Medicare Beneficiary who is also eligible for OMAP coverage.

(151) Radiological Services — Those professional and technical radiological and other imaging services for the purpose of diagnosis and treatment ordered by a physician or other licensed practitioner of the healing arts within the scope of practice as defined under state law and provided to a patient by or under the direction of a physician or appropriate licensed practitioner in an office or similar facility, hospital, or independent radiological facility.

(152) Recipient — A person who is currently eligible for medical assistance (also known as a Client).

(153) Recoupment — An accounts receivable system that collects money owed by the Provider to OMAP by withholding all or a portion of a Provider's future payments.

(154) Referral — The transfer of total or specified care of a Client from one Provider to another. As used by OMAP, the term Referral also includes a request for a consultation or evaluation or a request or approval of specific services. In the case of Clients whose medical care is contracted through a Prepaid Health Plan (PHP), or managed by a Primary Care Physician, a referral is required before non-emergency care is covered by the PHP or OMAP.

(155) Remittance Advice (RA) — The automated notice a Provider receives explaining payments or other claim actions. It is the only notice sent to Providers regarding claim actions.

(156) Request for Hearing — A clear expression, in writing, by an individual or representative that the person wishes to appeal a Department decision or action and wishes to have the decision considered by a higher authority.

(157) Retroactive Medical Eligibility — Eligibility for medical assistance granted to a Client retroactive to a date prior to the Client's application for medical assistance.

(158) Sanction — An action against Providers taken by OMAP in cases of Fraud, misuse or Abuse of OMAP requirements.

(159) School Based Health Service — A health service required by an Individualized Education Plan (IEP) during a child's education program which addresses physical or mental disabilities as recommended by a Physician or other licensed Practitioner.

(160) Seniors and People with Disabilities (SPD) — An Office of the Oregon Department of Human Services responsible for the administration of programs for seniors and people with disabilities.

(161) Service Agreement — An agreement between the OMAP and a specified Provider to provide identified services for a specified rate. Service agreements may be limited to services required for the special needs of an identified Client. Service Agreements do not preclude the requirement for a Provider to enroll as a Provider.

(162) Sliding Fee Schedule — A fee schedule with varying rates established by a Provider of health care to make services available to indigent and low-income individuals. The Sliding Fee Schedule is based on ability to pay.

(163) Social Worker — A person licensed by the Board of Clinical Social Workers to practice clinical social work.

(164) Speech-Language Pathologist — A person licensed by the Oregon Board of Examiners for Speech Pathology.

(165) Speech-Language Pathology Services — The application of principles, methods, and procedure for the measuring, evaluating, predicting, counseling or instruction related to the development and disorders of speech, voice, or language for the purpose of preventing, habilitating, rehabilitating, or modifying such disorders in individuals or groups of individuals.

(166) Spend-Down — The amount the Client must pay for medical expenses each month before becoming eligible for medical assistance under the Medically Needy Program. The spend-down is equal to the difference between the Client's total countable income and Medically Needy program income limits.

(167) State Facility — A hospital or training center operated by the State of Oregon, which provides long-term medical or psychiatric care.

(168) Subparts (of a Provider Organization)– For NPI application, Subparts of a health care Provider Organization would meet the definition of health care Provider (45 CFR 160.103) if it were a separate legal entity and if it conducted HIPAA-covered transactions electronically, or has an entity do so on its behalf, could be components of an organization or separate physical locations of an organization.

(169) Subrogation — Right of the State to stand in place of the Client in the collection of Third Party Resources.

(170) Supplemental Security Income (SSI) — A program available to certain aged and disabled persons which is administered by the Social Security Administration through the Social Security office.

(171) Surgical Assistant — A person performing required assistance in surgery as permitted by rules of the State Board of Medical Examiners.

(172) Suspension — A Sanction prohibiting a Provider's participation in DHS medical assistance programs by deactivation of the Provider's OMAP assigned billing number for a specified period of time. No payments, Title XIX or State Funds, will be made for services provided during the suspension. The number will be reactivated automatically after the suspension period has elapsed.

(173) Targeted Case Management (TCM)- Activities that will assist the Client in a target group in gaining access to needed medical, social, educational and other services. This includes locating, coordinating, and monitoring necessary and appropriate services. TCM services often provided by Allied Agency Providers.

(174) Termination — A sanction prohibiting a Provider's participation in OMAP's programs by canceling the Provider's OMAP assigned billing number and agreement. No payments, Title XIX or State Funds, will be made for services provided after the date of termination. Termination is permanent unless:

(a) The exceptions cited in 42 CFR 1001.221 are met; or

(b) Otherwise stated by OMAP at the time of termination.

(175) Third Party Resource (TPR) — A medical or financial resource which, under law, is available and applicable to pay for medical services and items for an OMAP Client.

(176) Transportation — See Medical Transportation.

(177) Type A Hospital — A Hospital identified by the Office of Rural Health as a Type A Hospital.

(178) Type B AAA Unit — A Type B Area Agency on Aging funded by Oregon Project Independence (OPI), Title III — Older Americans Act, and Title XIX of the Social Security Act.

(179) Type B Hospital — A Hospital identified by the Office of Rural Health as a Type B Hospital.

(180) Usual Charge (UC) — The lesser of the following unless prohibited from billing by federal statute or regulation:

(a) The Provider's charge per unit of service for the majority of non-medical assistance users of the same service based on the preceding month's charges;

(b) The Provider's lowest charge per unit of service on the same date that is advertised, quoted or posted. The lesser of these applies regardless of the payment source or means of payment;

(c) Where the Provider has established a written sliding fee scale based upon income for individuals and families with income equal to or less than 200% of the federal poverty level, the fees paid by these individuals and families are not considered in determining the usual charge. Any amounts charged to Third Party Resources are to be considered.

(181) Utilization Review (UR) — The process of reviewing, evaluating, and assuring appropriate use of medical resources and services. The review encompasses quality, quantity, and appropriateness of medical care to achieve the most effective and economic use of health care services.

(182) Valid Claim — An invoice received by OMAP or the appropriate Department office for payment of covered health care services rendered to an eligible Client which:

(a) Can be processed without obtaining additional information from the Provider of the goods or services or from a Third Party Resource; and

(b) Has been received within the time limitations prescribed in these General Rules (OAR 410 division 120).

(183) Vision Services — Provision of corrective eyewear, including ophthalmological or optometric examinations for determination of visual acuity and vision therapy and devices.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 5-1981, f. 1-23-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82, for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 81-1982, f. 8-30-82, ef. 9-1-82; AFS 4-1984, f. & ef. 2-1-84; AFS 12-1984, f. 3-16-84, ef. 4-1-84; AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 13-1987, f. 3-31-87, ef. 4-1-87; AFS 7-1988, f. & cert. ef. 2-1-88; AFS 69-1988, f. & cert. ef. 12-5-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0005; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; HR 2-1994, f. & cert. ef. 2-1-94; HR 31-1994, f. & cert. ef. 11-1-94; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; HR 21-1997, f. & cert. ef. 10-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2000, f. & cert. ef. 6-23-00; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-0025**
**Administration of Office of Medical Assistance Programs' Regulation and Rule Precedence**

(1) The Department of Human Services (DHS) and its Office of Medical Assistance Programs (OMAP) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), ORS 414.725 (Prepaid Health Plans), and ORS 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, OMAP will construe them as much as possible to be complementary. In the event that OMAP policies, procedures, rules and interpretations may not be complementary, OMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to OMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, OMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted OMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to OMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, OMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the Provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service Providers or other contractors, requirements applicable to the provision of covered medical assistance to OMAP Clients are provided in OMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in OAR 410-141-0480 to 410-141-0520, and the Provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by OMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs.

(b) For purposes of contract administration solely as between OMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to OMAP Clients.

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-0250**
**Managed Care Organizations**

(1) The Department of Human Services (DHS) provides some Oregon Health Plan (OHP) Clients with prepaid health services, through contracts with a Prepaid Health Plan (PHP), also known as a Managed Care Organization (MCO). An MCO may be a Fully Capitated Health Plan (FCHP), Chemical Dependency Organization (CDO), Dental Care Organization (DCO), Mental Health Organization (MHO) or Physician Care Organization (PCO).

(2) The MCO is responsible for providing, arranging and making reimbursement arrangements for covered services as governed by state and federal law, the MCO's contract with DHS and the OHP Administrative Rules governing PHPs (OAR 410 division 141).

(3) Authorization criteria may vary between MCO plans. It is the Providers' responsibility to comply with the MCO's Prior Authorization requirements or other policies necessary for reimbursement from the MCO, before providing services to any OHP Client enrolled in a MCO.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1140**
**Verification of Eligibility**

(1) The Client's Medical Care Identification is confirmation of eligibility for medical services, subject to the limitations contained in these General Rules and the appropriate individual Provider rules. There are three different types of Medical Care Identifications by which eligibility can be confirmed:

(a) Form OMAP 1417 — Office of Medical Assistance Programs (OMAP) Medical Care Identification. This is a computer-generated notice that is mailed to the Client once a month or anytime there is a change to the case (e. g., address change);

(b) Form OMAP 1086 — Temporary Medical Care Identification. The responsible branch office issues this handwritten form;

(c) Form WMMMID1C-A — Temporary Medical Care Identification. This is a computer-generated form that is signed by an authorized person in the responsible branch office.

(2) It is the responsibility of the Provider to verify that the individual receiving medical services is, in fact, an eligible individual on the date of service for the service provided and whether a managed care plan or OMAP is responsible for reimbursement. The Provider assumes full financial risk in serving a person not identified as eligible or not confirmed by OMAP as eligible for the service provided on the date(s) of service.

(3) Medical Care Identifications include:

(a) The name(s) of the eligible individual(s), and the eligible person(s) Recipient Identification Number;

(b) The case number;

(c) Dates of coverage, including fee-for-service and managed care enrollment dates;

(d) The benefit packages each Client is eligible for;

(e) Optional program messages (e.g., Third Party Resource information);

(f) The name of the responsible branch, the worker's identification code and the phone number of the branch;

(g) The name and phone number of the managed care Provider, if applicable;

(h) Medical Management and pharmacy restrictions, if applicable.

(4) The Medical Care Identification is not transferable, and is valid only for the individual(s) listed on the card.

(5) Eligibility is verified either:

(a) From the Medical Care Identification, which shows the dates on which the Client is eligible and indicates each Client's benefit package; or

(b) If a patient identifies him or herself as eligible, but does not have a valid Medical Care Identification, the Provider may either:

(A) Contact the OMAP Automated Information System (AIS), which is available on the Internet or via telephone;.

(B) Providers who have contracted with an Electronic Eligibility Verification Service (EEVS) vendor can access Client eligibility data 24 hours a day, 7 days a week; or

(C) Providers may contact the local Department of Human Services (DHS) branch office during regular working hours to confirm eligibility if the information is not available electronically.

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 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82, for remaining AFS branch offices; AFS 103-1982, f. & ef. 11-1-83; AFS 61-1983, f. 12-19-83, ef. 1-1-84; AFS 24-1985, f. 4-24-85, ef. 6-1-85; AFS 43-1986(Temp), f. 6-13-86, ef. 7-1-86; AFS 57-1986, f. 7-25-86, ef. 8-1-86; AFS 78-1986(Temp), f. 12-16-86, ef. 1-1-87; AFS 10-1987, f. 2-27-87, ef. 3-1-87; AFS 53-1987, f. 10-29-87, ef. 11-1-87; AFS 53-1988(Temp), f. 8-23-88, cert. ef. 9-1-88; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0040; Renumbered from 461-013-0103 & 461-013-0109; HR 25-1991(Temp), f. & cert. ef. 7-1-91; HR 41-1991, f. & cert. ef. 10-1-91; HR 22-1993(Temp), f. & cert. ef. 9-1-93; HR 32-1993, f. & cert. ef. 11-1-93; OMAP 10, 1999, f. & cert. ef. 4-1-99; Renumbered from 410-120-0080; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1160**
**Medical Assistance Benefits and Provider Rules**

(1) Providers enrolled with and seeking reimbursement for services through the Office of Medical Assistance Programs (OMAP) are responsible for compliance with current federal and state laws and regulations governing Medicaid services and reimbursement, including familiarity with periodic law and rule changes. The OMAP Administrative Rules are posted on the Department of Human Services (DHS) Web page for OMAP and its medical assistance programs. It is the provider's responsibility to become familiar with, and abide by, these rules.

(2) The following services are covered to the extent included in the OMAP Client's benefit package of health care services, when medically or dentally appropriate and within the limitations established by OMAP and set forth in the Oregon Administrative Rules (OARs) 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) OMAP covers alcohol and drug Inpatient Services for medical detoxification when provided in an acute care Hospital and when hospitalization is considered Medically Appropriate;

(B) OMAP does not cover residential level of care provided in an Inpatient Hospital setting for alcohol and drug abuse treatment;

(C) The Office of Mental Health and Addiction Services (OMHAS) covers non-hospital alcohol and drug treatment services on a residential or outpatient basis through direct contracts with counties or Providers. For information to access these services, contact the Client's managed care plan if enrolled, the community mental health program (CMHP), an outpatient alcohol and drug treatment provider, the residential treatment program or OMHAS.

(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 OARs 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);

(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 DHS OARs of Children, Adults and Families, OMHAS, and Seniors and People with Disabilities (SPD);

(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), and related Durable Medical Equipment and Medical Supplies rules (OAR 410 division 122) and Pharmacy rules (OAR 410 division 121);

(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 (OAR 410 division 125) 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 a Client's Medical Care Identification Card indicates that he or she has a benefit package that includes mental health, the mental health services provided will be based on the Prioritized List of Health Services.;

(w) Naturopathic Services, as described in the Medical-Surgical Services Provider rules (OAR 410 division 130);

(x) Nutritional Counseling 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 Department 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) Post Hospital Extended Care Benefit, as described in OAR 410 division 120 and141 and SPD program rules;

(ee) Prescription drugs, including home enteral and parenteral nutritional services and home intravenous services, as described in the Pharmaceutical Services (OAR 410 division 121), the Home Enteral/Parenteral Nutrition and IV Services (OAR 410 division 148) and the Hospital Services Provider rules (OAR 410 division 125);

(ff) Preventive Services, as described in the Medical-Surgical Services (OAR 410 division 130) and the Dental/Denturist Services Provider rules (OAR 410 division 123) and prevention guidelines associated with the Health Service Commission's Prioritized List of Health Services (OAR 410-141-0520);

(gg) Private Duty Nursing, as described in the Private Duty Nursing Provider rules (OAR 410 division 132);

(hh) Radiology and Imaging Services, as described in the Medical-Surgical Services (OAR 410 division 130), the Hospital Services (OAR 410 division 125), and Dental and Denturist Services Provider rules (OAR 410 division 123);

(ii) Rural Health Clinic Services, as described in the Federally Qualified Health Center and Rural Health Clinic Provider rules (OAR 410 division 147);

(jj) School-Based Health Services, as described in the School-Based Health Services Provider rules (OAR 410 division 133);

(kk) Speech and Language Therapy as described in the Speech-Language Pathology, Audiology and Hearing Aid Services (OAR 410 division 129) and Hospital Services Provider rules (OAR 410 division 125);

(ll) Transportation necessary to access a covered medical service or item, as described in the Medical Transportation Provider rules (OAR 410 division 136);

(mm) Vision Services as described in the Visual Services Provider rules (OAR 410 division 140).

(3) Other DHS units or Offices, including Vocational Rehabilitation, OMHAS, and SPD may offer services to Medicaid eligible Clients, which are not reimbursed by or available through OMAP.

[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; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1180**
**Medical Assistance Benefits: Out-of-State Services**

(1) Out-of-State Providers must enroll with the Office of Medical Assistance Programs (OMAP) as described in 410-120-1260, Provider Enrollment. Out-of-State Providers must provide services and bill in compliance with all of these General Rules and the Oregon Administrative Rules (OARs) for the appropriate type of service(s) provided..

(2) OMAP reimburses enrolled Out-of-State Providers in the same manner and at the same rates as in-state Providers unless otherwise specified in the individual Provider rules or by contract or Service Agreement with the individual Provider.

(3) OMAP reimburses enrolled non-contiguous, Out-of-State Providers for covered services under any of the following conditions:

(a) The service was emergent; or

(b) A delay in the provision of services until the Client is able to return to Oregon could reasonably be expected to result in prolonged impairment, or in increased risk that treatment will become more complex or hazardous, or in substantially increased risk of the development of chronic illness;

(c) OMAP authorized payment for the service in advance of the provision of services or was otherwise authorized in accordance with Payment Authorization requirements in the individual Provider rules or in the General Rules;

(d) The service was authorized by a Prepaid Health Plan (PHP) including a Fully Capitated Health Plan (FCHP), a Physician Care Organization (PCO) or a Dental Care Organization (DCO) and payment to the Out-of-State Provider is the responsibility of the PHP;

(e) The service is being billed for Qualified Medicare Beneficiary (QMB) deductible or co-insurance coverage.

(4) OMAP may give Prior Authorization for non-emergency out-of-state services provided by a non-contiguous enrolled Provider, under the following conditions:

(a) OMAP covers the service or item under the specific Client's benefit package; and

(b) The service or item is not available in the State of Oregon or provision of the service or item by an Out-of-State Provider is cost effective, as determined by OMAP (or, for those Clients covered by a managed care plan, the plan will make that determination); and

(c) The service or item is deemed Medically Appropriate and is recommended by a referring Oregon Physician;

(d) If a Client has coverage through a managed care plan, a PHP, the request for non-emergency services must be referred to the PHP.

(5) Laboratory analysis of specimens sent to out-of-state independent or hospital-based Laboratories is a covered service and does not require Prior Authorization. The Laboratory must meet the same certification requirements as Oregon Laboratories and must bill in accordance with OMAP rules.

(6) OMAP makes no reimbursement for services provided to a Client outside the territorial limits of the United States, unless the country operates a Title XIX Medical Assistance Program.

(7) OMAP will reimburse, within limits described in these General Rules and in individual Provider rules, all services provided by enrolled Providers to children:

(a) Who the Department of Human Services (DHS) has placed in foster care;

(b) Who DHS has placed in a subsidized adoption outside the State of Oregon; or

(c) Who are in the custody of DHS and traveling with the consent of DHS.

(8) OMAP does not require authorization of non-emergency services for the children covered by (7), except as specified in the individual Provider rules.

(9) Payment rates for Out-of-State Providers are established in the individual Provider rules, through contracts or Service Agreements and in accordance with OAR 410-120-1340, Payment.

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 27-1978(Temp), f. 6-30-78, ef. 7-1-78; AFS 39-1978, f. 10-10-78, ef. 11-1-78; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0130; AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 21-1985, f. 4-2-85, ef. 5-1-85; AFS 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0045 & 461-13-046; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0120, 410-120-0140 & 410-120-0160; HR 40-1994, f. 12-30-94, cert. ef. 1-1-95; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1195**
**SB 5548 Population**

(1) Certain individuals previously participating in the OSIP-MN Medically Needy Program as of January 31, 2003, and who are identified by the Department of Human Services (DHS) with specific health-related conditions as outlined in the Joint Ways and Means budget note accompanying Senate Bill 5548 (2003) shall be referred to as SB 5548 Clients.

(2) SB 5548 Clients are eligible for a State-funded, limited, prescription drug benefit for covered drugs described in subsection (3) of this rule.

(3) Eligibility for, and access to, covered drugs for SB 5548 Clients:

(a) SB 5548 Clients must have been participating in the former OSIP-MN Medically Needy Program as of January 31, 2003, and as of that date had a medical diagnosis of HIV or organ transplant status;

(b) SB 5548 Clients receiving anti-retrovirals and other prescriptions necessary for the direct support of HIV symptoms:

(A) Must agree to participate in the DHS CareAssist Program in order to obtain access to this limited prescription drug benefit; and

(B) Prescriptions are limited to those listed on the CareAssist Formulary which can be found at www.dhs.state.or.us/publichealth/hiv/careassist/frmlry.cfm.

(c) SB 5548 Clients receiving prescriptions necessary for the direct support of organ transplants are limited :

(A) Drug coverage includes any Medicaid reimbursable immunosuppressive, anti-infectives or other prescriptions necessary for the direct support of organ transplants.

(B) Some drug classes are subject to restrictions or limitations based upon the Practitioner-Managed Prescription Drug Plan, OAR 410-121-0030.

(4) Reimbursement for covered prescription drugs is limited by the terms and conditions described in this rule. This limited drug benefit provides State-funded reimbursement to pharmacies choosing to participate according to the terms and conditions of this rule:

(a) DHS will send SB 5548 Clients a letter from the Department, instead of a Medical Care Identification, which will document their eligibility for this limited drug benefit;

(b) Retail pharmacies choosing to participate will be reimbursed for covered prescription drugs for the direct support of organ transplants described in subsection (3)(c) of this rule at the lesser of billed, Average Wholesale Price (AWP) minus 15% or Oregon Maximum Allowable Cost (OMAC), plus a dispensing fee of $3.50;

(c) DHS pharmacy benefits manager, First Health, will process retail pharmacy drug benefit reimbursement claims for SB 5548 Clients;

(d) Mail order reimbursement will be subject to DHS contract rates;

(e) Prescription drugs through the CareAssist program will be subject to the DHS contract rates;

(f) Reimbursement for this limited drug benefit is not subject to the following rules:

(A) 410-120-1230, Client Copayments;

(B) 410-121-0300, Federal Upper Limit (FUL) for prescription drugs.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 28-2003(Temp), f. & cert. ef. 4-1-03 thru 9-1-03; OMAP 44-2003, f. & cert. ef. 6-30-03; OMAP 45-2003(Temp), f. & cert. ef. 7-1-03 thru 12-15-03; OMAP 56-2003, f. 8-28-03, cert. ef. 9-1-03; OMAP 89-2003, f. 12-30-03 cert. ef. 1-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1200**
**Excluded Services and Limitations**

(1) 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.

(2) The Office of Medical Assistance Programs (OMAP) will make no payment for any expense incurred for any of the following services or items:

(a) That are not expected to significantly improve the basic health status of the Client as determined by OMAP staff, or its contracted entities (e.g., OMAP's Medical Director, medical consultants, dental consultants or Peer Review Organizations (PROs) also known as Quality Improvement Organizations (QIOs));

b) That are not reasonable or necessary for the diagnosis and treatment of disability, illness, or injury;

(c) That are determined not medically or dentally appropriate by OMAP staff or authorized representatives, including OMPRO or any contracted utilization review organization.

(d) That are not properly prescribed as required by law or administrative rule by a licensed practitioner practicing within his or her scope of practice or licensure;

(e) 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;

(f) That are provided by friends or relatives of eligible Clients or members of his or her household, except:

(A) When the friend, relative or household member is a health professional, acting in a professional capacity; or

(B) When the friend, relative or household member is directly employed by the Client under the Department of Human Services (DHS) Seniors & People with Disabilities (SPD) Home and Community Based Waiver or the SPD administrative rules, OAR 411-034-000 through 411-034-0090, governing Personal Care Services covered by the State Plan; or

(C) When the friend, relative or household member is directly employed by the Client under the Children, Adults and Families (CAF) administrative rules, OAR 413-090-0100 through 413-090-0220, for services to children in the care and custody of the Department who have special needs inconsistent with their ages. A family member of a minor Client (under the age of 18) must not be legally responsible for the Client in order to be a Provider of personal care services;

(g) 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 OMAP administrative rules;

(h) When 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 that OMAP rented or purchased;

(i) That are related to a non-covered service; some exceptions are identified in the individual Provider rules. If OMAP determines the provision of a service related to a non-covered service is cost-effective, the related medical service may, at OMAP's discretion and with OMAP's Prior Authorization, be covered;

(j) That are considered experimental or investigational, including clinical trials and demonstration projects, or which deviate from acceptable and customary standards of medical practice or for which there is insufficient outcome data to indicate efficacy;

(k) That are identified in the appropriate program rules including the Hospital rules, Revenue Codes Section, as Non- Covered Services.

(l) That are requested by or for a Client whom OMAP has determined to be non-compliant with treatment and who is unlikely to benefit from additional related, identical, or similar services;

(m) 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;

(n) Whose primary intent is to improve appearance;

(o) That are similar or identical to services or items that 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;

(p) That are 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).

(q) Items or services which are for the convenience of the Client and are not medically or dentally appropriate;

(r) 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;

(s) Educational or training classes that are not Medically Appropriate (Lamaze classes, for example);

(t) Outpatient social services except Maternity Case Management services and other social services described as covered in the individual Provider rules;

(u) Plasma infusions for treatment of Multiple Sclerosis;

(v) Post-mortem exams or burial costs, or other services subsequent to the death of a Client;

(w) Radial keratotomies;

(x) Recreational therapy;

(y) 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 OAR 410-130-0587;

(z) Transsexual surgery or any related services or items;

(aa) 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;

(bb) Whole blood (whole blood is available at no cost from the Red Cross); the processing, storage and costs of administering whole blood are covered;

(cc) Immunizations prescribed for foreign travel;

(dd) Services that 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);

(ee) DUII-related services already covered by the Intoxicated Driver Program Fund as directed by ORS 813.270(1) and (5);

(ff) Transportation to meet a Client's personal choice of a Provider;

(gg) Pain center evaluation and treatment;

(hh) Alcoholics Anonymous (AA) and other self help programs.

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; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1210**
**Medical Assistance Benefit Packages and Delivery System**

(1) Some medical assistance Clients have limited benefits. The text in the box marked "Benefit Package Messages," on the Medical Care Identification, describe the package of medical benefits the Recipient is eligible to receive.

(2) Names of the Office of Medical Assistance Programs (OMAP) Benefit Packages, effective February 1, 2003, and the Clients eligible to receive the various packages, are identified as follows:

(a) The Oregon Health Plan (OHP) Plus Benefit Package is available to Clients who are categorically eligible for medical assistance as defined in federal regulations and in the OHP waiver granted on October 15, 2002. A Client is categorically eligible for medical assistance if he or she is eligible under a mandatory, selected, optional Medicaid program or the Children's Health Insurance Program and is also within the income and other eligibility criteria adopted by the Department of Human Services (DHS);

(b) The OHP Standard Benefit Package is available to Clients eligible for OHP through the Medicaid expansion waiver granted on October 15, 2002. These Clients are adults and childless couples who are also within the income and other eligibility criteria adopted by DHS. The Department identifies these Clients through the program acronym, OHP-OPU;

(c) Qualified Medicare Beneficiary (QMB)-Only Clients are Medicare beneficiaries who have limited income but do not meet the income standard for full medical assistance coverage. QMB Clients have coverage through Medicare Parts A and B for most covered services;

(d) Qualified Medicare Beneficiary (QMB) + OHP Plus Clients covered by the QMB-OHP Plus Benefit Package are Medicare beneficiaries that have met the income standard for full medical assistance coverage. DHS identifies these Clients through the program acronym QMM;

(e) The Citizen/Alien-Waived Emergency Medical (CAWEM) Clients are certain eligible, non-qualified aliens that are not eligible for other Medicaid programs pursuant to Oregon Administrative Rules (OAR) 461-135-1070. The Medical Care Identification that the Client is issued indicates coverage. The CAWEM Benefit Package is limited to services listed in OAR 410-120-1210(3)(e).

(3)The benefit limitations and exclusions listed here are in addition to those described in OAR 410-120-1200 and in individual program Provider rules. The benefits and limitations included in each OHP benefit package follow:

(a) OHP Plus coverage includes:

(A) Services above the funding line on the Health Services Commission's (HSC) Prioritized List of Health Services, (OAR 410-141-0480 through 410-141-0520);

(B) Ancillary services, (OAR 410-141-0480);

(C) Chemical dependency services provided through local alcohol and drug treatment Providers;

(D) Mental health services based on the Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(E) Hospice;

(F) Post Hospital Extended Care benefit, up to a 20-day stay in a Nursing Facility for non-Medicare OMAP Clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires Prior Authorization by Pre-Admission Screening (OAR 411-070-0043), or by the Fully Capitated Health Plan (FCHP) for Clients enrolled in an FCHP;

(G) Cost sharing may apply to some covered services.

(b) OHP Standard benefits adhere to the following provisions:

(A) OHP Standard coverage, subject to sections (B) and (C) of this section includes:

(i) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

(ii) Ancillary services, (OAR 410-141-0480);

(iii) Outpatient chemical dependency services provided through local alcohol and drug treatment Providers;

(iv) Outpatient mental health services based on the Prioritized List of Health Services, to be provided through Community Mental Health Programs or their subcontractors;

(v) Hospice;

(vi) Post Hospital Extended Care benefit, up to a 20-day stay in a nursing facility for non-Medicare OMAP Clients who meet Medicare criteria for a post-hospital skilled nursing placement. This benefit requires Prior Authorization by Pre-Admission Screening (OAR 411-070-0043) or by the Fully Capitated Health Plan (FCHP) for Clients enrolled in an FCHP.

(B) The following services have limited coverage for the OHP Standard benefit package (Refer to the cited OAR chapters and divisions for details):

(i) Selected dental (OAR chapter 410 division 123);

(ii) Selected Durable Medical Equipment and medical supplies (OAR chapter 410, division 122 and 130);

(iii) Selected home enteral/parenteral services (OAR chapter 410, division 148);

(iv) Selected Hospital services (OAR chapter 410, division 125);

(v) Other limitations as identified in individual OMAP program administrative rules.

(C) The following services are not covered under the OHP Standard Benefit Package. Refer to the cited OAR chapters and divisions for details:

(i) Acupuncture services, except when provided for chemical dependency treatment (OAR chapter, 410 division 130);

(ii) Chiropractic and osteopathic manipulation services (OAR chapter 410, division 130);

(iii) Hearing aids and related services (i.e., exams for the sole purpose of determining the need for or the type of hearing aid), (OAR chapter 410, division 129);

(iv) Home Health Services (OAR chapter 410, division 127), except when related to limited EPIV services (OAR chapter 410, division 148);

(v) Non-emergency Medical Transportation (OAR chapter 410, division 136);

(vi) Occupational Therapy services (OAR chapter 410, division 131);

(vii) Physical Therapy services (OAR chapter 410, division 131);

(viii) Private Duty Nursing Services (OAR chapter 410, division 132), except when related to limited EPIV services;

(ix) Speech and Language Therapy services (OAR chapter 410, division 129);

(x) Vision Services such as frames, lenses, contacts corrective devices and eye exams for the purpose of prescribing glasses or contacts (OAR chapter 410, division 140);

(xi) Other limitations as identified in individual OMAP program administrative rules.

(c) The QMB-Only Benefit Package provides only services that are also covered by Medicare:

(A) Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible, but no more than the Medicare allowable;

(B) Providers may bill QMB Clients for services that are not covered by Medicare. Providers may not bill QMB Clients for the deductible and coinsurance amounts due for services that are covered by Medicare.

(d) QMB + OHP Plus Benefit Package coverage includes any service covered by Medicare. Payment for services is the Medicaid allowed payment less the Medicare payment up to the amount of co-insurance and deductible. This package also covers:

(A) Services above the funding line on the HSC Prioritized List, (OAR 410-141-0480 through 410-141-0520);

(B) Mental health services;

(C) Chemical dependency services provided through a local alcohol and drug treatment Provider.

(e) Citizen/Alien-Waived Emergency Medical Assistance (CAWEM) services are limited to:

(A) Emergency labor and delivery services or services to treat emergency medical. CAWEM services are strictly defined by 42 CFR 440.255 (the definition does not apply a prudent layperson standard);

(B) A CAWEM Client is eligible for services only after sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

(C) The following services are not covered for CAWEM Clients, even if they are seeking emergency services:

(i) Prenatal or postpartum care;

(ii) Sterilization;

(iii) Family Planning;

(iv) Preventive care;

(v) Organ transplants and transplant-related services;

(vi) Chemotherapy;

(vii) Hospice;

(viii) Home Health;

(ix) Private Duty Nursing;

(x) Dialysis;

(xi) Dental Services provided outside of an Emergency Department Hospital setting;

(xii) Outpatient drugs or over-the-counter products;

(xiii) Non-emergency Medical Transportation;

(xiv) Therapy services;

(xv) Durable Medical Equipment and medical supplies;

(xvi) Rehabilitation services.

(4) OMAP services are delivered through one of several means:

(a) Prepaid Health Plan (PHP):

(A) These Clients are enrolled in a PHP for their medical, dental and mental health care;

(B) Most non-emergency services are obtained from the PHP or require a referral from the PHP that is responsible for the provision and reimbursement for the medical, dental or mental health service;

(C) Inpatient hospitalization services that are not the responsibility of a Physician Care Organization (PCO) are governed by the Hospital rules (OAR 410 division 125);

(D) The name and phone number of the PHP appears on the Medical Care Identification.

(b) Primary Care Managers:

(A) These Clients are enrolled with a Primary Care Manager (PCM) for their medical care;

(B) Most non-emergency services provided to Clients enrolled with a PCM require referral from the PCM.

(c) Fee-For-Service (FFS):

(A) These Clients are not enrolled in a PHP or assigned to a PCM;

(B) Subject to limitations and restrictions in individual program rules, the Client can receive health care from any OMAP-enrolled Provider that accepts FFS Clients. The Provider will bill OMAP directly for any covered service and will receive a fee for the service provided.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: 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 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1230**
**Client Copayment**

(1) Oregon Health Plan (OHP) Plus Clients shall be responsible for paying a copayment for some services. This copayment shall be paid directly to the Provider.

(2) The following services are exempt from copayment:

(a) Emergency medical services, as defined in OAR 410-120-0000;

(b) Family planning services and supplies;

(c) Prescription drugs ordered through Office of Medical Assistance Program's (OMAP) Mail Order (a.k.a., Home-Delivery) Pharmacy program;

(d) Any service not listed in (10) below.

(3) The following Clients are exempt from copayments:

(a) Services provided to pregnant women;

(b) Children under age 19;

(c) Any Client receiving services under the Home and Community based waiver and Developmental Disability waiver, or is an inpatient in a hospital, Nursing Facility (NF), Intermediate Care Facility for the Mentally Retarded (ICF/MR);

(d) American Indian/Alaska Native (AI/AN) Clients who are members of a federally recognized Indian tribe or receive services through Indian Health Services (IHS), tribal organization or services provided at an Urban Tribal Health Clinic as provided under P.L. 93-638.

(4) Clients enrolled in an OMAP contracted Prepaid Health Plan (PHP) will be exempt from copayments for any services paid for by their plan(s).

(5) Services to a Client cannot be denied solely because of an inability to pay an applicable copayment. This does not relieve the Client of the responsibility to pay, nor does it prevent the Provider from attempting to collect any applicable copayments from the Client; the amount is a legal debt, and is due and payable to the Provider of service.

(6) A Client must pay the copayment at the time service is provided unless exempted (see (2), (3) and (4) above).

(7) The Provider should not deduct the copayment amount from the usual and customary fee submitted on the claim. Except as provided in subsection (2) of this rule, DHS will deduct the amount of the copayment from the amount paid to the Provider (whether or not Provider collects the copayment from the Client). If the OMAP paid amount is less than the required copayment, the copayment amount will be equal to what OMAP would have paid, unless the Client or services is exempt according to exclusions listed in (2), (3) and (4) above.

(8) Unless specified otherwise in individual program rules, and to the extent permitted under 42 CFR 1001.951 – 1001.952, OMAP does not require Providers to bill or collect a copayment from the Medicaid Client. The Provider may choose not to bill or collect a copayment from a Medicaid Client, however, OMAP will still deduct the copayment amount from the Medicaid reimbursement made to the Provider.

(9) OHP Standard copayments are eliminated for OHP Standard Clients effective June 19, 2004. Elimination of copayments by this rule shall supercede any other General Rule, 410-120-0000 et seq; any Oregon Health Plan Rule, OAR 410-141-0000 et seq; or individual OMAP program rule(s), that contain or refer to OHP Standard copayment requirements.

(10) Services which require copayments are listed in Table 120-1230-1:

(a) For the purposes of this rule, dental diagnostic services are considered oral examinations used to determine changes in the patient's health or dental status. Diagnostic visits include all routine cleanings, x-rays, laboratory services and tests associated with making a diagnosis and/or treatment. One copayment assessed per Provider/per visit /per day unless otherwise specified. Copayment applies regardless of location, i.e. Provider's office or Client's residence;

(b) Mental Health Service copayments are defined as follows:

(A) Inpatient hospitalization- includes ancillary, facility and professional fees (DRG 424-432);

(B) Outpatient hospital — Electroconvulsive (ECT) treatment (Rev code 901) including facility, professional fees (90870-90871) and anesthesiology fees (00104);

(C) Initial assessment/evaluation by psychiatrist or psychiatric mental health nurse practitioners (90801);

(D) Medication Management by psychiatrist or psychiatric mental health nurse practitioner (90862);

(E) Consultation between psychiatrist/psychiatric mental health nurse practitioner and primary care physician (90887).

Table 120-1230-1
[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stat. Implemented: ORS 414.065
Hist.: OMAP 73-2002, f. 12-24-02, cert. ef. 1-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2004(Temp), f. 6-14-04 cert. ef. 6-19-04 thru 11-30-04; OMAP 49-2004, f. 7-28-04 cert. ef. 8-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1260**
**Provider Enrollment**

(1) This rule applies only to Providers seeking reimbursement from the Office of Medical Assistance Programs (OMAP), except as otherwise provided in OAR 410-120-1295.

(2) Signing the Provider application constitutes agreement by Performing and Billing Providers to comply with all applicable OMAP Provider rules and federal and state laws and regulations.

(3) The Department of Human Services (DHS) is taking action to permit compliance with the National Provider Identification Number (NPI) requirements in 45 CFR Part 142 when those requirements become effective. During the transition period, the following requirements for Providers and Provider applicants will apply:

(a) Providers that obtain an NPI should update their records with OMAP's Provider Enrollment Unit. Provider applicants that have been issued an NPI should include that NPI number with the OMAP Provider enrollment application.

(b) A Provider enrolled with OMAP must bill using the OMAP assigned Provider number, in addition to the NPI, if available, and continue to bill using the OMAP assigned Provider number until the Department informs the Provider that the OMAP assigned Provider number is no longer required. Failure to use the OMAP assigned Provider number during this transition period will result in delay or rejection of claims and other transactions.

(c) The NPI number will be cross-referenced with the OMAP assigned Provider number for billing purposes.

(d) A Provider agrees to cooperate with the Department with reasonable consultation and testing procedures, if any, related to implementation of the use of NPI numbers.

(4) A Performing Provider is the Provider of a service or item. A Billing Provider is a person, agent, business, corporation, clinic, group, institution, or business entity that submits claims to and receives payment from OMAP on behalf of a Performing Provider. All references to Provider in this and other OMAP rules include both Performing and Billing Providers:

(a) A Performing Provider is responsible for identifying and keeping current the identification of their Billing Provider (if any) to OMAP. In order to facilitate timely claims processing and claims payment consistent with applicable privacy and security requirements, DHS requires Billing Providers to be enrolled consistent with subsection (11) of this rule. A Performing Provider's use of a Billing Agent or Billing Service that falls within the definition of a Billing Provider but that is not enrolled with OMAP may result in delay or rejection of claims processing or payment;

(b) If the Performing Provider uses electronic media to conduct transactions with the Department, or authorizes a Billing Agent or Billing Service to conduct such electronic transactions, the Performing Provider must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et.seq. Enrollment as a Performing or Billing Provider is a necessary requirement for submitting electronic claims, but the Provider must also register as a Trading Partner and identify the EDI Submitter.

(5) To be enrolled and able to bill as a Provider, an individual or organization must meet applicable licensing and regulatory requirements set forth by federal and state statutes, regulations and rules, and must comply with all Oregon statutes and regulations for provision of Medicaid and SCHIP services. In addition, all Providers of services within the State of Oregon must have a valid Oregon business license if such a license is a requirement of the state, federal, county or city government to operate a business or to provide services.

(6) An individual or organization that is currently subject to Sanction(s) by OMAP, another state's Medicaid program, or federal government is not eligible for enrollment (see Provider Sanctions). In addition, individuals or organizations that apply for enrollment are subject to the following disclosure requirements:

(a) Before OMAP issues or renews a Provider enrollment or contract for Provider services, or at any time upon written request by the DHS, the Provider must disclose to the Department the identity of any person who: Has ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program since the inception of those programs;

(b) A Medicaid Provider that is an entity other than an individual practitioner or group of practitioners, must disclose certain information about ownership and control of the entity: the name and address of each person with an ownership or control interest in the Provider, or in any subcontractor in which the Provider has a direct or indirect ownership interest of 5 percent or more; whether any of the persons so named is related to another as spouse, parent, child, or sibling; and the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest;

(c) All Providers must agree to furnish to the Department or to the U.S. Department of Health and Human Services on request, information related to certain business transactions: A Provider must submit, within 35 days of the date on a request, full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request.

(d) OMAP may refuse to enter into or renew a Provider enrollment agreement, or contract for Provider services, with a Provider if any person who has an ownership or control interest in the Provider, or who is an agent or managing employee of the Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX services program.

(e) OMAP may refuse to enter into or may terminate a Provider enrollment agreement, or contract for Provider services, if it determines that the Provider did not fully and accurately make any disclosure required under this section (6).

(7) Enrollment of Performing Providers. An OMAP assigned Performing Provider number will be issued to an individual or organization providing covered health care services or items upon:

(a) Completion of the application and submission of the required documents;

(b) The signing of the Provider application by the Performing Provider or a person authorized by the Performing Provider to legally bind the organization or individual to compliance with these rules;

(c) Verification of licensing or certification. Loss of the appropriate licensure or certification will result in immediate disenrollment of the Provider and recovery of payments made subsequent to the loss of licensure or certification;

(d) Approval of the application by OMAP or the DHS unit responsible for enrolling the Provider.

(8) Performing Providers may be enrolled retroactive to the date services were provided to an OMAP Client only if:

(a) The Provider was appropriately licensed, certified and otherwise met all OMAP requirements for Providers at the time services were provided; and

(b) Services were provided less than 12 months prior to the date the application for Provider status was received by OMAP as evidenced by the date stamp placed on the application.

(9) Issuance of an OMAP assigned Provider number establishes enrollment of an individual or organization as a Provider for the specific category (ies) of services covered by the OMAP enrollment application. For example, a pharmacy Provider number applies to pharmacy services but not to durable medical equipment, which requires a separate Provider application and establishes a separate OMAP assigned Provider number.

(10) Required Updates: A Provider is responsible for providing, and continuing to provide, to the Department accurate, complete and truthful information concerning their qualification for enrollment. An enrolled Provider must notify OMAP in writing of a material change in any status or condition that relates to their qualifications or eligibility to provide medical assistance services including but not limited to a change in any of the following information address, business affiliation, licensure, certification, Billing Provider, NPI, or Federal Tax Identification Number, or if the Provider's ownership or control information changes; or if the Provider or a person with an ownership or control interest, or an agent or managing employee of the Provider; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX services program. The Provider must notify OMAP of changes in any of this information in writing within 30 calendar days of the change.

(a) Failure to notify OMAP of a change of Federal Tax Identification Number may result in the imposing of a $50 fine;

(b) In addition to subsection (a), if OMAP notifies a Provider about an error in Federal Tax Identification Number, the Provider must supply a valid Federal Tax Identification Number within 30 calendar days of the date of OMAP's notice. Failure to comply with this requirement may result in OMAP imposing a fine of $50 for each such notice. Federal Tax

Identification Number requirements described in this rule refer to any such requirements established by the Internal Revenue Service;

(c) Changes in business affiliation, ownership, NPI and Federal Tax Identification Number, ownership and control information, or criminal convictions may require the submission of a new application;

(d) Claims submitted by, or payments made to, Providers who have not furnished the notification required by this rule or to a Provider that has failed to submit a new application as required by OMAP under this rule may be denied or recovered.

(11) Enrollment of Out-of-State Providers: Providers of services outside the state of Oregon will be enrolled as a Provider under section (7) of this rule if they comply with the requirements of section (7) and under the following conditions:

(a) The Provider is appropriately licensed or certified and meets standards and is enrolled within the Provider's state for participation in the state's Medicaid program. Disenrollment or sanction from the other state's Medicaid program, or exclusion from any other federal or state health care program is a basis for disenrollment, termination or suspension from participation as a Provider in Oregon's medical assistance programs;

(b) The Provider bills only for services provided within the Provider's scope of licensure or certification;

(c) For noncontiguous Out-of-State Providers, the services provided must be authorized, in the manner required under these rules for Out-of-State Services (OAR 410-120-1180) or other applicable DHS rules:

(A) For a specific Oregon Medicaid Client who is temporarily outside Oregon or the contiguous area of Oregon; or

(B) For foster care or subsidized adoption children placed out of state; or

(C) The Provider is seeking Medicare deductible or coinsurance coverage for Oregon QMB Clients.

(d) The services for which the Provider bills are covered services under the Oregon Health Plan;

(e) Facilities, including but not restricted to Hospitals, rehabilitative facilities, institutions for care of individuals with mental retardation, Psychiatric Hospitals, and residential care facilities, will be enrolled as Providers only if the facility is enrolled as a Medicaid Provider in the state in which the facility is located or is licensed as a facility Provider of services by the State of Oregon;

(f) Out-of-State Providers may provide contracted services per OAR 410-120-1880.

(12) Enrollment of Billing Providers:

(a) A person or business entity that submits claims to OMAP and receives payments from OMAP on the behalf of a professional Performing Provider (e.g., Physician, Physical Therapist, Speech Therapist) must be enrolled as a Billing Provider with OMAP and meet all applicable federal and state laws and regulations. A Billing Agent or Billing Service submitting claims or providing other business services on behalf of a Performing Provider but not receiving payment in the name of or on behalf of the performing Provider does not meet the requirements for Billing Provider enrollment and is not eligible for enrollment as a Billing Provider;

(b) An OMAP assigned Billing Provider number will be issued only to Billing Providers that have a contract with an enrolled performing Provider to conduct billing and receive payments on behalf of the Performing Provider, that have met the standards for enrollment as a Billing Provider and that have been delegated the authority to act on behalf of the Performing Provider and to submit claims or receive payment on behalf of the Provider of services. A Billing Provider that submits claims and conducts electronic transactions on behalf of the Performing Provider must register with the Department as an EDI Submitter; however, not all EDI Submitters qualify to enroll as Billing Providers, e.g., Billing Agents or Billing Services, that are not authorized to receive payment on behalf of the performing Provider;

(A) A corporate or business entity related to the Performing Provider under one of the relationships authorized by 42 CFR 447.10(g) may have the authority to submit the Performing Provider enrollment application and supporting documentation on behalf of the Performing Provider, and such entities with the authority to submit claims and obtain payment on behalf of the Performing Provider must enroll as a Billing Provider;

(B) Any other contracted Billing Agent or Billing Service except as are described in subsection (A) of this section only has such authority to submit claims and to receive payment in the name of the Performing Provider pursuant to 42 CFR 447.10(f), and such entities meeting the definition and requirements of Billing Provider must enroll as a Billing Provider;

(C) These Billing Provider enrollment requirements do not apply to the staff directly employed by an enrolled Performing Provider, rather than pursuant to a contractual arrangement. Nothing in this rule is meant to prevent an enrolled Performing Provider from submitting his or her own claims and receiving payment in his or her own name. Notwithstanding this provision, if the Performing Provider is conducting electronic transactions, the DHS Electronic Data Interchange rules will apply, consistent with section (4) of this rule.

(c) A Billing Provider must maintain, and make available to OMAP, upon request, records indicating the Billing Provider's relationship with the Provider of service;

(d) Prior to submission of any claims or receipt of any payment from OMAP, the Billing Provider must obtain signed confirmation from the performing Provider that the Billing Provider has been authorized by the Performing Provider to submit claims and receive payment on behalf of the performing Provider. This authorization, and any limitations or termination of such authorization, must be maintained in the Billing Provider's files for at least five years, following the submission of claims to OMAP;

(e) The Billing Provider fee must not be based on a percentage of the amount billed or collected or whether or not they collect the subject's payment (42 CFR 447 subpart A).

(f) If the Billing Provider is authorized to use electronic media to conduct transactions on behalf of the Performing Provider, the Performing Provider must register with the Department as a Trading Partner and authorize the Billing Provider to act as an EDI Submitter, as required in the Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq. Enrollment as a Billing Provider does not provide that authority. If the Performing Provider uses electronic media to conduct transactions, and authorizes a Billing Agent or Billing Service that is not authorized to receive reimbursement or otherwise obligate the Performing Provider, the Billing Agent or Billing Service does not meet the requirements of a Billing Provider. The Performing Provider and Billing Agent or Billing Service must comply with the DHS Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et.seq.;

(g) Out-of-state Billing Providers may need to register with the Secretary of State and the Department of Revenue to transact business in Oregon.

(13) Utilization of Locum Tenens:

(a) For purposes of this rule, a locum tenens means a substitute physician retained to take over another physician's professional practice while he or she is absent (i.e., absentee physician) for reasons such as illness, vacation, continuing medical education, pregnancy, etc.

(b) Locum tenens are not required to enroll with OMAP; however, in no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs.

(c) The absentee physician must be an enrolled OMAP Provider and must bill with their individual OMAP assigned Provider number and receive payment for covered services provided by the locum tenens physician. Services provided by the locum tenens must be billed with a modifier Q6:

(A) In entering the Q6 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection, and are services for which the absentee physician is authorized to submit a claim;

(B) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled Provider's right to receive payment or to submit claims may be revoked.

(14) Reciprocal Billing Arrangements:

(a) For purposes of this rule, reciprocal billing arrangements are similar in nature to a locum tenens in that a substitute physician is retained to take over another physician's professional practice on an occasional basis if the regular physician is unavailable (absentee physician);

(b) Providers with reciprocal billing arrangements are not required to enroll with OMAP; however, in no instance may an enrolled absentee physician utilize a substitute physician who is, at that time, excluded from participation in or under sanction by Medicaid or federally funded or federally assisted health programs;

(c) The absentee physician must be an enrolled OMAP Provider and must bill with his or her individual OMAP assigned Provider number and receive payment for covered services provided by the substitute physician. The absentee physician identifies the services provided by the substitute physician by using modifier Q5:

(A) In entering the Q5 modifier, the absentee physician is certifying that the services are provided by a substitute physician identified in a record of the absentee physician that is available for inspection, and are services for which the absentee physician is authorized to submit a claim.

(B) A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud, and the enrolled Provider's right to receive payment or to submit claims may be revoked.

(d) These requirements do not apply to substitute arrangements among physicians in the same medical practice when claims are submitted in the name of the Billing Provider or group name.Nothing in this rules prohibits physicians sharing call responsibilities from opting out of the reciprocal billing (substitute Provider) arrangement described in this rule and submitting their own claims for services provided, as long as all such physicians are themselves enrolled Performing Providers and as long as duplicate claims for services are not submitted.

(15) Provider termination:

(a) The Provider may terminate enrollment at any time. The request must be in writing, and signed by the Provider. The notice shall specify the OMAP assigned Provider number to be terminated and the effective date of termination. Termination of the Provider enrollment does not terminate any obligations of the Provider for dates of services during which the enrollment was in effect;

(b) OMAP Provider terminations or suspensions may be for, but are not limited to the following reasons:

(A) Breaches of Provider agreement;

(B) Failure to comply with the statutes, regulations and policies of the Department of Human Services, Federal or State regulations that are applicable to the Provider.

(C) When no claims have been submitted in an 18-month period. The Provider must reapply for enrollment.

(16) When a Provider fails to meet one or more of the requirements governing a Provider's participation in Oregon's medical assistance programs, the Provider's OMAP assigned Provider number may be immediately suspended. The Provider is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1840 to determine whether the Provider's OMAP assigned number will be revoked.

(17) The provision of health care services or items to OMAP Clients is a voluntary action on the part of the Provider. Providers are not required to serve all OMAP Clients seeking service.

(18) In the event of bankruptcy proceedings, the Provider must immediately notify the Director of OMAP in writing.

[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 33-1981, f. 6-23-81, ef. 7-1-81; AFS 47-1982, f. 4-30-82, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 57-1982, f. 6-28-82, ef. 7-1-82; AFS 117-1982, f. 12-30-82, ef. 1-1-83; AFS 42-1983, f. 9-2-83, ef. 10-1-83; AFS 38-1986, f. 4-29-86, ef. 6-1-86; AFS 73-1989, f. & cert. ef. 12-7-89; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0063, 461-013-0075 & 461-013-0180; HR 19-1990, f. & cert. ef. 7-9-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 51-1991(Temp), f. 11-29-91, cert. ef. 12-1-91; HR 5-1992, f. & cert. ef. 1-16-92; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0020, 410-120-0040 & 410-120-0060; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert ef. 7-1-98; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 9-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1280**
**Billing**

(1) A Provider enrolled with the Office of Medical Assistance Programs (OMAP) must bill using the OMAP assigned provider number, in addition to the National Provider Identification (NPI) number, if the NPI is available.

(2) For Medicaid covered services the Provider must not bill the OMAP more than the Provider's Usual Charge (see definitions) or the reimbursement specified in the applicable Provider rules:

(a) A Provider enrolled with OMAP or providing services to a Client in a managed care plan under the Oregon Health Plan (OHP) must not seek payment for any services covered by Medicaid fee-for-service or through contracted managed care plans, except any coinsurance, co-payments, and deductibles expressly authorized by the General Rules, OHP Rules or individual Provider rules:

(A) An OMAP Client for covered benefits; or

(B) A financially responsible relative or representative of that individual.

(b) Exceptions under which an enrolled Provider may seek payment from an eligible Client or Client representative are described below:

(A) The Provider may seek any applicable coinsurance, copayments and deductibles expressly authorized by OMAP rules in OAR 410 division 120, OAR 410 division 141, or any other individual Provider rules;

(B) The Client did not inform the Provider of OHP eligibility, of OHP managed health plan enrollment, or of other third party insurance coverage, either at the time the service was provided or subsequent to the provision of the service or item, and as a result the Provider could not bill OMAP, the managed health care plan, or third party payer for any reason, including timeliness of claims, lack of Prior Authorization, etc. The Provider must document attempts to obtain information on eligibility or enrollment;

(C) The Client became eligible for OMAP benefits retroactively but did not meet other established criteria described in these General Rules and the appropriate Provider rules (i.e., retroactive authorization);

(D) A Third Party Resource made payments directly to the Client for services provided;

(E) The Client did not have full OMAP benefits. Clients receiving a limited Medicaid coverage, such as the Citizen Alien Waived Emergency Medical Program, may be billed for services that are not benefits of those programs. The Provider must document pursuant to section (3) of this rule that the Client was informed that the service or item would not be covered by OMAP;

(F) The Client has requested continuation of benefits during the Administrative Hearing process and final decision was not in favor of the Client. The Client will be responsible for any charges since the effective date of the initial notice of denial;

(G) A Client cannot be billed for services or treatment that has been denied due to Provider error (e.g., required documentation not submitted, Prior Authorization not obtained, etc.);

(H) The charge is for a copayment when a Client is required to make a copayment as outlined in OMAP General Rules (410-120-1230) and individual Provider rules;

(I) In exceptional circumstances, a Client may request continuation of a covered service while asserting the right to privately pay for that service. Under this exceptional circumstance, a Client can be billed for a covered service if the Client is informed in advance of receiving the specific service of all of the following:

(i) That the requested service is a covered service and that the Provider would be paid in full for the covered service if the claim is submitted to OMAP or the Client's managed care plan, if the Client is a member of a managed care plan; and

(ii) The estimated cost of the covered service, including all related charges, the amount that 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; and

(iii) That the Provider cannot require the Client to enter into a voluntary payment agreement for any amount for the covered service; and

(iv) That, if the Client knowingly and voluntarily agrees to pay for the covered service, the Provider must not submit a claim for payment to OMAP or the Client's managed care plan; and

(v) The Provider must be able to document in writing, signed by the Client or the Client's representative, that the Client was provided the information described above; that the Client was provided an opportunity to ask questions, obtain additional information and consult with the Client's caseworker or Client representative; and the Client agreed to be responsible for payment by signing an agreement incorporating all of the information described above. The Client must be given a copy of the signed agreement. A Provider must not submit a claim for payment for covered services to OMAP or to the Client's managed care plan that is subject to such agreement.

(3) Non-Covered Medicaid Services:

(a) A Provider may bill a Client for services that are not covered by OMAP or the managed care plan. However, the Client must be informed in advance of receiving the specific service that it is not covered, the estimated cost of the service, and that the Client or Client's representative is financially responsible for payment for the specific service. Providers must be able to document in writing signed by the Client or Client's representative, that the Client was provided this information and the Client knowingly and voluntarily agreed to be responsible for payment;

(b) Services which are considered non-covered are listed in the following rules (in rule precedence order):

(A) OAR 410-141-0480, Benefit Package of Covered Services; and

(B) OAR 410-141-0520, Prioritized List of Health Services; and

(C) OAR 410-120-1200, Medical Assistance Benefits: Excluded services and limitations; and

(D) Applicable Provider rules.

(c) A Client cannot be billed for missed appointments. A missed appointment is not considered to be a distinct Medicaid service by the federal government and as such is not billable to the Client or OMAP.

(4) All claims must be billed on the appropriate form as described in the individual Provider rules or submitted electronically in a manner authorized by the Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et. seq.

(5) Upon submission of a claim to OMAP for payment, the Provider agrees that it has complied with all OMAP Provider rules. Submission of a claim, however, does not relieve the Provider from the requirement of a signed Provider agreement.

(6) All billings must be for services provided within the Provider's licensure or certification.

(7) It is the responsibility of the Provider to submit true and accurate information when billing OMAP. Use of a Billing Provider does not abrogate the Performing Provider's responsibility for the truth and accuracy of submitted information.

(8) A claim must not be submitted prior to delivery of service. A claim must not be submitted prior to dispensing, shipment or mailing of the item unless specified otherwise in OMAP's individual Provider rules.

(9) A claim is considered a Valid Claim only if all required data is entered on or attached to the claim form. See the appropriate Provider rules and supplemental information for specific instructions and requirements. Also, see Valid Claim in the Definitions section of these rules.

(10) The HIPAA Codes rules, 45 CFR 162, apply to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for Prior Authorization, claims submissions and payments. Code Set has the meaning established in 45 CFR 162.100, and it includes the codes and the descriptors of the codes. These federal Code Set requirements are mandatory and OMAP lacks any authority to delay or alter their application or effective dates as established by the U.S. Department of Health and Human Services.

(a) OMAP will adhere to the national Code Set requirements in 45 CFR 162.1000 – 162.1011, regardless of whether a request is made verbally, or a claim is submitted on paper or electronically;

(b) Periodically, OMAP will update its Provider rules and tables to conform to national codes. In the event of an alleged variation between an OMAP-listed code and a national code, OMAP will apply the national code in effect on the date of request or date of service and the Provider, and the OMAP-listed code may be used for the limited purpose of describing OMAP's intent in identifying the applicable national code;

(c) Only codes with limitations or requiring Prior Authorization are noted in rules. National Code Set issuance alone should not be construed as OMAP coverage, or a covered service.

(11) Diagnosis Code Requirement:

(a) A primary diagnosis code is required on all claims, using the HIPAA nationally required diagnosis Code Set, unless specifically excluded in individual OMAP Provider rules;

(b) When billing using ICD-9-CM codes, all diagnosis codes are required to the highest degree of specificity;

(c) Hospitals are always required to bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups.

(12) For claims requiring a procedure code the Provider must bill as instructed in the appropriate OMAP Provider rules and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-9-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011, which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the Client's condition and the service(s) provided. Providers must use the ICD-9-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Provider rules. Hospitals must follow national coding guidelines:

(a) When there is no appropriate descriptive procedure code to bill OMAP, 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 OMAP using that code rather than itemizing the services under multiple codes. Providers must not "unbundled" services in order to increase OMAP payment.

(13) No Provider or its contracted agency (including Billing Providers) shall submit or cause to be submitted to OMAP:

(a) Any false claim for payment;

(b) Any claim altered in such a way as to result in a payment for a service that has already been paid;

(c) Any claim upon which payment has been made or is expected to be made by another source unless the amount paid or to be paid by the other party is clearly entered on the claim form;

(d) Any claim for furnishing specific care, item(s), or service(s) that have not been provided.

(14) The Provider is required to submit an Individual Adjustment Request, or to refund the amount of the overpayment, on any claim where the Provider identifies an overpayment made by OMAP.

(15) A Provider who, after having been previously warned in writing by OMAP 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 OMAP for up to triple the amount of the OMAP established overpayment received as a result of such violation.

(16) Third Party Resources (TPR):

(a) Federal law requires that state Medicaid agencies take all reasonable measures to ensure that in most instances OMAP will be the payer of last resort;

(b) Providers must make reasonable efforts to obtain payment first from other resources. For the purposes of this rule "reasonable efforts" include, but are not limited to:

(A) Determining the existence of insurance or other resource by asking the recipient;

(B) Using an insurance database such as Electronic Eligibility Verification Services (EEVS) available to the Provider;

(C) Verifying the Client's insurance coverage through the Automated Information System (AIS) or the Medical Care Identification on each date of service and at the time of billing.

(c) Except as noted in (16)(d)(A through E), when third party coverage is known to the Provider, as indicated on the Medical Care Identification or through AIS, or any other means available, prior to billing OMAP the Provider must:

(A) Bill the TPR; 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; and

(C) Comply with the insurer's billing and authorization requirements; and

(D) Appeal a denied claim when the service is payable in whole or in part by an insurer.

(d) In accordance with federal regulations the Provider must bill the TPR prior to billing OMAP, except under the following circumstances:

(A) The covered health service is provided by an Intermediate Care Facility Services for the Mentally Retarded (ICF/MR);

(B) The covered health service is provided by institutional services for the mentally and emotionally disturbed;

(C) The covered health services are prenatal and preventive pediatric services;

(D) Services are covered by a third party insurer through an absent parent where the medical coverage is administratively or court ordered;

(E) When another party may be liable for an injury or illness (see definition of Liability Insurance), the Provider may bill the insurer or liable party or place a lien against a settlement or the Provider may bill OMAP. The Provider may not both place a lien against a settlement and bill OMAP. The Provider may withdraw the lien and bill OMAP within 12 months of the date of service. If the Provider bills OMAP the Provider must accept payment made by OMAP as payment in full. The Provider must not return the payment made by OMAP in order to accept payment from a liability settlement or liability insurer or place a lien against that settlement:

(i) In the circumstances outlined in (16)(d)(A through E) above, the Provider may choose to bill the primary insurance prior to billing OMAP. Otherwise, OMAP will process the claim and, if applicable, will pay the OMAP allowable rate 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 serv-

ice at a higher rate than OMAP, and that once OMAP makes payment no additional billing to the third party is permitted by the Provider.

(e) The Provider may bill OMAP directly for services that are never covered by Medicare or another insurer on the appropriate form identified in the relevant Provider rules. Documentation must be on file in the Provider's records indicating this is a non-covered service for purposes of Third Party Resources. See the individual Provider rules for further information on services that must be billed to Medicare first;

(f) Providers are required to submit an Individual Adjustment Request showing the amount of the third party payment or to refund the amount received from another source within 30 days of the date the payment is received. Failure to submit the Individual Adjustment Request within 30 days of receipt of the third party payment or to refund the appropriate amount within this time frame is considered concealment of material facts and grounds for recovery and/or sanction;

(A) When a Provider receives a payment from any source prior to the submission of a claim to OMAP, the amount of the payment must be shown as a credit on the claim in the appropriate field;

(B) Except as described in (15), any Provider who accepts third party payment for furnishing a service or item to an OMAP Client shall:

(i) Submit an Individual Adjustment Request after submitting a claim to OMAP following instructions in the individual Provider rules and supplemental billing information, indicating the amount of the third party payment; or

(ii) When the Provider has already accepted payment from OMAP for the specific service or item, the Provider shall make direct payment of the amount of the third party payment to OMAP. When the Provider chooses to directly repay the amount of the third party payment to OMAP, 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 OMAP payment.

(g) OMAP reserves the right to make a claim against any third party payer after making payment to the Provider of service. OMAP may pursue alternate resources following payment if it deems this a more efficient approach. Pursue alternate resources includes, but is not limited to, requesting the Provider to bill the third party and to refund OMAP in accordance with (15) of this rule;

(h) For services rendered to a Medicare and Medicaid dual eligible Client, OMAP 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.

(17) Full Use of Alternate Resources:

(a) OMAP will generally make payment only when other resources are not available for the Client's medical needs. Full use must be made of reasonable alternate resources in the local community;

(b) Except as provided in subsection (18) of this rule, alternate resources may be available:

(A) Under a federal or state worker's compensation law or plan;

(B) For items or services furnished by reason of membership in a prepayment plan;

(C) For items or services provided or paid for directly or indirectly by a health insurance plan or as health benefits of a governmental entity, such as:

(i) Armed Forces Retirees and Dependents Act (CHAMPVA);

(ii) Armed Forces Active Duty and Dependents Military Medical Benefits Act (CHAMPUS); and

(iii) Medicare Parts A and B.

(D) To residents of another state under that state's Title XIX or state funded medical assistance programs; or

(E) Through other reasonably available resources.

(18) Exceptions:

(a) Indian Health Services or Tribal Health Facilities. Pursuant to 42 CFR 35.61 subpart G and the Memorandum of Agreement in OAR 310-146-0000, Indian Health Services facilities and tribal facilities operating under a section 638 agreement are payors of last resort, and are not considered an alternate resource or TPR;

(b) Veterans Administration. Veterans who are also eligible for Medicaid benefits are encouraged to utilize Veterans' Administration facilities whenever possible. Veterans' benefits are prioritized for service related conditions and as such are not considered an alternate or TPR. [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; OMAP 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1300**
**Timely Submission of Claims**

(1) All claims for services must be submitted within 12 months of the date of service. The date of service for an Inpatient Hospital stay is considered the date of discharge.

(2) A claim that was submitted within 12 months of the date of service, but that was denied, may be resubmitted within 18 months of the date of service. These claims must be submitted to the Office of Medical Assistance Programs (OMAP) at the address listed in the Provider Contacts document. The Provider must present documentation acceptable to OMAP verifying the claim was originally submitted within 12 months of the date of service, unless otherwise stated in individual Provider rules. Acceptable documentation is:

(a) A remittance advice from OMAP that shows the claim was submitted before the claim was one year old;

(b) A copy of a billing record or ledger showing dates of submission to OMAP.

(3) Exceptions to the 12-month requirement that may be submitted to OMAP are as follows:

(a) When OMAP or the Client's branch office has made an error that caused the Provider not to be able to bill within 12 months of the date of service. OMAP must confirm the error;

(b) When a court or an Administrative Law Judge has ordered OMAP to make payment;

(c) When the Department determines a Client is retroactively eligible for OMAP medical coverage and more than 12 months have passed between the date of service and the determination of the Client's eligibility.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: PWC 683, f. 7-198-74, ef. 8-11-74; PWC 803(Temp), f. & ef. 7-1-76; PWC 812, f. & ef. 10-1-76; AFS 46-1980, f. & ef. 8-1-80; AFS 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0080; 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 117-1982, f. 12-30-82, ef. 1-1-83; AFS 17-1985, f. 3-27-85, ef. 5-1-85; AFS 55-1987, f. 10-29-87, ef. 11-1-87; HR 2-1990, f. 12-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0145; 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 410-120-0340; HR 31-1994, f. & cert. ef. 11-1-94; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 20-1998, f. & cert. ef. 7-1-98; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1320**
**Authorization of Payment**

(1) Some of the services or items covered by the Office of Medical Assistance Programs (OMAP) require authorization before payment will be made. Some services require authorization before the service can be provided. See the appropriate Provider rules for information on services requiring authorization and the process to be followed to obtain authorization. Services (except Medical Transportation) for Clients identified by OMAP as "medically fragile children," shall be authorized by the Department of Human Services (DHS) Medically Fragile Children's Unit.

(2) Documentation submitted when requesting authorization must support the medical justification for the service. A complete request is one

that contains all necessary documentation and meets any other requirements as described in the appropriate Provider rules.

(3) The authorizing agency will authorize for the level of care or type of service that meets the Client's medical need. Only services which are Medically Appropriate and for which the required documentation has been supplied may be authorized. The authorizing agency may request additional information from the Provider to determine medical appropriateness or appropriateness of the service.

(4) The Department and its authorizing agencies are not required to authorize services or to make payment for authorized services under the following circumstances:

(a) The Client was not eligible at the time services were provided. The Provider is responsible for checking the Client's eligibility each time services are provided;

(b) The Provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the authorizing agency;

(c) The service has not been adequately documented (see 410-120-1360, Requirements for Financial, Clinical and Other Records); that is, the documentation in the Provider's files is not adequate to determine the type, medical appropriateness, or quantity of services provided and required documentation is not in the Provider's files;

(d) The services billed or provided are not consistent with the information submitted when authorization was requested or the services provided are determined retrospectively not to be medically appropriate;

(e) The services billed are not consistent with those provided;

(f) The services were not provided within the timeframe specified on the authorization of payment document;

(g) The services were not authorized or provided in compliance with the rules in these General Rules and in the appropriate Provider rules.

(5) Payment made for services described in subsections (a) through (g) of this rule will be recovered (see also Basis for Mandatory Sanctions and Basis for Discretionary Sanctions).

(6) Retroactive Eligibility:

(a) In those instances when Clients are made retroactively eligible, authorization for payment may be given if (6)(b)(A) through (C) of this rule are met;

(b) Services provided when a Title XIX Client is retroactively disenrolled from a Prepaid Health Plan (PHP) or services provided after the Client was disenrolled from a PHP may be authorized if (6)(b)(A) through (C) of this rule are met:

(A) The Client was eligible on the date of service;

(B) The services provided meet all other criteria and Oregon Administrative Rules;

(C) The request for authorization is received by the appropriate DHS branch or OMAP within 90 days of the date of service.

(c) Any requests for authorization after 90 days from date of service require documentation from the Provider that authorization could not have been obtained within 90 days of the date of service.

(7) Payment Authorization is valid for the time period specified on the authorization notice, but not to exceed 12 months, unless the Client's benefit package no longer covers the service, in which case the authorization will terminate on the date coverage ends.

(8) Payment Authorization for Clients with other insurance or for Medicare beneficiaries:

(a) When Medicare is the primary payer for a service, no Payment Authorization from OMAP is required, unless specified in the appropriate program Provider rules;

(b) For Clients who have private insurance or other Third Party Resources (TPRs), such as Blue Cross, CHAMPUS, etc., OMAP requires Payment Authorization as specified above and in the appropriate Provider rules when the other insurer or resource does not cover the service or when the other insurer reimburses less than the OMAP rate;

(c) For Clients in a Medicare's Social Health Maintenance Organization (SHMO), the SHMO requires Payment Authorization for some services. OMAP requires Payment Authorization for services which are covered by OMAP but which are not covered under the SHMO as specified above and in the appropriate Provider rules.

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 5-1981, f. 1-23-81, ef. 3-1-81; Renumbered from 461-013-0060; AFS 13-1981, f. 2-27-81, ef. 3-1-81; AFS 33-1981, f. 6-23-81, ef. 7-1-81; Renumbered from 461-013-0041; 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 7-1984(Temp), f. 2-28-84, ef. 3-15-84; AFS 11-1984(Temp), f. 3-14-84, ef. 3-15-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; AFS 38-1986, f. 4-29-86, ef. 16-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0106 & 461-013-0180; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0180; HR 22-1994, f. 5-31-94, cert. ef. 6-1-94; 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; 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 10-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1340**
**Payment**

(1) The Office of Medical Assistance Programs (OMAP) will make payment only to the enrolled Provider who actually performs the service or to the Provider's enrolled Billing Provider for covered services rendered to eligible Clients. Any contracted Billing Agent or Billing Service submitting claims on behalf of a Provider but not receiving payment in the name of or on behalf of the Provider does not meet the requirements for Billing Provider enrollment. If electronic transactions will be submitted, Billing Agents and Billing Services must register and comply with Department of Human Services (DHS) Electronic Data Interchange (EDI) rules, OAR 410-001-0100 et.seq. OMAP may require that payment for services be made only after review by OMAP.

(2) OMAP or the Department of Human Services (DHS) office administering the program under which the billed services or items are provided sets fee-for-service payment rates.

(3) All fee-for-service payment rates are the rates in effect on the date of service that are the lesser of the amount billed, the OMAP maximum allowable amount or the reimbursement specified in the individual program Provider rules:

(a) Amount billed may not exceed the Provider's Usual Charge (see definitions);

(b) OMAP's maximum allowable rate setting process uses the following methodology. The rates are posted on the OMAP web site athttp://www.oregon.gov/DHS/healthplan/data_pubs/feeschedule/main.shtml and, updated periodically;

(A) For all CPT/HCPCS codes assigned a Relative Value Unit (RVU) weight OMAP converted to the 2005 Fully Implemented Non-Facility Total RVU weights published in the Federal Register November 15, 2004 (69 FR 66236).to be effective October 1, 2005.

(i) The base rate for labor and delivery (59400-59622) is $38.80.

(ii) CPT codes 92340-92342 and 92352-92353 remain at a flat rate of $25.00.

(iii) All remaining RVU weight based CPT/HCPCS codes have a base rate of $25.95;

(B) Surgical assist reimburses at 20% of the surgical rate;

(C) The base rate for anesthesia services 00100-01996 is $23.35 and is based on per unit of service;

(D) Non-RVU weight based Lab are paid at 97% of 62% or Medicare's rates or as minimally required by Medicare. Other non-RVU Lab services are priced based on the Centers for Medicare and Medicaid Service mandates;

(E) All approved Ambulatory Surgical Center (ASC) procedures are priced using Medicare's Group assignment for each surgical procedure.

(F) Maximum allowable reimbursement for drugs billed under a HCPCS code is based on pricing information provided by First Data bank. These rates may change periodically based on drug costs;

(G) All procedures used for vision materials and supplies are based on contracted rates which include acquisition cost plus shipping and handling;

(c) Individual Provider rules may specify reimbursement rates for particular services or items.

(4) OMAP reimburses Inpatient Hospital service under the DRG methodology, unless specified otherwise in the Hospital services rules. Reimbursement for services, including claims paid at DRG rates, will not exceed any Upper Limits established by federal regulation.

(5) OMAP reimburses all out-of-state Hospital services at Oregon DRG or fee-for-service rates as published in the Hospital Services rules (OAR 410 division 125) unless the Hospital has a contract or Service Agreement with OMAP to provide highly specialized services.

(6) Payment rates for in-home services provided through DHS Seniors and People with Disabilities (SPD) will not be greater than the current OMAP rate for Nursing Facility payment.

(7) DHS sets payment rates for out-of-state institutions and similar facilities, such as skilled nursing care facilities, psychiatric and rehabilitative care facilities at a rate:

(a) That is consistent with similar services provided in the State of Oregon; and (b) Is the lesser of the rate paid to the most similar facility

licensed in the State of Oregon or the rate paid by the Medical Assistance Programs in that state for that service; or

(c) Is the rate established by SPD for out-of-state Nursing Facilities.

(8) OMAP will not make payment on claims that have been assigned, sold, or otherwise transferred or on which the Billing Provider, Billing Agent or Billing Service receives a percentage of the amount billed or collected or payment authorized. This includes, but is not limited to, transfer to a collection agency or individual who advances money to a Provider for accounts receivable.

(9) OMAP will not make a separate payment or copayment to a Nursing Facility or other Provider for services included in the Nursing Facility's All-Inclusive Rate. The following services are not included in the All-Inclusive Rate and may be separately reimbursed:

(a) Legend drugs, biologicals and hyperalimentation drugs and supplies, and enteral nutritional formula as addressed in the Pharmaceutical Services (OAR 410 division 121) and Home Enteral/Parenteral Nutrition and IV Services Provider rules, (OAR 410 division 148);

(b) Physical Therapy, Speech Therapy, and Occupational Therapy provided by a non-employee of the Nursing Facility within the appropriate program Provider rules, (OAR 410 division 131 and 129);

(c) Continuous oxygen which exceeds 1,000 liters per day by lease of a concentrator or concentrators as addressed in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122);

(d) Influenza immunization serum as described in the Pharmaceutical Services Provider rules, (OAR 410 division 121);

(e) Podiatry services provided under the rules in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(f) Medical services provided by Physician or other Provider of medical services, such as radiology and Laboratory, as outlined in the Medical-Surgical Services Provider rules, (OAR 410 division 130);

(g) Certain custom fitted or specialized equipment as specified in the Durable Medical Equipment and Medical Supplies Provider rules, (OAR 410 division 122).

(10) OMAP 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 OMAP Clients with Medicare and Medicaid:

(a) OMAP limits payment to the Medicaid allowed amount less the Medicare payment up to the OMAP allowable rate. OMAP payment cannot exceed the co-insurance and deductible amounts due;

(b) OMAP pays the OMAP allowable rate for OMAP covered services that are not covered by Medicare.

(12) For Clients with Third-Party Resources (TPR), OMAP pays the OMAP allowed rate less the TPR payment but not to exceed the billed amount.

(13) OMAP payments, including contracted Prepaid Health Plan (PHP) payments, unless in error, constitute payment in full, except in limited instances involving allowable spend-down or copayments. For OMAP such payment in full includes:

(a) Zero payments for claims where a third party or other resource has paid an amount equivalent to or exceeding OMAP's allowable payment; and

(b) Denials of payment for failure to submit a claim in a timely manner, failure to obtain Payment Authorization in a timely and appropriate manner, or failure to follow other required procedures identified in the individual Provider rules.

(14) Payment by OMAP does not limit the Department of Human Services or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit or other post-payment review determines the service was not provided in accordance with applicable rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment.

[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; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1350**
**Buying-Up**

(1) Providers are not permitted to bill and accept payment from the Office of Medical Assistance Programs (OMAP) or a managed care plan for a covered service:

(a) When a Non-Covered Service has been provided; and

(b) Additional payment is sought or accepted from the OMAP Client;

(2) Examples include, but are not limited to, charging the Client an additional payment to obtain a gold crown (non covered) instead of the stainless steel crown (covered) or charging an additional Client payment to obtain eyeglass frames not on the OMAP or managed care plan contract.

(3) If a Client wants to purchase a Non-Covered Service or item, the Client must be responsible for full payment. OMAP or managed care plan payment for a covered service cannot be credited toward the Non-Covered Service.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1360**
**Requirements for Financial, Clinical and Other Records**

The Department of Human Services (DHS) is responsible for analyzing and monitoring the operation of the Office of Medical Assistance Programs (OMAP) 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 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 that are adequately documented. Documentation must be completed before the service is billed to OMAP:

(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 rules 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 DHS, the Medicaid Fraud Unit, Oregon Secretary of State, or the Department of Health and Human Services (DHHS), 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 DHS, Medicaid Fraud Unit, or DHHS, 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 DHHS; 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 DHS 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 OMAP 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. 8-11-74; 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 461-013-0060; 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; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1380**
**Compliance with Federal and State Statutes**

(1) When a Provider submits a claim for medical services or supplies provided to an Office of Medical Assistance Programs (OMAP) Client, OMAP will deem the submission as a representation by the medical Provider to the Medical Assistance Program of the medical Provider's compliance with the applicable sections of the federal and state statutes referenced in this rule:

(a) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973;

(b) 42 CFR Part 493 Laboratory Requirements and ORS 438 (Clinical Laboratories).

(c) Unless exempt under 45CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, the Provider must comply and, as indicated, cause all sub-contractors to comply with the following federal requirements to the extent that they are applicable to the goods and services governed by these rules. For purposes of these rules, all references to federal and state laws are references to federal and state laws as they may be amended from time to time:

(A) The Provider must comply and cause all subcontractors to comply with all federal laws, regulations, executive orders applicable to the goods and services provided under these rules. Without limiting the generality of the foregoing, the Provider expressly agrees to comply and cause all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the goods and services provided under these rules:

(i) Title VI and VII of the Civil Rights Act of 1964, as amended;

(ii) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended;

(iii) The Americans with Disabilities Act of 1990, as amended;

(iv) Executive Order 11246, as amended;

(v) The Health Insurance Portability and Accountability Act of 1996;

(vi) The Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended;

(vii) The Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (viii) all regulations and administrative rules established pursuant to the foregoing laws;

(viii) All other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations;

(ix) All federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the goods and services governed by these rules and required by law to be so incorporated. No federal funds may be used to provide services in violation of 42 USC 14402.

(B) If the goods and services governed under these rules exceed $10,000, the Provider must comply and cause all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in DHS of Labor regulations (41 CFR Part 60);

(C) If the goods and services governed under these rules exceed $100,000, the Provider must comply and cause all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act — 33 U.S.C. 1251 to 1387), specifically including, but not limited to, Section 508 (33 U.S.C. 1368). Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 32), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations must be reported to the Department of Human Services (DHS), the federal Department of Health and Human Services (DHHS) and the appropriate Regional Office of the Environmental Protection Agency. The Provider must include and cause all subcontractors to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section;

(D) The Provider must comply and cause all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act, 42 U.S.C. 6201 et seq. (Pub. L. 94-163);

(E) The Provider certifies, to the best of the Provider's knowledge and belief, that:

(i) No federal appropriated funds have been paid or will be paid, by or on behalf of the Provider, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement;

(ii) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Provider must complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions;

(iii) The Provider must require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients and subcontractors must certify and disclose accordingly;

(iv) This certification is a material representation of fact upon which reliance was placed when this Provider agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Provider agreement imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification will be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

(F) If the goods and services funded in whole or in part with financial assistance provided under these rules are covered by the Health Insurance Portability and Accountability Act or the federal regulations implementing the Act (collectively referred to as HIPAA), the Provider agrees to deliver the goods and services in compliance with HIPAA. Without limiting the generality of the foregoing, goods and services funded in whole or in part

with financial assistance provided under these rules are covered by HIPAA. The Provider must comply and cause all subcontractors to comply with the following:

(i) Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between the Provider and DHS for purposes directly related to the provision to Clients of services that are funded in whole or in part under these rules. However, the Provider must not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate DHS Privacy Rules, OAR 410-014-0000 et. seq., or DHS Notice of Privacy Practices, if done by DHS. A copy of the most recent DHS Notice of Privacy Practices is posted on the DHS Web site or may be obtained from DHS;

(ii) If the Provider intends to engage in Electronic Data Interchange (EDI) transactions with DHS in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transactions, the Provider must execute an EDI Trading Partner Agreement with DHS and must comply with the DHS EDI rules;

(iii) If a Provider reasonably believes that the Provider's or the DHS' data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, the Provider must promptly consult the DHS Privacy Officer. The Provider or DHS may initiate a request to test HIPAA transactions, subject to available resources and the DHS testing schedule.

(G) The Provider must comply and cause all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Parts 247;

(H) The Provider must comply and, if applicable, cause a subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations;"

(I) The Provider must not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12,549 and No. 12,689, "Debarment and Suspension". (See 45 CFR part 76). This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and Providers and subcontractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold must provide the required certification regarding their exclusion status and that of their principals prior to award;

(J) The Provider must comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace:

(i) The Provider certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in the Provider's workplace or while providing services to DHS Clients. The Provider's notice must specify the actions that will be taken by the Provider against its employees for violation of such prohibitions;

(ii) Establish a drug-free awareness program to inform its employees about the dangers of drug abuse in the workplace, the Provider's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations;

(iii) Provide each employee to be engaged in the performance of services under these rules a copy of the statement mentioned in paragraph (J)(i) above;

(iv) Notify each employee in the statement required by paragraph (J)(i) that, as a condition of employment to provide services under these rules, the employee will abide by the terms of the statement and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

(v) Notify DHS within ten (10) days after receiving notice under subparagraph (J)(iv) from an employee or otherwise receiving actual notice of such conviction;

(vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988;

(vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (J)(i) through (J)(vi);

(viii) Require any subcontractor to comply with subparagraphs (J)(i) through (J)(vii);

(ix) Neither the Provider, nor any of the Provider's employees, officers, agents or subcontractors may provide any service required under these rules while under the influence of drugs. For purposes of this provision, "under the influence" means observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Provider or Provider's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Provider or Provider's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to DHS Clients or others. Examples of abnormal behavior include, but are not limited to hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to slurred speech, difficulty walking or performing job activities;

(x) Violation of any provision of this subsection may result in termination of the Provider agreement under these rules.

(K) The Provider must comply and cause all sub-contractors to comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.);

(L) The Provider must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. Seq., including without limitation:

(i) Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and must furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 USC Section 1396a(a)(27); 42 CFR 431.107(b)(1) & (2);

(ii) Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B);

(iii) Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I;

(iv) Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. The Provider must acknowledge Provider's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(2) Hospitals, Nursing Facilities, Home Health Agencies (including those providing personal care), Hospices and Health Maintenance Organizations will comply with the Patient Self-Determination Act as set forth in Section 4751 of OBRA 1991. To comply with the obligation under the above listed laws to deliver information on the rights of the individual under Oregon law to make health care decisions, the named Providers and organizations will give capable individuals over the age of 18 a copy of "Your Right to Make Health Care Decisions in Oregon," copyright 1993, by the Oregon State Bar Health Law Section. Out-of-State Providers of these services should comply with Medicare and Medicaid regulations in their state. Submittal to OMAP of the appropriate billing form requesting payment for medical services provided to a Medicaid eligible Client shall be deemed representation to OMAP of the medical Provider's compliance with the above-listed laws.

(3) Providers described in ORS chapter 419B are required to report suspected child abuse to their local DHS Children, Adults and Families office or police, in the manner described in ORS 419.

(4) The Clinical Laboratory Improvement Act (CLIA), requires all entities that perform even one laboratory 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.

[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 461-13-160 & 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 & 410-120-0400; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 10-1999, f. & cert. ef 4-1-99; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1385**
**Compliance with Public Meetings Law**

(1) Advisory committees with the authority to make decisions for, conduct policy research for, or make recommendations on administration or policy related to the medical assistance programs operated by the Department of Human Services (DHS) pursuant to ORS Chapter 414 must comply with provisions of ORS 192.610 to 192.690 — Public Meetings Law.

(2) This rule applies to those advisory committees of the medical assistance programs operated under ORS Chapter 414 that are both:

(a) Created by state constitution, statutes, administrative rule, order, intergovernmental agreement, or other official act, including direct or delegated authority from the Director of DHS; and

(b) Comprised of at least two committee members who are not employed by a public body.

(3) Advisory committees subject to this rule must comply with the following provisions:

(a) Meetings must be open to public attendance unless an executive session is authorized. Committees must meet in a place accessible to persons with disabilities and, upon request, shall make a good faith effort to provide a sign language interpreter for persons with hearing impairment.

(b) Groups must provide advanced notice of meetings, location, and principal subjects to be discussed. Posting notices on the Web site operated by the DHS Office of Medical Assistance Programs (OMAP) will be sufficient compliance of the advanced notice requirement. Interested persons, including news media, may request hard copy notices by contacting the OMAP Communications Unit;

(c) Groups must take minutes at meetings and make them available to the public upon request to the contact person identified on the public notice;

(d) Any meeting that is held through the use of telephone or other electronic communication must be conducted in accordance with the Public Meetings Law.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 62-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1390**
**Premium Sponsorships**

(1) Premium donations made for the benefit of one or more specified Office of Medical Assistance Programs (OMAP) Clients will be referred to as a Premium Sponsorship and the donor shall be referred to as a sponsor.

(2) The Department of Human Services (DHS) may accept Premium Sponsorships consistent with the requirements of this rule. DHS may adopt such forms and reporting requirements, and change the forms and reporting requirements, as necessary to carry out its functions under this rule. DHS may identify one or more designees to perform one or more of the functions of DHS under this rule.

(3) This rule does not create or establish any Premium Sponsorship program. DHS does not operate or administer a Premium Sponsorship program. DHS does not find sponsors for Clients or take requests or applications from Clients to be sponsored.

(4) This rule does not create a right for any OMAP Client to be sponsored. Premium Sponsorship is based solely on the decisions of sponsors. DHS only applies the Premium Sponsorship funds that are accepted by DHS as instructed by the sponsor. DHS does not determine who may be sponsored. Any operations of a Premium Sponsorship program are solely the responsibility of the sponsoring entity.

(5) A Premium Sponsorship amount that is not actually received by the OMAP Client will not be deemed to be cash or other resource attributed to the OMAP Client, except to the extent otherwise required by federal law. An OMAP Client's own payment of his or her obligation, or payment made by an authorized representative of the OMAP Client, is not a sponsorship except to the extent that the authorized representative is otherwise subject to subsection (8) of this rule.

(6) Nothing in this rule alters the OMAP Client's personal responsibility for assuring that his or her own payments (including current or past due premium payments) are made on time as required under any DHS rule

(7) If DHS accepts a Premium Sponsorship payment for the benefit of a specified Client, DHS or its designee will credit the amount of the sponsorship payment toward any outstanding amount owed by the specified Client. DHS or its designee is not responsible for notifying the Client that a Premium Sponsorship payment is made or that a sponsorship payment has stopped being made.

(7) If a sponsor is a health care Provider, or an entity related to a health care Provider, or an organization making a donation on behalf of such Provider or entity, the following requirements apply:

(a) DHS will decline to accept Premium Sponsorships that are not "bona fide donations" within the meaning of 42 CFR 433.54. A Premium Sponsorship is a "bona fide donation" if the sponsorship has no direct or indirect relationship to Medicaid payments made to a health care Provider, a related entity providing health care items or services, or other Providers furnishing the same class of items or services as the Provider or entity;

(b) For purposes of this rule, terms "health care Provider," "entity related to a health care Provider" and "Provider-related donation" will have the same meaning as those terms are defined in 42 CFR 433.52. A health care Provider includes but is not limited to any Provider enrolled with OMAP or contracting with a Prepaid Health Plan for services to Oregon Health Plan Clients.

(c) Premium Sponsorships made to DHS by a health care Provider or an entity related to a health care Provider do not qualify as a "bona fide donation" within the meaning of subsection (a) of this section, and DHS will decline to accept such sponsorships;

(d) If a health care Provider or an entity related to a health care Provider donates money to an organization, which in turn donates money in the form of a Premium Sponsorship to DHS, the organization will be referred to as an organizational sponsor. DHS may accept Premium Sponsorship from an organizational sponsor if the organizational sponsor has completed the initial DHS certification process and complies with this rule. An organizational sponsor may not itself be a health care Provider, Provider-related entity, or a unit of local government;

(e) All organizational sponsors that make Premium Sponsorships to DHS submit quarterly reports to DHS about the percentage of its revenues that are from donations by Providers and Provider-related entities. The organization's chief executive officer or chief financial officer must certify the quarterly report. In its certification, the organizational sponsor must agree that its records may be reviewed to confirm the accuracy, completeness and full disclosure of the donations, donation amounts and sources of donations. DHS will decline to accept donations or gifts from an organization that refuses or fails to execute necessary certifications or to provide access to documentation upon request;

(f) DHS will decline to accept Premium Sponsorships from an organizational sponsor if the organization receives more than 25 percent of its revenue from donations from Providers or Provider-related entities during the State's fiscal year;

(g) Any health care Provider or entity related to a health care Provider making a donation to an organizational sponsor, or causing another to make a Premium Sponsorship on its behalf, and any organizational sponsor, is solely responsible for compliance with laws and regulations applicable to any donation, including but not limited to 42 CFR 1001.951 and 1001.952.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 38-2004(Temp), f. 5-28-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 72-2004, f. 9-23-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1395**
**Program Integrity**

(1) The Department of Human Services (DHS) uses several approaches to promote program integrity. These rules describe program integrity actions related to Provider payments. Our program integrity goal is to pay the correct amount to a properly enrolled Provider for covered, Medically Appropriate services provided to an eligible Client according to the Client's benefit package of health care services in effect on the date of service. Types of program integrity activities include but are not limited to the following activities:

(a) Medical review and Prior Authorization processes, including all actions taken to determine the medical appropriateness of services or items;

(b) Provider obligations to submit correct claims;

(c) Onsite visits to verify compliance with standards;

(d) Implementation of Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards to improve accuracy and timeliness of claims processing and encounter reporting;

(e) Provider credentialing activities;

(f) Accessing federal Department of Health and Human Services database (exclusions);

(g) Quality improvement activities;

(h) Cost report settlement processes;

(i) Audits;

(j) Investigation of fraud or prohibited kickback relationships;

(k) Coordination with the Department of Justice Medicaid Fraud Control Unit (MFCU) and other health oversight authorities;

(2) Providers must maintain clinical, financial and other records, capable of being audited or reviewed, consistent with the requirements of OAR 410-120-1360 Requirements for Financial, Clinical and Other Records, the General Rules, the Oregon Health Plan Administrative Rules, and the rules applicable to the service or item.

(3) The following people may review a request for services or items, or audit a claim for care, services or items, before or after payment, for assurance that the specific care, item or service was provided in accordance with the Office of Medical Assistance Program's (OMAP's) rules and the generally accepted standards of a Provider's field of practice or specialty:

(a) DHS staff or designee; or

(b) Medical utilization and review contractor; or

(c) Dental utilization and review contractor; or

(d) Federal or state oversight authority.

(4) Payment may be denied or subject to recovery if the review or audit determines the care, service or item was not provided in accordance with OMAP rules or does not meet the criteria for quality or medical appropriateness of the care, service or item or payment. Related Provider and Hospital billings will also be denied or subject to recovery.

(5) When the Department determines that an Overpayment has been made to a Provider, the amount of Overpayment is subject to recovery.

(6) The Department may communicate with and coordinate any program integrity actions with the MFCU, DHHS, and other federal and state oversight authorities.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1397**
**Recovery of Overpayments to Providers - Recoupments and Refunds**

(1) The Department of Human Services (DHS) requires Providers to submit true, accurate, and complete claims or encounters. The Office of Medical Assistance Programs (OMAP) treats the submission of a claim or encounter, whether on paper or electronically, as certification by the Provider of the following: "This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim or encounter will be from federal and state funds, and that any falsification or concealment of a material fact maybe prosecuted under federal and state laws."

(2) DHS staff or a medical or dental utilization and review contractor may review or audit a claim before or after payment for assurance that the specific care, item or service was provided in accordance with the rules and policies of OMAP and the generally accepted standards of a Provider's field of practice or specialty.

(3) OMAP may deny payment or may deem payments subject to recovery if a medical review or audit determines the service was not provided in accordance with OMAP's policy and rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment. Related Provider and Hospital billings will also be denied or subject to recovery.

(4) If a Provider determines that a submitted claim or encounter is incorrect, the Provider is obligated to submit an Individual Adjustment Request and refund the amount of the Overpayment, if any, consistent with the requirements of OAR 410-120-1280. When the Provider determines that an Overpayment has been made, the Provider must notify and reimburse the Department immediately, following one of the reimbursement procedures described below:

(a) Submitting a Medicaid adjustment form (OMAP 1036-Individual Adjustment Request). It is not necessary to refund with a check;

(b) Providers preferring to make a refund by check will attach a copy of the remittance statement page indicating the Overpayment information. If the Overpayment involves an insurance payment or another Third Party Resource, Providers will attach a copy of the remittance statement from the insurance payer:

(A) Refund checks not involving Third Party Resource payments will be made payable to OMAP Receipting — Checks in Salem;

(B) Refunds involving Third Party Resource payments will be made payable and submitted to OMAP Receipting — MPR Checks in Salem.

(5) The Department may determine, as a result of review or other information, that a payment should be denied or that an Overpayment has been made to a Provider, which indicates that a Provider may have submitted claims or encounters, or received payment to which the Provider is not properly entitled. Such payment denial or Overpayment determinations may be based on, but not limited to, the following grounds:

(a) The Department paid the Provider an amount in excess of the amount authorized under the state plan or other DHS policy;

(b) A third party paid the Provider for services (or a portion thereof) previously paid by the Department;

(c) The Department paid the Provider for services, items, or drugs that the Provider did not perform or provide;

(d) The Department paid for claims submitted by a data processing agent for whom a written Provider or Billing Agent/Billing Service agreement was not on file at the time of submission;

(e) The Department paid for services and later determined they were not part of the client's benefit package;

(f) Data processing submission or data entry errors;

(g) Medical review determines the service was not provided in accordance with OMAP's rules or does not meet the criteria for quality of care, or medical appropriateness of the care or payment;

(h) The Department paid the Provider for services, items, or drugs when the Provider did not comply with OMAP's rules and requirements for reimbursement.

(6) When an Overpayment is identified, OMAP will notify the Provider in writing, as to the nature of the discrepancy, the method of computing the dollar amount of the Overpayment, and any further action that the Department may take in the matter;

(7) The Department may recover Overpayments made to a Provider by direct reimbursement, offset, civil action, or other actions authorized by law:

(a) The Provider must make a direct reimbursement to OMAP within thirty (30) calendar days from the date of the notice of the Overpayment, unless other regulations apply;

(b) The Department may grant the Provider an additional 30-day grace period upon request;

(c) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due;

(d) OMAP may withhold payment on pending claims and on subsequently received claims for the amount of the overpayment when Overpayments are not paid as a result of Section (7)(a);

(e) OMAP may file a civil action in the appropriate Court and exercise all other civil remedies available to DHS in order to recover the amount of an overpayment.

(8) In addition to any Overpayment, the Department may impose a Sanction on the Provider in connection with the actions that resulted in the Overpayment. The Department may, at its discretion, combine a notice of Sanction with a notice of Overpayment.

(9) Voluntary submission of an Individual Adjustment Request or Overpayment amount after notice from the Department does not prevent the Department from issuing a notice of Sanction, but the Department may take such voluntary payment into account in determining the Sanction.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.010
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1400**
**Provider Sanctions**

(1) The Department of Human Services (DHS) recognizes two classes of Provider Sanctions, mandatory and discretionary, outlined in (3) and (4) respectively.

(2) Except as otherwise noted, DHS will impose Provider Sanctions at the discretion of the DHS Director or the Administrator of the DHS Office whose budget includes payment for the services involved.

(3) The Office of Medical Assistance Programs (OMAP) will impose mandatory Sanctions and suspend the Provider from participation in Oregon's medical assistance programs:

(a) When a Provider of Medical Services has been convicted (as that term is defined in 42 CFR 1001.2) of a felony or misdemeanor related to a crime, or violation of Title XVIII, XIX, or XX of the Social Security Act or related state laws;

(b) When a Provider is excluded from participation in federal or state health care programs by the Office of the Inspector General of the U.S. Department of Health and Human Services or from the Medicare (Title XVIII) program of the Social Security Act as determined by the Secretary of Health and Human Services. The Provider will be excluded and suspended from participation with OMAP for the duration of exclusion or suspension from the Medicare program or by the Office of the Inspector General.

(c) If the Provider fails to disclose ownership or control information required under 42 CFR 455.104 that is required to be reported at the time the Provider submits a Provider enrollment application or when there is a material change in the information that must be reported, or information related to business transactions required to be provided under 42 CFR 455.105 upon request of federal or state authorities.

(4) OMAP may impose discretionary Sanctions when OMAP determines that the Provider fails to meet one or more of OMAP's requirements governing participation in its medical assistance programs. Conditions that may result in a discretionary Sanction include, but are not limited to, when a Provider has:

(a) Been convicted of Fraud related to any federal, state, or locally financed health care program or committed Fraud, received kickbacks, or committed other acts that are subject to criminal or civil penalties under the Medicare or Medicaid statutes; (b) Been convicted of interfering with the investigation of health care Fraud;

(c) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(d) By actions of any state licensing authority for reasons relating to the Provider's professional competence, professional conduct, or financial integrity either:

(A) Had his or her health care license suspended or revoked, or has otherwise lost such license; or

(B) Surrendered his or her license while a formal disciplinary proceeding is pending before such licensing authority.

(e) Been suspended or excluded from participation in any federal or state health care program for reasons related to professional competence, professional performance, or other reason;

(f) Billed excessive charges (i.e., charges in excess of the Usual Charge); furnished items or services substantially in excess of the OMAP Client's needs or in excess of those services ordered by a medical Provider or in excess of generally accepted standards or of a quality that fails to meet professionally recognized standards;

(g) Failed to furnish medically necessary services as required by law or contract with OMAP if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the OMAP Client;

(h) Failed to disclose required ownership information;

(i) Failed to supply requested information on subcontractors and suppliers of goods or services;

(j) Failed to supply requested payment information;

(k) Failed to grant access or to furnish as requested, records, or grant access to facilities upon request of OMAP or the State of Oregon's Medicaid Fraud Unit conducting their regulatory or statutory functions;

(l) In the case of a Hospital, failed to take corrective action as required by OMAP, based on information supplied by the Quality Improvement Organization (formerly referred to as the Professional Review Organization), to prevent or correct inappropriate admissions or practice patterns, within the time specified by OMAP;

(m) Defaulted on repayment of federal or state government scholarship obligations or loans in connection with the Provider's health profession education. OMAP:

(A) Must have made a reasonable effort to secure payment;

(B) Must take into account access of beneficiaries to services; and

(C) Will not exclude a community's sole physician or source of essential specialized services.

(n) Repeatedly submitted a claim with required data missing or incorrect:

(A) When the missing or incorrect data has allowed the Provider to:

(i) Obtain greater payment than is appropriate;

(ii) Circumvent Prior Authorization requirements;

(iii) Charge more than the Provider's Usual Charge to the general public;

(iv) Receive payments for services provided to persons who were not eligible;

(v) Establish multiple claims using procedure codes that overstate or misrepresent the level, amount or type of health care provided.

(B) Does not comply with the requirements of OAR 410-120-1280.

(o) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate clinical or other records that document the medical appropriateness, nature, and extent of the health care provided;

(p) Failed to develop, maintain, and retain in accordance with relevant rules and standards adequate financial records that document charges incurred by a Client and payments received from any source;

(q) Failed to develop, maintain and retain adequate financial or other records that support information submitted on a cost report;

(r) Failed to follow generally accepted accounting principles or accounting standards or cost principles required by federal or state laws, rules, or regulations;

(s) Submitted claims or written orders contrary to generally accepted standards of medical practice;

(t) Submitted claims for services that exceed that requested or agreed to by the Client or the responsible relative or guardian or requested by another medical Provider;

(u) Breached the terms of the Provider contract or agreement. This includes failure to comply with the terms of the Provider certifications on the medical claim form;

(v) Rebated or accepted a fee or portion of a fee or charge for an OMAP Client referral; or collected a portion of a service fee from the Client, and billed OMAP for the same service;

(w) Submitted false or fraudulent information when applying for an OMAP assigned Provider number, or failed to disclose information requested on the Provider enrollment application;

(x) Failed to correct deficiencies in operations after receiving written notice of the deficiencies from OMAP;

(y) Submitted any claim for payment for which payment has already been made by OMAP or any other source unless the amount of the payment from the other source is clearly identified;

(z) Threatened, intimidated or harassed Clients or their relatives in an attempt to influence payment rates or affect the outcome of disputes between the Provider and OMAP;

(aa) Failed to properly account for an OMAP Client's Personal Incidental Funds; including but not limited to using a Client's Personal Incidental Funds for payment of services which are included in a medical facility's all-inclusive rates;

(bb) Provided or billed for services provided by ineligible or unsupervised staff;

(cc) Participated in collusion that resulted in an inappropriate money flow between the parties involved, for example, referring Clients unnecessarily to another Provider;

(dd) Refused or failed to repay, in accordance with an accepted schedule, an overpayment established by OMAP;

(ee) Failed to report to OMAP payments received from any other source after OMAP has made payment for the service;

(ff) Collected or made repeated attempts to collect payment from Clients for services covered by OMAP, per OAR 410-120-1280, Billing.

(5) A Provider who has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, shall not submit claims for payment, either personally or through claims submitted by any Billing Agent/Service, Billing Provider or other Provider, for any services or supplies provided under the medical assistance programs, except those services or supplies provided prior to the date of exclusion, suspension or termination.

(6) Providers must not submit claims for payment to OMAP for any services or supplies provided by a person or Provider entity that has been excluded, suspended or terminated from participation in a federal or state medical program, such as Medicare or Medicaid, or whose license to practice has been suspended or revoked by a state licensing board, except for those services or supplies provided prior to the date of exclusion, suspension or termination.

(7) When the provisions of subsections (5) or (6) are violated, OMAP may suspend or terminate the Billing Provider or any individual performing Provider within said organization who is responsible for the violation(s).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: 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 42-1983, f. 9-2-83, ef. 10-1-83; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0600; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1460**
**Type, Duration, and Determination of Sanction**

(1) The Office of Medical Assistance Programs (OMAP) may impose mandatory Sanctions on a Provider pursuant to OAR 410-120-1400(3), in which case:

(a) The Provider will be either terminated or suspended from participation in Oregon's medical assistance programs;

(b) If suspended, the minimum duration of suspension will be determined by the Secretary of the Department of Health and Human Services

(DHHS), under the provisions of 42 CFR Parts 420, 455, 1001, or 1002. The State may suspend a Provider from participation in Oregon's medical assistance programs longer than the minimum suspension determined by the DHHS Secretary.

(2) OMAP may impose the following discretionary Sanctions on a Provider pursuant to OAR 410-120-1400(4):

(a) The Provider may be terminated from participation in Oregon's medical assistance programs;

(b) The Provider may be suspended from participation in Oregon's medical assistance programs for a specified length of time, or until specified conditions for reinstatement are met and approved by OMAP;

(c) OMAP may withhold payments to a Provider;

(d) The Provider may be required to attend Provider education sessions at the expense of the sanctioned Provider;

(e) OMAP may require that payment for certain services are made only after OMAP has reviewed documentation supporting the services;

(f) OMAP may recover investigative and legal costs;

(g) OMAP may provide for reduction of any amount otherwise due the Provider; and the reduction may be up to three times the amount a Provider sought to collect from a Client in violation of OAR 410-120-1280;

(h) Any other Sanctions reasonably designed to remedy or compel future compliances with federal, state or OMAP regulations.

(3) OMAP will consider the following factors in determining the Sanction(s) to be imposed (this list includes but is not limited to these factors):

(a) Seriousness of the offense(s);

(b) Extent of violations by the Provider;

(c) History of prior violations by the Provider;

(d) Prior imposition of Sanctions;

(e) Prior Provider education;

(f) Provider willingness to comply with program rules;

(g) Actions taken or recommended by peer review groups, licensing boards or a Quality Improvement Organization (QIO) formerly termed a Peer Review Organization (PRO); and

(h) Adverse impact on the health of OMAP Clients living in the Provider's service area.

(4) When a Provider fails to meet one or more of the requirements identified in this rule OMAP, at its sole discretion, may immediately suspend the Provider's OMAP assigned billing number to prevent public harm or inappropriate expenditure of public funds.

(a) The Provider subject to immediate suspension is entitled to a contested case hearing as outlined in 410-120-1600 through 410-120-1700 to determine whether the Provider's OMAP assigned number will be revoked.

(b) The notice requirements described in (5) do not preclude immediate suspension at OMAP's sole discretion to prevent public harm or inappropriate expenditure of public funds. Suspension may be invoked immediately while the notice and contested case hearing rights are exercised.

(5) If OMAP decides to Sanction a Provider, OMAP will notify the Provider by certified mail or personal delivery service of the intent to Sanction. The notice of immediate or proposed Sanction will identify:

(a) The factual basis used to determine the alleged deficiencies;

(b) Explanation of actions expected of the Provider;

(c) Explanation of subsequent actions OMAP intends to take;

(d) The Provider's right to dispute OMAP's allegations, and submit evidence to support the Provider's position; and

(e) The Provider's right to appeal OMAP's proposed actions pursuant to OAR 410-120-1560 through 410-120-1700.

(6) If OMAP makes a final decision to Sanction a Provider, OMAP will notify the Provider in writing at least 15 days before the effective date of action, except in the case of immediate suspension to avoid public harm or inappropriate expenditure of funds.

(7) The Provider may appeal OMAP's immediate or proposed Sanction(s) or other action(s) the Department intends to take, including but not limited to the following list. The Provider must appeal these actions separately from any appeal of audit findings and overpayments:

(a) Termination or suspension from participation in the Medicaid-funded medical assistance programs;

(b) Termination or suspension from participation in OMAP's state-funded programs;

(c) Revocation of the Provider's OMAP assigned Provider number.

(8) Other provisions:

(a) When a Provider has been Sanctioned, all other Provider entities in which the Provider has ownership (five percent or greater) or control of, may also be Sanctioned;

(b) When a Provider has been Sanctioned, OMAP may notify the applicable professional society, board of registration or licensure, federal or state agencies, Oregon Health Plan Prepaid Health Plans and the National Practitioner Data Base of the findings and the Sanctions imposed;

(c) At the discretion of OMAP, Providers who have previously been terminated or suspended may or may not be re-enrolled as Providers of Medicaid services in Oregon;

(d) Nothing in this rule prevents the Department from simultaneously seeking monetary recovery and imposing Sanctions against the Provider;

(e) If OMAP discovers continued improper billing practices from a Provider who, after having been previously warned in writing by OMAP or the Department of Justice about improper billing practices and has had an opportunity for a contested case hearing, that Provider will be liable to OMAP for up to triple the amount of OMAP's established overpayment received as a result of such violation.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
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; 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 24-1985, f. 4-24-85, cert. ef. 6-1-85; AFS 33-1986, f. 4-11-86, ef. 6-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0095 & 461-013-0140; 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 410-120-0260 & 410-120-0660; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1505**
**Provider Audits**

(1) Providers receiving payments from the Office of Medical Assistance Programs (OMAP) are subject to audit for all payments applicable to services rendered or items supplied to or on behalf of OMAP Clients. The audit ensures that proper payments were made on the basis of the requirements applicable to covered services, to recover Overpayments, and to discover possible instances or Fraud and Abuse.

(2) The Department may employ such staff, consultants, contractors or other designee, as it deems appropriate, to conduct an audit. The Department will identify one or more persons assigned to conduct the audit. For purposes of these rules, the person assigned to conduct the audit will be referred to as the Auditor.

(3) The Auditor determines the scope and time period covered by the audit.

(4) The Auditor may conduct an on-site visit, examine and copy records and documents, interview employees, and conduct such field work as it determines will provide a sufficient and competent evidential basis for drawing conclusions about the subject matter of the audit.

(5) The Auditor may consider other audits of the Provider, including but not limited to the Provider's independent auditors of the Provider's financial statements, but may include those performed by internal auditors or audit organizations established by the federal or state government for programs other than Medicaid. The Auditor may also consider other indicators such as Prior Authorization issues related to program integrity activities., and whether past or present program integrity activities such as those listed in OAR 410-120-1395 have identified the same or similar instances of non-compliance. The Auditor is responsible for evaluating the reliability of the other audit work, and to consider the scope of the other audit and its relationship to the scope and objective of the audit being conducted by the Department, in determining the weight to be given to the other audit work.

(6) The Auditor may use a 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., (a.k.a., Calvin Paper). The Department of Human Services (DHS) hereby adopts by reference, but is not limited to, the method of random sampling and calculation of Overpayment described in the Calvin Paper.

(a) In determining whether to use the Overpayment calculation method set forth in subsection (6) of this rule, the Department may consider:

(A) The Provider's overall error rate identified in the audit;

(B) Whether past audits have identified same or similar instances of non-compliance;

(C) The severity of the errors;

(D) Adverse impact on the health of OMAP Clients and their access to services in the Provider's service area.

(b) If the Auditor determines an Overpayment amount by the random sampling and Overpayment calculation method set forth in subsection (6) of this rule, the Provider may request a 100 percent audit of all billings submitted to OMAP for services provided during a period specified by the DHS Auditor. 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 an Auditor (such as a certified public accountant or other person designated as the Auditor) whose qualifications DHS has determined, in writing, to be acceptable, who is knowledgeable with the Oregon Administrative Rules covering the payments in question, and the Provider must waive any privilege in relation to the work papers and work product of the Auditor; and

(C) The audit must be conducted within 120 calendar days of the Provider's request to use such audit in lieu of the Department's random sample.

(7) The Auditor will prepare a preliminary audit report and send it to the Provider for review and comment. The preliminary audit report will inform the Provider of the opportunity to provide additional information to the Auditor about the information within the scope of the audit report, and to permit the Provider to request a meeting with the Auditor to review the preliminary audit report.

(8) The Auditor will prepare a final audit report and include an Overpayment assessment, where applicable. The amount of audit Overpayment to be recovered:

(a) Will be the entire amount determined or agreed to by the Department; 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.

(9) The final audit report will be delivered to the Provider in person or by registered or certified mail.

(10) If the Provider disagrees with the final audit report or the amount of Overpayment, the Provider may appeal the decision by requesting an administrative review from OMAP, unless OMAP declines to conduct an administrative review, then the Provider may appeal to a contested case hearing. In general, appeals limited to legal or policy issues may be appropriate for administrative review. Appeals that require the decision-maker to resolve disputed factual issues and the development of a factual record should be appealed as a contested case.

(a) The Provider must submit to OMAP a written request for hearing or administrative review of the decision being appealed pursuant to OAR 410-120-1560, Provider Appeals. The request must specify the area(s) of disagreement;

(b) Failure to request either a hearing or an administrative review in a timely manner constitutes acceptance by the Provider of the final audit report, the amount of the Overpayment, and any Sanctions, if combined with the final audit report.

(11) The Overpayment is due and payable 30 calendar days from the date of the Department's decision:

(a) The Department may grant the Provider an additional 30-day grace period upon request;

(b) A request for a hearing or administrative review does not change the date the repayment of the overpayment is due.

(12) The Department may extend the reimbursement period or accept an offer of repayment terms. The Department must make any change in reimbursement period or terms in writing.

(13) If the Provider refuses to reimburse the overpayment or does not adhere to an agreed upon payment schedule, the Department may:

(a) Recoup future Provider payments up to the amount of the overpayment; and

(b) Pursue civil action to recover the overpayment.

(14) As the result of a hearing or review, the amount of the overpayment may be reduced in part or in full.

(15) The Department may, at any time, change the amount of the Overpayment upon receipt of additional information. The Department will verify any changes in writing. OMAP will refund to the Provider any monies paid to OMAP that exceed an Overpayment.

(16) If a Provider is terminated or sanctioned for any reason, the Department may pursue civil action to recover any amounts due and payable to OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.010
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1510**
**Fraud and Abuse**

(1) This rule sets forth requirements for detecting and investigating Fraud and Abuse. The terms Fraud and Abuse in this rule are defined in OAR 410-120-0000. As used in these rules, terms have the following meanings:

(a) "Conviction" or "convicted" means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending;

(b) "Exclusion" means that OMAP will not reimburse a specific Provider who has defrauded or abused OMAP for items or services that Provider furnished;

(c) "Prohibited kickback relationships" means remuneration or payment practices that may result in federal civil penalties or exclusion for violation of 42 CFR 1001.951;

(d) "Suspension" means OMAP will not reimburse a specified Provider who has been convicted of a program-related offense in a federal, state or local court for items or services that Provider furnished.

(2) Provider is required to promptly refer all suspected Fraud and Abuse, including Fraud or Abuse by its employees or in OMAP administration, to the Medicaid Fraud Control Unit (MFCU) of the Department of Justice or to the Department of Human Services (DHS) Audit Unit. The Department of Justice Medicaid Fraud Control Unit (MFCU) phone number is (503) 229-5725, address 1515 SW 5th Avenue, Suite 410, Portland, Oregon 97201, and fax is (503) 229-5459. The Department of Human Services Audit Unit phone number is (503) 945-6691, address 500 Summer St. NE, Salem, Oregon 97301-1097, and fax is (503) 947-5400.

(3) Provider shall permit the MFCU or DHS or both to inspect, copy, evaluate or audit books, records, documents, files, accounts, and facilities, without charge, as required to investigate an incident of Fraud or Abuse.

(4) Provider, if aware of suspected Fraud or Abuse by an OMAP Client (i.e., Provider reporting OMAP Client Fraud and Abuse) must report the incident to the Department Fraud Unit. Address suspected OMAP Client Fraud and Abuse reports to the Department Fraud Investigation Unit, P.O. Box 14150, Salem, Oregon 97309-5027, or phone (503) 378-1872, or fax (503) 373-1525.

(5) The Department may share information for health oversight purposes with the MFCU and other federal or state health oversight authorities.

(6) The Department is authorized to take the actions necessary to investigate and respond to substantiated allegations of Fraud and Abuse, including but not limited to suspending or terminating the Provider from participation in the medical assistance programs, withholding payments or seeking recovery of payments made to the Provider, or imposing other Sanctions provided under state law or regulations. Such actions by the Department may be reported to the Centers for Medicare and Medicaid Services, or other federal or state entities as appropriate.

(7) Providers and their fiscal agents must disclose ownership and control information, and disclose information on a Provider's owners and other persons convicted of criminal offenses against Medicare, Medicaid or the Title XX services program. Such disclosure and reporting is made a part of the Provider enrollment agreement, and the Provider is obligated to update that information with an amended Provider enrollment agreement if any of the information materially changes. The Department will use that information to meet the requirements of 42 CFR 455.100 to 455.106, and this rule must be construed in a manner that is consistent with the Department acting in compliance with those requirements.

(8) The Department will not pay for covered services provided by persons who are currently suspended, debarred or otherwise excluded from participating in Medicaid, Medicare, or SCHIP, or who have been convicted of a felony or misdemeanor related to a crime or violation of Title XVIII, XIX, or XX of the Social Security Act or related laws.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1560**
**Provider Appeals**

Effective for services provided on or after October 1, 2005.

(1) An enrolled Provider may appeal a claim payment, claim decision, Overpayment determination, Sanction decision or other decision in which the Provider is directly adversely affected in the manner provided in this rule:

(a) Client appeals of Actions must be handled in accordance with OAR 140-120-1860 and 410-120-1865.

(b) An Office of Medical Assistance Programs (OMAP) denial of or limitation of payment allowed or OMAP overpayment determination for

services or items provided to a Client must be appealed as Claim Reconsideration under OAR 410-120-1570;

(c) An OMAP denial of a Provider's application for participation in the Department's medical assistance programs must be appealed as administrative review under OAR 410-120-1580; or

(d) A notice of Sanctions imposed, or intended to be imposed, on a Provider, or denial of continued participation as an enrolled Provider, must be appealed as administrative review under OAR 410-120-1580, unless the effect of the notice of Sanction is, or will be, to suspend or revoke a right of privilege of the Provider which must be appealed as a contested case hearing under OAR 410-120-1600. A Provider that is entitled to appeal a notice of Sanction as a contested case may request administrative review instead of contested case hearing under the following circumstances:

(i) The Provider submits a written request for administrative review of the notice of Sanction and agrees in writing to waive the right to a contested case hearing; and

(ii) OMAP agrees to review the appeal of the notice of Sanction as an administrative review;

(e) Final audit report Overpayment determinations as a result of an audit may be appealed by requesting either a contested case hearing or an administrative review from OMAP as provided in OAR 410-120-1505 (Provider Audits). If a final audit report is combined with a notice of Sanction, the procedure in subsection (d) will apply to the appeal of the audit report and the notice of Sanction.

(f) Some decisions that adversely affect a Provider may be made by other program areas within the Department of Human Services (DHS) such as the audits unit or the information security office, or by DHS contractors such as OMAP's pharmacy benefits manager, or by entities performing statutory functions related to the medical assistance programs such as the Drug Use Review Board, in the conduct of program integrity activities applicable to the administration of the medical assistance programs. However, other program areas within DHS that have responsibility for administering medical assistance funding, such as nursing home care or community mental health and developmental disabilities program services, may make decisions that adversely affect a Provider. Those Providers are subject to the Provider grievance or appeal processes applicable to those program areas. Only if OMAP has legal authority to make the final decision in the matter, a Provider may appeal such a decision to OMAP as an administrative review and OMAP may accept such review.

(2) For Prepaid Health Plan (PHP) Providers of services, supplies or items to Clients in a PHP, the PHP Provider must exhaust all levels of the appeals process outlined by the Participating Provider's contract, or the rules applicable to claims submission or payment by a Non-Participating Provider, with the PHP prior to submitting an appeal to OMAP. PHP Provider appeals to OMAP must be appealed as an administrative review under OAR 410-120-1580.

(3) This rule does not apply to contract administration issues that may arise solely between OMAP and a PHP. Such issues shall be governed by the terms of the applicable contract.

(4) A Provider appeal is initiated by filing a request for review with OMAP on time.

(a) A request for review does not have to follow a specific format as long as it provides a clear written expression from a Provider or Provider applicant expressing disagreement with an OMAP decision or from a PHP Provider expressing disagreement with a decision by a PHP. The request should identify the decision made by OMAP or a PHP that is being appealed and the reason the Provider disagrees with that decision.

(b) A request for review should specify the type of appeal being requested, such as claim reconsideration, administrative review, or contested case hearing as provided for in these Provider appeal rules. Failure to correctly identify the proper type of appeal will not be used to invalidate a request for review. If OMAP determines at any time prior to a claim reconsideration, administrative review meeting or contested case hearing that a different type of appeal applies to the request, OMAP will notify the Provider and refer the appeal to the appropriate procedure as long as the request for review is otherwise timely filed and eligible for appeal.

(5) In the event a request for review is not timely, OMAP will determine whether the failure to file the request was caused by circumstances beyond the control of the Provider, and enter an order accordingly. In determining whether to accept a late request for review, OMAP requires the request to be supported by a written statement that explains why the request for review is late. OMAP may conduct such further inquiry as OMAP deems appropriate. In determining timeliness of filing a request for review, the amount of time that OMAP determines accounts for circumstances beyond the control of the Provider is not counted. OMAP may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness.

(6) For purposes of these Provider appeal rules, the following terms have these meanings:

(a) "Provider" means a person or entity enrolled with OMAP that has requested an appeal in relation to health care services, supplies or items provided or requested to be provided to a Client on a fee-for-service basis or under contract with OMAP where that contract expressly incorporates these rules.

(b) "Provider Applicant" means a person or entity that has submitted an application to become an enrolled Provider with OMAP but the application has not been approved.

(c) "Prepaid Health Plan" has the meaning in OAR 410-141-0000, except to the extent that Mental Health Organizations (MHO) have separate procedures applicable to Provider grievances and appeals.

(d) "Prepaid Health Plan Provider" means a person or entity providing health care services, supplies or items to a Client enrolled with a PHP, including both Participating Providers and Non-participating Providers as those terms are defined in OAR 410-141-0000, except that services provided to a Client enrolled with an MHO shall be governed by the Provider grievance and appeal procedures administered by the Office of Mental Health and Addiction Services.

(e) The "Provider Appeal Rules" refers to the rules in OAR 410-120-1560 to 410-120-1700, describing the availability of appeal procedures and the procedures applicable to each appeal procedure.

(7) The burden of presenting evidence to support a fact or position rests on the proponent of the fact or position. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(8) Administrative review and contested case hearings will be held in Salem, unless otherwise stipulated to by all parties and agreed to by OMAP.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 409.010

Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; 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; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 0461-013-0191; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0780; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1570**

**Provider Appeals — Claims Reconsideration**

(1) A Provider disputing an Office of Medical Assistance Programs (OMAP) claim payment, or claim decision, including Prior Authorization issues, or OMAP overpayment notice (other than Overpayment determinations made in an audit report) may request claim reconsideration. The Provider must submit a request for review in writing to OMAP, Provider Services Unit within one year from OMAP's decision. If the request for claim reconsideration is filed late, OMAP will determine whether to accept a late filing in accordance with OAR 410-120-1560(5).

(2) The request for review must include the specific service, supply or item for which claim reconsideration is being requested and why the Provider disagrees with that determination. The Provider should include a copy of the denial decision or Remittance Advice that describes the basis for the claim denial under reconsideration, and any information pertinent to the resolution of the dispute.

(3) OMAP will complete an additional review, which may include such further inquiry as OMAP deems appropriate. OMAP will respond back to the Provider in writing.

(4) If the Provider disagrees with the results of the claim reconsideration on the basis of the application of law or policy to the claim or authorization denial, the Provider may request an administrative review as outlined in OAR 410-120-1580 if the request for administrative review is made within 30 calendar days of the date the decision on claim reconsideration is issued.

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; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1580**
**Provider Appeals — Administrative Review**

(1) An administrative review allows an opportunity for the Administrator of the Office of Medical Assistance Programs (OMAP) or designee to review a decision affecting the Provider, Provider Applicant, or Prepaid Health Plan (PHP) Provider, where administrative review is appropriate and consistent with these Provider appeal rules. The administrative review may include the provision of new information or other actions that may result in OMAP, or the PHP, changing its decision. The request for an administrative review:

(a) Must be in writing to the OMAP Administrator;

(b) Must specify the issues or decisions being appealed and the reason for the appeal on each issue or decision. Give specifics for each claim such as procedure code, diagnosis code, reason for denial, administrative rule(s) or other authority applicable to the issue, and why the Provider, Provider Applicant, or PHP Provider disagrees with the decision. If this information is not included in the request, in a manner that reasonably permits OMAP to understand the decision being appealed and the basis for the appeal the request for review will be returned and will need to be resubmitted within the time specified by OMAP in writing;

(c) PHP Providers must exhaust all levels of the appeals process outlined by the PHP prior to submitting an appeal to the Administrator (Participating and Non-Participating Providers). The PHP will be contacted to provide information about their decision. The PHP Provider must submit documentation that reflects completion of the review with the PHP, in addition to the information specified in subsection (b);

(d) Must be filed and received by the OMAP Administrator within 30 calendar days of decision from OMAP or the final decision from the PHP. In the event a request for review is late, OMAP will determine whether to accept a late filing in accordance with OAR 410-120-1560(5).

(2) The OMAP Administrator or designee will decide which decisions may be suitable for review as administrative review, taking into consideration the issues presented in the request for review and such other inquiry as OMAP deems appropriate.

(a) In general, appeals presenting legal or policy issues may be appropriate to administrative review. Appeals that require the decision-maker to resolve disputed factual issues and to develop a factual record may be determined to be appropriate for contested case hearing;

(b) If the Administrator denies a request for an administrative review that was timely filed on the basis that the appeal should be heard as a contested case hearing, the Administrator or designee will notify the Provider or PHP Provider and refer the appeal directly for a contested case hearing under these rules;

(c) A decision to deny review of a decision previously reviewed as Claim Reconsideration under OAR 410-120-1570 is a final decision on administrative review; but if the appeal has not been reviewed first as a Claim Reconsideration but OMAP determines that Claim Reconsideration is appropriate, the Administrator may refer the request for review to the procedures established under OAR 410-120-1570 (Claim Reconsideration).

(d) If preliminary review indicates that the matter should be handled as a Client contested case, the Administrator should refer the Provider or PHP Provider to the procedures established under OAR 410-120-1860 and 410-120-1865 and should dismiss the Provider appeal if the matter is addressed under those Client appeal procedures.

(3) If the Administrator decides that a meeting between the Provider, Provider Applicant or PHP Provider and OMAP staff will assist the review, the Administrator or designee will:

(a) Notify the Provider, Provider Applicant or PHP Provider requesting the review of the date, time, and place the meeting is scheduled;

(b) Notify the PHP (when Client is enrolled in a PHP) of the date, time, and place the meeting is scheduled. The PHP is not required to participate, but is invited to participate in the process.

(4) The review meeting will be conducted in the following manner:

(a) It will be conducted by the OMAP Administrator, or designee;

(b) No minutes or transcript of the review will be made;

(c) The Provider, Provider Applicant or PHP Provider requesting the review does not have to be represented by counsel during an administrative review meeting and will be given ample opportunity to present relevant information;

(d) OMAP staff will not be available for cross-examination, but OMAP staff may attend and participate in the review meeting;

(e) Failure to appear constitutes acceptance of OMAP's determination;

(f) The Administrator may combine similar administrative review proceedings, including the meeting, if the Administrator determines that joint proceedings may facilitate the review;

(g) The OMAP Administrator or designee may request the Provider, Provider Applicant or PHP Provider making the appeal to submit, in writing, new information that has been presented orally. In such an instance, a specific date for receiving such information will be established.

(5) The results of the administrative review will be sent to the Provider Provider Applicant or PHP Provider, involved in the review, and to the PHP when review involved a PHP Provider, in writing, within 30 calendar days of the conclusion of the administrative review proceeding. The result of the administrative review is final and binding on the parties to the administrative review.

(6) All administrative review decisions are subject to the procedures established in OAR 137-004-0080 to 137-004-0092 and judicial review under ORS 183.484 in the Circuit Court.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: 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 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0191 & 461-013-0220; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0800; 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 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1600**
**Provider Appeals (Level 3) — Contested Case Hearings**

(1) These rules apply to all contested case hearings of the Office of Medical Assistance Programs (OMAP) involving Providers or Prepaid Health Plan (PHP) Providers. The hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to the Office of Medical Assistance Programs for purposes of these rules. OAR 410-120-1560, Provider Appeals, to OAR 410-120-1700, Provider Hearings — Proposed and Final Orders, are the procedural rules applying to contested case hearings for Provider appeals conducted by the Office of Medical Assistance Programs (OMAP). The method described in OAR 137-003-0520(8) is used in computing any period of time applicable to timely filing of Provider requests for contested case hearings.

(2) A request for a contested case hearing is considered filed when the written request for review asking for a contested case hearing is received by the OMAP Administrator or by the person designated by the Administrator, within thirty (30) calendar days of the date of the decision affecting the Provider.

(a) If OMAP receives a request for contested case hearing from a Provider, Provider Applicant, or PHP Provider, OMAP will preliminarily review the request to determine whether it is properly reviewed as a contested case under OAR 410-120-1560. If the request for hearing was timely filed but should have been filed as claim reconsideration or administrative review, OMAP will refer the request to the proper appeal procedure and notify the Provider, Provider Applicant or PHP Provider.

(b) Client appeals that request a contested case hearing will be handled in accordance with OAR 410-120-1860 and 410-120-1865.

(3) In the event a request for contested case hearing is not timely, OMAP will determine whether to accept late filing in accordance with OAR 410-120-1560(5).

(4) In the event the Provider has no right to a contested case hearing on an issue, OMAP may enter an order accordingly. OMAP may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the Provider has a right to a contested case hearing.

(5) The party to a Provider hearing is the Provider. In the event that OMAP determines that a PHP Provider is entitled to a contested case hearing, the PHP Provider and the PHP are parties to the hearing. A Provider, PHP Provider or PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(6) The burden of presenting evidence to support a fact or position rests on the proponent of the fact or position. Consistent with OAR 410-120-1360, payment on a claim will only be made for services that are adequately documented and billed in accordance with OAR 410-120-1280 and all applicable administrative rules related to covered services for the Client's benefit package and establishing the conditions under which services, supplies or items are covered, such as the Prioritized List, medical appropriateness and other applicable standards.

(7) Hearings will be held in Salem, unless otherwise stipulated to by all parties and agreed to by OMAP.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-44, ef. 9-1-84; AFS 51-1985, f. 8-16-85, ef. 9-1-85; 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; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0191 & 461-013-0225; 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 410-120-0820; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 73-2003, f. & cert. ef. 10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1680**
**Provider Appeals — Contested Case Pre-Hearing Conference**

(1) After a request for review is timely filed and the Office of Medical Assistance Programs (OMAP) determines that the appeal should be conducted as a contested case hearing, OMAP shall notify the Provider(s) of the time and place of an informal conference, without the presence of the Administrative Law Judge (ALJ). The purposes of this informal conference are:

(a) To provide an opportunity to settle the matter;

(b) To make sure the parties and the Department understand the reason for the action that is the subject of the hearing request;

(c) To give the parties and the Department an opportunity to review the information which is the basis for that action;

(d) To give the parties and the Department the chance to correct any misunderstanding of the facts; and

(e) To determine if the parties wish to have any witness subpoenas issued when the contested case hearing is conducted; and

(f) To discuss any of the maters listed in OAR 137-003-0575.

(2) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(3) The parties must participate in the informal conference or provide to OMAP a statement of the issues being contested, including a detailed statement of the basis for the Provider's disagreement.

(4) OMAP may grant to the Provider or the PHP Provider the relief sought at any time.

(5) The Provider may, at any time prior to the hearing date, request an additional informal conference with the Department representative, which may be granted if the Department representative finds, in his or her sole discretion, that the additional informal conference will facilitate the hearing process or resolution of disputed issues.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: AFS 51-1985, f. 8-16-85; HR 2-1990, f.2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0205; HR 41-1991, f. & cert. ef. 10-1-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-012-0900; OMAP 19-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1700**
**Provider Appeals — Proposed and Final Orders**

(1) The Administrative Law Judge (ALJ) will conduct the contested case hearing using the Attorney General's Model Rules at OAR 137-003-0501 and following:

(2) In a contested case hearing, the ALJ will serve a proposed order to all parties and the Office of Medical Assistance Programs (OMAP) unless prior to the hearing, OMAP notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (2), unless OMAP notifies the parties and the ALJ that OMAP will issue the final order.

(3) If the ALJ issues a proposed order, and the proposed order is adverse to a party, the party may file exceptions or written argument to the proposed order to be considered by OMAP. The exceptions must be in writing and reach OMAP not later than 10 calendar days after the date of the proposed order is issued by the ALJ. No additional evidence may be submitted without prior approval of OMAP. After receiving the exceptions or argument, if any, OMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, OMAP may issue an amended proposed order.

(4) A Provider may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by OMAP or the ALJ, whichever is first. The ALJ will send a final order confirming the withdrawal to the Provider. The Provider may cancel the withdrawal up to the 10th calendar day following the date such order is effective.

(5) If neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing, OMAP may elect one of the following options in its sole discretion:

(a) The hearing request may be dismissed by order, effective on the date scheduled for the hearing. OMAP may cancel the dismissal order on request of the party on a showing that the party was unable to attend the hearing and unable to request a postponement for reasons beyond his or her control; or

(b) OMAP may enter a final order by default, consistent with the procedures established in OAR 137-003-0670. Entry of a final order by default may be made when the agency determines that the issuance of a final order with findings is appropriate as a basis of sanction authority or to establish a basis for future Sanction authority or other reason consistent with the administration of the medical assistance programs. The designated record for purposes of a default order shall be the record as designated in the notice issued to the party or, if not so designated, shall consist of the files and records held by the Department in the hearing packet prepared by the Department in preparation for the hearing and such other information that may have been submitted by a party in advance of the hearing for use in the hearing.

(6) The final order is effective immediately upon being signed or as otherwise provided in the order. Final orders resulting from a Provider's withdrawal of a hearing request are effective the date the Provider withdraws. When the Provider fails to appear for the hearing, the effective date of the dismissal order or the final order by default is the date of the scheduled hearing.

(7) All contested case hearing decisions are subject to the procedures established in OAR 137-003-675 to 137-003-0700 and to judicial review under ORS 183.482 in the Court of Appeals.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0920; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1855**
**Client's Rights and Responsibilities**

(1) Office of Medical Assistance Programs (OMAP) Clients shall have the following rights:

(a) To be treated with dignity and respect;

(b) To be treated by Providers the same as other people seeking health care benefits to which they are entitled;

(c) To refer oneself directly to mental health, chemical dependency or family planning services without getting a referral from a PCP or other Provider;

(d) To have a friend, family member, or advocate present during appointments and at other times as needed within clinical guidelines;

(e) To be actively involved in the development of his/her treatment plan;

(f) To be given information about his/her condition and covered and non-covered services to allow an informed decision about proposed treatment(s);

(g) To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;

(h) To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

(i) To have written materials explained in a manner that is understandable to the OMAP Client;

(j) To receive necessary and reasonable services to diagnose the presenting condition;

(k) To receive OMAP covered services that meet generally accepted standards of practice and are Medically Appropriate;

(l) To obtain covered Preventive Services;

(m) To receive a referral to specialty Providers for Medically Appropriate covered services;

(n) To have a clinical record maintained which documents conditions, services received, and referrals made;

(o) To have access to one's own clinical record, unless restricted by statute;

(p) To transfer of a copy of his/her clinical record to another Provider;

(q) To execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or mental health treatment and the right to execute directives and powers of attorney for health care established under ORS 127 as amended by the Oregon Legislative Assembly 1993 and the OBRA 1990 — Patient Self-Determination Act;

(r) To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;

(s) To know how to make a Complaint, Grievance or Appeal with OMAP and receive a response as defined in OAR 410-120-1860 and 410-120-1865;

(t) To request an Administrative Hearing with the Department of Human Services;

(u) To receive a notice of an appointment cancellation in a timely manner;

(v) To receive adequate notice of DHS privacy practices.

(2) OMAP Clients shall have the following responsibilities:

(a) To treat the Providers and clinic's staff with respect;

(b) To be on time for appointments made with Providers and to call in advance either to cancel if unable to keep the appointment or if he/she expects to be late;

(c) To seek periodic health exams and preventive services from his/her PCP or clinic;

(d) To use his/her PCP or clinic for diagnostic and other care except in an Emergency;

(e) To obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

(f) To use Emergency Services appropriately

(g) To give accurate information for inclusion in the Clinical Record;

(h) To help the Provider or clinic obtain Clinical Records from other Providers which may include signing an authorization for release of information;

(i) To ask questions about conditions, treatments and other issues related to his/her care that is not understood;

(j) To use information to make informed decisions about treatment before it is given;

(k) To help in the creation of a treatment plan with the Provider;

(l) To follow prescribed agreed upon treatment plans;

(m) To tell the Provider that his or her health care is covered with OMAP before services are received and, if requested, to show the Provider the OMAP Medical Care Identification form;

(n) To tell the DHS worker of a change of address or phone number;

(o) To tell the DHS worker if the OMAP Client becomes pregnant and to notify the DHS worker of the birth of the OMAP Client's child;

(p) To tell the DHS worker if any family members move in or out of the household;

(q) To tell the DHS worker if there is any other insurance available;

(r) To pay for Non-covered services under the provisions described in OAR 410-120-1200 and 410-120-1280;

(s) To pay the monthly OHP premium on time if so required;

(t) To assist OMAP in pursuing any Third Party Resources available and to pay OMAP the amount of benefits it paid for an injury from any recovery received from that injury;

(u) To bring issues, or Complaints or Grievances to the attention of the OMAP; and

(v) To sign an authorization for release of medical information so that DHS can get information which is pertinent and needed to respond to an Administrative Hearing request in an effective and efficient manner.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1860**
**Client Contested Case Hearing Procedures**

(1) These rules apply to all contested case hearings provided by the Office of Medical Assistance Programs (OMAP) involving a Client's medical or dental benefits, except as otherwise provided in OAR 410-141-0263. The hearings are conducted in accordance with the Attorney General's model rules at OAR 137-003-0501 and following. When the term "agency" is used in the Attorney General's model rules, it shall refer to OMAP for purposes of this rule. The method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in this division of rules (OAR 410 division 120) applicable to timely filing of Client requests for hearing.

(2) Medical Provider appeals and administrative reviews involving OMAP are governed by OAR 410-120-1560 through 410-120-1700 .

(3) Complaints and appeals for Clients requesting or receiving medical assistance from a Prepaid Health Plan (PHP) shall be governed exclusively by the procedures in OAR 410-0141-0260. This rule describes the procedures applicable when those Clients request and are eligible for an OMAP contested case hearing.

(4) Contested Case Hearing Requests:

(a) A Client has the right to a contested case hearing in the following situations upon the timely completion of a request for a hearing:

(A) The Department acts to deny Client services, payment of a claim, or to terminate, discontinue or reduce a course of treatment, or issues related to disenrollment in a Fully Capitated Health Plan (FCHP), Physician Care Organization (PCO), Dental Care Organization (DCO) or Chemical Dependency Organization (CDO); or

(B) The right of a Client to request a contested case hearing is otherwise provided by statute or rule, including OAR 410-141-0264(10) describing when a Client of a PHP may request a state hearing.

(b) To be timely, a request for a hearing is complete when OMAP receives the Department's Administrative Hearing request form (DHS 443) not later than the 45th day following the date of the decision notice;

(c) In the event a request for hearing is not timely, OMAP will determine whether the failure to timely file the hearing request was caused by circumstances beyond the control of the Client and enter an order accordingly. In determining whether to accept a late hearing request, OMAP requires the request to be supported by a written statement that explains why the request for hearing is late. OMAP may conduct such further inquiry as OMAP deems appropriate. In determining timeliness of filing a hearing request, the amount of time that OMAP determines accounts for circumstances beyond the control of the Client is not counted. OMAP may refer an untimely request to the Office of Administrative Hearings for a hearing on the question of timeliness;

(d) In the event the claimant has no right to a contested case hearing on an issue, OMAP may enter an order accordingly. OMAP may refer a hearing request to the Office of Administrative Hearings for a hearing on the question of whether the claimant has a right to a contested case hearing;

(e) A Client who requests a hearing shall be referred to as a claimant. The parties to a contested case hearing are the claimant and, if the claimant has requested a hearing about a decision of a PHP, the claimant's PHP;

(f) A Client may be represented by any of the persons identified in ORS 183.458. A PHP that is a corporation may be represented by any of the persons identified in ORS 410.190.

(5) Expedited Hearings:

(a) A claimant who feels his or her medical or dental problem cannot wait for the normal review process may be entitled to an expedited hearing.

(b) Expedited hearings are requested using **DHS Form 443**.

(c) OMAP's staff will request all relevant medical documentation and present the documentation obtained in response to that request to OMAP's Medical Director or the Medical Director's designee for review. The OMAP's Medical Director or the Medical Director's designee will decide if the claimant is entitled to an expedited hearing within, as nearly as possible, two working days from the date of receiving the documentation applicable to the request;

(d) An expedited hearing will be allowed, if OMAP's Medical Director or the Medical Director's designee, determines that the claimant has a medical condition which is an immediate, serious threat to claimant's life or health and claimant has been denied a medical service.

(6) Informal Conference:

(a) The OMAP hearing representative and the claimant, and their legal representative if any, may have an informal conference, without the presence of the Administrative law Judge (ALJ), to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for OMAP and the claimant to settle the matter;

(B) Provide an opportunity to make sure the claimant understands the reason for the action that is subject of the hearing request;

(C) Give the claimant and OMAP an opportunity to review the information that is the basis for that action;

(D) Inform the claimant of the rules that serve as the basis for the contested action;

(E) Give the claimant and OMAP the chance to correct any misunderstanding of the facts;

(F) Determine if the claimant wishes to have any witness subpoenas issued for the hearing; and

(G) Give OMAP an opportunity to review its action.

(b) The claimant may, at any time prior to the hearing date, request an additional informal conference with the Department representative, which may be granted if the Department representative finds, in his or her sole dis-

cretion, that the additional informal discussion will facilitate the hearing process or resolution of disputed issues;

(c) OMAP may provide to the claimant the relief sought at any time before the Final Order is served.

(d) Any agreement reached in an informal conference shall be submitted to the ALJ in writing or presented orally on the record at the hearing.

(7) A claimant may withdraw a hearing request at any time. The withdrawal is effective on the date it is received by OMAP or the ALJ, whichever is first. The ALJ will send a Final Order confirming the withdrawal to the claimant's last known address. The claimant may cancel the withdrawal up to the tenth calendar day following the date such an order is effective.

(8) Contested case hearings are closed to non-participants in the hearing.

(9) Proposed and Final Orders:

(a) In a contested case, an ALJ assigned by the Office of Administrative Hearings will serve a proposed order on all parties and OMAP, unless, prior to the hearing, OMAP notifies the ALJ that a final order may be served. The proposed order issued by the ALJ will become a final order if no exceptions are filed within the time specified in subsection (b) unless OMAP notifies the parties and the ALJ that OMAP will issue the final order.

(b) If the ALJ issues a proposed order, and a party adversely affected by the proposed order may file exceptions to the proposed order or present argument for OMAP's consideration:

(A) The exceptions must be in writing and reach OMAP not later than 10 working days after date the proposed order is issued by the ALJ;

(B) After receiving the exceptions, if any, OMAP may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Department will issue an amended proposed order.

(10) A hearing request is dismissed by order when neither the party nor the party's legal representative, if any, appears at the time and place specified for the hearing. The order is effective on the date scheduled for the hearing. OMAP will cancel the dismissal order on request of the party on a showing that the party was unable to attend the hearing and unable to request a postponement for reasons beyond his or her control.

(11) The final order is effective immediately upon being signed or as otherwise provided in the order. A final order resulting from the claimant's withdrawal of the hearing request are effective the date the claimant withdraws. When claimant fails to appear for the hearing and the hearing request is dismissed by final order, the effective date of the order is the date of the scheduled hearing.

(12) All contested case hearing decisions are subject to judicial review under ORS 183.482 in the Court of Appeals.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: 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 13-1984(Temp), f. & ef. 4-2-84; AFS 37-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0053; HR 19-1990, f. & cert. ef. 7-9-90; HR 35-1990(Temp), f. & cert. ef. 10-15-90; HR 32-1990, f. 9-24-90, cert. ef. 10-1-90; HR 41-1990, f. & cert. ef. 11-26-90; HR 11-1991(Temp), f. & cert. ef. 3-1-91; HR 34-1991, f. & cert. ef. 8-26-91; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0760; HR 7-1996, f. 5-31-96 & cert. ef. 6-1-96; HR 5-1997, f. 1-31-97, cert. ef. 2-1-97; OMAP 41-2000, f. & cert. ef. 12-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1865**
**Denial, Reduction, or Termination of Services**

(1) The purpose of this rule is to describe the requirements governing the denial, reduction or termination of medical assistance, and access to the Office of Medical Assistance Programs (OMAP) administrative hearings process, for Clients requesting or receiving medical assistance services paid for by the Department on a fee-for-service basis. Complaint and appeal procedures for Clients receiving services from a Prepaid Health Plan shall be governed exclusively by the procedures in OAR 410-0141-0260.

(2) When the Department authorizes a course of treatment or covered service, but subsequently acts (as defined in 42 CFR 431.201) to terminate, suspend or reduce the course of treatment or a covered service, the Department or its designee shall mail a written notice to the Client at least ten (10) calendar days before the date of the termination or reduction of the covered service unless there is documentation that the Client had previously agreed to the change as part of the course of treatment or as otherwise provided in 42 CFR 431.213.

(3) The written Client notice must inform the Client of the action the Department has taken or intends to take and reasons for the action; a reference to the particular sections of the statutes and rules involved for each reason identified in the notice; the Client's right to request an administrative hearing; an explanation of the circumstances under which benefits may continue pending resolution of the hearing; and how to contact the Department for additional information. The Department is not required to grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

(4) The Department shall have the following responsibilities in relation to continuation or reinstatement of benefit under this rule:

(a) If the Client requests an administrative hearing before the effective date of the Client notice and requests that the services be continued, the Department shall continue the services. The service shall be continued until whichever of the following occurs first (but in no event should exceed ninety (90) days from the date of the Client's request for an administrative hearing):

(A) The current authorization expires; or

(B) A decision is rendered about the case that is the subject of the administrative hearing; or

(C) The Client is no longer eligible for medical assistance benefits, or the health service, supply or item that is the subject of the administrative hearing is no longer a covered benefit in the Client's medical assistance benefit package; or

(D) The sole issue is one of federal or state law or policy and the Department promptly informs the Client in writing that services are to be terminated or reduced pending the hearing decision.

(b) The Division shall notify the Client in writing that it is continuing the service. The notice shall inform the Client that if the hearing is resolved against the Client, the cost of any services continued after the effective date of the Client notice may be recovered from the Client pursuant to 42 CFR 431.230(b);

(c) The Department shall reinstate services if:

(A) The Department takes an action without providing the required notice and the Client requests a hearing;

(B) The Department does not provide the notice in the time required under section (2) of this rule and the Client requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the Client, but the Client's whereabouts become known during the time the Client is still eligible for services;

(D) The reinstated services must be continued until a hearing decision unless, at the hearing, it is determined that the sole issue is one of federal or state law or policy.

(d) The Department shall promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the Client, or the Department decides in the Client's favor before the hearing.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 30-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1870**
**Client Premium Payments**

(1) All non-exempt Clients in the benefit group are responsible for payment of premiums as outlined in OAR 461-135-1120.

(2) Nonpayment of premium can result in a disqualification of benefits per OAR 461-135-1130.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 7-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 10-1999, f. & cert. ef. 4-1-99; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1875**
**Agency Hearing Representatives**

(1) Subject to the approval of the Attorney General, an agency officer or employee is authorized to appear (but not make legal argument) on behalf of the Department in the following classes of hearings:

(a) Contested case hearings requested by Clients in accordance with OAR 410-120-1860 and 410-130-1865; and

(b) Contested case hearings involving Providers in accordance with OAR 410-120-1560 to 410-120-1700.

(2) Subject to the approval of the Attorney General, the Department of Human Services (DHS) Audit Manager responsible for the Office of Medical Assistance Programs (OMAP) audits is authorized to appear (but not make legal argument) on behalf of the Department in the following classes of hearings:

(a) OMAP Overpayment determinations made in an audit under OAR 410-120-1505 (Provider audit);

(b) OMAP Provider Sanction decisions made in conjunction with or in lieu of an overpayment determination in OAR 410-120-1505 (Provider audit).

(3) Legal argument as used in ORS 183.452 and this rule has the same meaning as defined in OAR 137-003-0008(1)(c) and (d) 137-003-0545.

(4) When a Department officer or employee, or the DHS Audit Manager, represents the Department, the presiding officer will advise such representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection. Where such objections involve legal argument, the presiding officer will provide reasonable opportunity for the Department officer or employee, or the DHS Audit Manager, to consult legal counsel and permit such legal counsel to file written legal argument within a reasonable time after the conclusion of the hearing.

Stat. Auth.: ORS 409
Statutes Implemented: ORS 414.065
Hist.: HR 8-1996, f. 5-31-96, cert. ef. 6-1-96; OMAP 35-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 34-2003, f. & cert. ef. 5-1-03; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1880**
**Contracted Services**

(1) Except as otherwise provided in OAR 410-120-1260 et seq. applicable to Provider enrollment or OAR 410-141-0000 et seq. governing Prepaid Health Plans (PHPs), insurance and service contracts as provided for under ORS 414.115, 414.125, 414.135 and 414.145 may be implemented for covered medical assistance services in any program area(s) of the Department of Human Services (DHS) in order to achieve one or more of the following purposes:

(a) To implement and maintain PHP services.

(b) To ensure access to appropriate Medical Services which would otherwise not be available.

(c) To more fully specify the scope, quantity, or quality of the services to be provided or to specify requirements of the Provider or to specify requirements of DHS in relation to the Provider.

(d) To obtain services more cost effectively, (e.g., to reduce the costs of program administration or to obtain comparable services at less cost than the fee-for-service rate).

(2) Contracts, interagency agreements, or intergovernmental agreements under OAR 410-120-1880, subsection (1) funded with federal funds will be subject to applicable federal procurement and contracting requirements, and this rule will be interpreted and applied to satisfy such requirements. To the extent required by the federal funding agency, DHS will seek prior federal approval of solicitations and/or contracts when DHS plans to acquire or enhance services or equipment that will be paid in whole or on part with federal funds.

(3) DHS is exempt from the Public Contracting Code for purposes of source selection pursuant to ORS 279A.025(2). DHS will use the following source selection procedures when entering into contracts under OAR 410-120-1880, subsection (1). Interagency agreements and intergovernmental agreements are not subject to competitive solicitation as the basis of source selection, and may be selected in accordance with ORS 190.003 to 190.130 and other applicable law or authority.Competition must be used in obtaining contract services to the maximum extent practical, except as otherwise provided in subsection (4):

(a) Small Procurement Procedure may be used for the procurement of supplies and services less than or equal to $5,000.DHS may use any method reasonably appropriate to the nature of the supply or service and the business needs of the Department to identify potential contractors;

(b) Informal Solicitation Procedure may be used for the procurement of services if the estimated cost or contract price is $150,000 or less. Proposals will be solicited from at least three sources, except as otherwise provided in these rules;

(b) Formal Solicitation Procedure will be used for the procurement of services when the estimated cost or contract price is more than $150,000. Proposals must be solicited as outlined in these rules.

(4) Selection by Negotiation may be used in lieu of a competitive procurement under subsection (3) of this rule for the procurement of goods or services if:

(a) The good or service is available only from a single source or the sole source has special skills that are only available based upon his or her expertise or situation. If the DHS Director , or designee, determines that only a single contractor is available or practical for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the reasons for using a sole source contract must be placed in the contract file;

(b) Public need, significant risk of interruption of services, or emergency advises against a delay incident to competitive solicitation. If the DHS Director, or designee, determines that an emergency exists for purposes of this rule, the Director or designee may approve selection by negotiation. A memorandum signed by the Director or designee setting forth the nature of the emergency must be placed in the file;

(c) Compliance with federal requirements necessitated proceeding without competitive solicitation. Documentation of the applicable federal requirements must be placed in the contract file;

(d) Other authority including but not limited to statutory authority in ORS 414.115, 414.125, 414.135, and 414.145, or such other authority, exemptions and delegations of authority that may be applicable to the source selection for the procurement: Documentation of the authority must be placed in the contract file.

(5) A Request for Proposal (RFP) or similar solicitation mechanism must be prepared for contracts for which the Formal Solicitation Procedure will be used. The solicitation document should include at a minimum the following elements, when applicable:

(a) Statement of required work, including a clear description of the services to be provided, standards by which performance of the services will be measured and/or conditions affecting the delivery of services;

(b) Minimum standards and qualifications which contractors must meet to be eligible to provide the services;

(c) Information which the prospective contractors must submit in their proposals to support their capability, such as references and experience providing the same or similar services (when, where, for whom, type of service, etc.);

(d) Funding information and budget requirements;

(e) Information about ownership interests in software or hardware designed, acquired, developed or installed with federal funds, in compliance with federal requirements for ownership, management and disposition;

(f) The form and organization of proposals, when and where proposals are to be submitted, whether late proposals may be considered, and when an award of a contract is expected;

(g) The method and criteria to be used in evaluating proposals and the weighting assigned to each criterion;

(h) Provisions stating how and when the solicitation document must be contested, and how and when the final award must be contested;

(i) Notice that all costs incurred in the preparation of a proposal will be the responsibility of the proposer and will not be reimbursed by DHS; and

(j) Contract provisions, subject to subsection (8) of this rule.

(6) Proposals must be evaluated in a manner consistent with the evaluation criteria in the solicitation document. A written document stating why the selection was made will be placed in the contract file.

(7) Unless exempt under ORS 291.045 to 291.049 or rules adopted there under, DHS will obtain the review and approval of the solicitation document, contract or agreement by the Department of Justice.

(8) The terms and conditions of the contract to be awarded to a contractor selected using these source selection rules will be governed by the Public Contracting Code, except for interagency agreements or intergovernmental agreements exempt under ORS 279A.025(2), or contracts or agreements under other exemptions from the Public Contracting Code. The Public Contracting Code, if applicable, and such delegation of authority, if any, as may be made by the Department of Administrative Services to DHS determine contract approval authority.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 62-1986, f. 8-22-86, ef. 9-1-86; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0172; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0580; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 11-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1920**
**Institutional Reimbursement Changes**

(1) The Office of Medical Assistance Programs (OMAP) is required under federal regulations, **42 CFR 447**, to submit specific assurances and related information to the Centers for Medicare and Medicaid Services (CMS) whenever it makes a significant change in its methods and standards for setting payment rates for Inpatient Hospital Services or long-term care facilities.

(2) A "significant change" is defined as a change in payment rates which affects the general method of payment to all Providers of a particular type or is projected to affect total reimbursement for that particular type of Provider by six percent or more during the 12 months following the effective date.

(3) Federal regulation specifies that a public notice will be published in one of the following:

(a) A state register similar to the Federal Register. For the Department of Human Services (DHS), the state register is the Oregon Bulletin published by the Secretary of State;

(b) The newspaper of widest circulation in each city with a population of 50,000 or more;

(c) The newspaper of widest circulation in the state, if there is no city with a population of 50,000 or more.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 409.010
Hist.: AFS 13-1985, f. 3-4-85, ef. 4-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0006; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0380; OMAP 62-2003, f. 9-8-03, cert. ef.10-1-03; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1940**
**Interest Payments on Overdue Claims**

(1) Upon request by the provider, the Medical Assistance Program will pay interest on an overdue claim:

(a) A claim is considered "overdue" if not paid by the Medical Assistance Program within 45 days of receipt of a valid claim;

(b) The interest rate shall be the usual rate charged by the provider to the provider's clientele, but not more than 2/3 percent per month or eight percent per year.

(2) When billing the Medical Assistance Program for interest on an overdue valid claim the provider must furnish the following information in writing:

(a) Name of the service and the location the service was provided;

(b) The name of the client who received the service;

(c) Client ID Number;

(d) Date of service;

(e) Date of initial valid billing of the Medical Assistance Program;

(f) Amount of billing on initial valid claim;

(g) Medical Assistance Program Internal Control Number (ICN) of claim;

(h) Certification, signed by the provider or the provider's authorized agent, that the amount claimed does not exceed the usual overdue account charges assessed by the provider to the provider's clientele.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: 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 24-1985, f. 4-24-85, ef. 6-1-85; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-103-0185; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0360; OMAP 31-1999, f. & cert. ef. 10-1-99; OMAP 42-2002, f. & cert. ef. 10-1-02; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1960**
**Payment of Private Insurance Premiums**

(1) Upon request by the Provider, the Office of Medical Assistance Programs (OMAP) will pay interest on an overdue claim:

(a) A claim is considered "overdue" if OMAP does not make payment within 45 days of receipt of a Valid Claim;

(b) The interest rate shall be the usual rate charged by the Provider to the Provider's clientele, but not more than two-thirds (2/3) percent per month or eight percent per year.

(2) When billing OMAP for interest on an overdue Valid Claim, the Provider must furnish the following information in writing:

(a) Name of the service and the location the service was provided;

(b) The name of the Client who received the service;

(c) Client ID Number;

(d) Date of service;

(e) Date of initial valid billing of OMAP;

(f) Amount of billing on initial Valid Claim;

(g) OMAP Internal Control Number (ICN) of claim;

(h) Certification, signed by the Provider or the Provider's authorized agent, that the amount claimed does not exceed the usual overdue account charges assessed by the Provider to the Provider's clientele.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.115
Hist.: 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 38-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90; Renumbered from 461-013-0170; HR 32-1993, f. & cert. ef. 11-1-93; Renumbered from 410-120-0500 & 410-120-0520; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

**410-120-1980**
**Requests for Information and Public Records**

(1) The Office of Medical Assistance Programs (OMAP) will make non-exempt public records available for inspection to persons making a public records request under ORS 192.410 to 192.500.

(2) OMAP will charge the requestor for copies of non-exempt public records to cover actual costs. The requestor must pay the charge before the requested copies are released. The charges will be based on the following:

(a) If the request for copies involves minimal staff time, the charge will be 20 cents a page;

(b) If the request is for ten pages or more and requires 15 minutes or more of staff time, the requestor will be charged for the actual cost of staff time taken to search, glean and edit the records, for computer costs if required, and for photocopying at 20 cents a page. The minimum hourly charge for staff time will be $8;

(c) When OMAP requires an Attorney General's review or consultation, an additional charge will be made to cover the cost of that service.

(3) Part or all of the actual charges may be waived when the services provided will directly benefit OMAP or when a Client has need for copies of records and cannot afford the fee.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 192.410 - 192.500
Hist.: HR 32-1993, f. & cert. ef. 11-1-93; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 40-2005
**Filed with Sec. of State:** 9-2-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 410-127-0000, 410-132-0000
**Subject:** The Home Health Services program and the Private Duty Nursing Services program rules govern the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP amended 410-127-0000 in the Home Health Services program and 410-132-0000 in the Private Duty Nursing Services program to remove outdated information and clarify language.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-127-0000**
**Foreword**

The Office of Medical Assistance Programs (OMAP) Administrative Rules for Home Health Services are used in conjunction with the OMAP Oregon Health Plan Administrative Rules and General Rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 184.750 & 184.770
Stats. Implemented: ORS 414.065
Hist.: HR 28-1990, f. 8-31-90, cert. ef. 9-1-90; OMAP 19-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 1-2003, f. 1-31-03, cert. f. 2-1-03; OMAP 40-2005, f. 9-2-05, cert. ef. 10-1-05

**410-132-0000**
**Foreword**

The Office of Medical Assistance Programs (OMAP) Administrative Rules for Private Duty Nursing Services are used in conjunction with the OMAP Oregon Health Plan Administrative Rules and General Rules.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 43-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the AFS branch offices located in North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices.; HR 9-1991, f. 1-28-91, cert. ef. 3-1-91; Renumbered from 461-019-0201; HR 6-1997, f. & cert. ef. 2-19-97; OMAP 6-1999, f. 3-4-99, cert. ef. 4-1-99; OMAP 16-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 40-2005, f. 9-2-05, cert. ef. 10-1-05

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**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Repealed:** 410-129-0000, 410-131-0000, 410-140-0000
**Subject:** The Speech-language pathology, Audiology, and Hearing Aid Services program (Div. 129), the Physical and Occupational Therapy Services program (Div. 131) and the Visual Services program (Div. 140) rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for certain services provided to clients. OMAP permanently repealed 410-129-0000, 410-131-0000 and 410-140-0000 to remove inaccurate text.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**Adm. Order No.:** OMAP 42-2005
**Filed with Sec. of State:** 9-2-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 410-136-0200
**Subject:** The Transportation Services program rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for certain services provided to clients. OMAP amended rule 410-136-0200 to ensure payment for ambulance providers when services, that are within the definitions provided in OMAP General Rules, have been rendered to clients. The revision also clarified language regarding precedence for OMAP rules.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-136-0200**
**Emergency Medical Transportation (With Need for an Emergency Medical Technician)**

(1) A service will qualify for Office of Medical Assistance Programs (OMAP) reimbursement as an emergency ambulance transport when a sudden, unexpected medical condition creates a medical crisis requiring immediate transportation (with need for an Emergency Medical Technician) to a site, usually a hospital, where appropriate Emergency Medical Service is available.

(a) An Emergency Medical Service, including the prudent layperson standard, is defined under OAR 410-120-0000. For purposes of this rule, emergency medical transportation is treated as an Emergency Medical Service if the OMAP Member's medical condition that requires transport meets the prudent layperson standard.

(b) Notwithstanding the other provisions of this rule, OMAP Clients with the CAWEM benefit package are governed by OAR 410-120-1210(3)(e)(B) that does not apply the prudent layperson standard.

(2) When transport occurs, the client must be transported to the nearest appropriate facility able to meet the client's medical needs.

(3) Authorizations of, and billings for, emergency ambulance services provided to clients enrolled in Fully Capitated Health Plans (FCHPs) must be submitted to the FCHP. The FCHP will review for Emergency Medical Condition using the prudent layperson standard as defined in OAR 410-141-0000(42) (Emergency Medical Condition) prior to payment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 54-1981, f. 8-19-81, ef. 10-1-81; AFS 5-1984, f. & ef. 2-3-84; AFS 30-1985, f. 5-30-85, ef. 7-1-85; AFS 64-1986, f. 9-8-86, ef. 10-1-86; HR 12-1993, f. 4-30-93, cert. ef. 5-1-93; Renumbered from 461-020-0032; HR 25-1995, f. 12-29-95, cert. ef. 1-1-96; OMAP 33-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 60-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 42-2005, f. 9-2-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 43-2005
**Filed with Sec. of State:** 9-2-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 410-142-0000, 410-142-0040, 410-142-0300, 410-142-0380
**Rules Repealed:** 410-142-0320
**Subject:** The Hospice Services program rules govern the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP permanently amended rules as follows: 410-142-0000 to rename the rule and remove outdated information and clarify language; 410-142-0040, 410-142-0380 to remove outdated information and clarify language; 410-142-0300 to update hospice payment rates in compliance with federal regulation pursuant to communications received from the Centers for Medicare and Medicaid Services (CMS). Medicaid hospice payment rates are calculated based on the annual hospice rates established by CMS. These rates are authorized by section 1814 of the Social Security Act. OMAP repealed 410-142-0320 to remove unnecessary billing information from rule.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-142-0000**
**Foreword**

The Office of Medical Assistance Programs (OMAP) Administrative Rules for Hospice Services are used in conjunction with the OMAP Oregon Health Plan Administrative Rules and General Rules.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 409.010
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

**410-142-0040**
**Eligibility for Hospice Services**

(1) Hospice services are covered for clients who have:

(a) Been certified as terminally ill in accordance with OAR 410-142-0060; and

(b) Oregon Health Plan (OHP) Plus or OHP Standard benefit package coverage.

(2) Hospice services for clients with Medicare Part A coverage must be provided by a Medicare certified hospice. If a Medicare certified hospice is not available in the area, services may be provided in a hospice as defined in OAR 410-142-0020. For services provided by Medicare certified hospices, bill Medicare. Medicare's payment is considered payment in full.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

**410-142-0300**
**Billing and Rate Information**

(1) When billing for hospice services, the provider must bill the usual charge or the rate based upon the geographic location in which the care is furnished, whichever is lower. See Table 142-0300: (Hospice Rate Chart — Revised 10/01/05. Rates were calculated per CMS State Agency Letter dated August 25, 2005.)

(2) See the Hospice Services Supplemental Information booklet on the Office of Medical Assistance Program's website for billing information.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1994, f. & cert. ef. 2-1-94; HR 16-1995, f. & cert. ef. 8-1-95; OMAP 47-1998, f. & cert. ef. 12-1-98; OMAP 40-1999, f. & cert. ef. 10-1-99; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 55-2001(Temp) f. 10-31-01, cert. ef. 11-1-01 thru 4-15-02; OMAP 65-2001, f. 12-28-01, cert. ef. 1-1-02; OMAP 41-2002(Temp), f. & cert. ef. 10-1-02 thru 3-15-03; OMAP 15-2003, f. & cert. ef. 2-28-03; OMAP 80-2003(Temp), f. & cert. ef. 10-10-03 thru 3-15-04; OMAP 86-2003, f. 11-25-03 cert. ef. 12-1-03; OMAP 66-2004, f. 9-13-04, cert. ef. 10-1-04; OMAP 79-2004(Temp), f. & cert. ef. 10-1-04 thru 3-15-05; OMAP 90-2004, f. 11-24-04 cert. ef. 12-16-04; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

**410-142-0380**
**Death With Dignity**

(1) Death with dignity services are defined in the Office of Medical Assistance Programs (OMAP) Medical-Surgical Services and Pharmaceutical Services program rules.

(2) All death with dignity services must be billed directly to OMAP, even if the client is in a prepaid health plan (PHP).

(3) Death with dignity services are not included in the hospice care per diem payment.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 40-1999, f. & cert. ef. 10-1-99; OMAP 34-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 43-2005, f. 9-2-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 44-2005
**Filed with Sec. of State:** 9-9-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 410-122-0020, 410-122-0080, 410-122-0184, 410-122-0186, 410-122-0190, 410-122-0202, 410-122-0205, 410-122-0320, 410-122-0325, 410-122-0340, 410-122-0500, 410-122-0560, 410-122-0590, 410-122-0630, 410-122-0720
**Subject:** The DMEPOS program rules govern the Office of Medical Assistance Programs' (OMAP) payments for services provided to clients. OMAP amended rules as follows: 410-122-0020, 410-122-0186, 410-122-0202, 410-122-0205, 410-122-0320, 410-122-0325, 410-122-0340, 410-122-0590, 410-122-0630 and 410-122-0720 to reflect technical changes, code updates, word clarification and to clarify intent; 410-122-0184 (Repairs, Maintenance, Replacement and Delivery) 410-122-0190 (Miscellaneous DME and Supplies), and 410-122-0560 (Urological Supplies) to rename the rules and to clarify language and intent; and, 410-122-0080, 410-122-0500 to clarify language and intent.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-122-0020**
**Orders**

(1) The purchase, rental or modifications of durable medical equipment, and the purchase of supplies must have an order prior to dispensing items to a client.

(2) For any durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), a provider must have a written order signed and dated by the treating practitioner prior to submitting a claim to the Office of Medical Assistance Programs (OMAP).

(3) A provider may dispense some items based on a verbal order from the treating practitioner, except those items requiring a written order prior to delivery (see below) or as specified in a particular rule:

(a) A provider must maintain documentation of the verbal order and this documentation must be available to OMAP upon request;

(b) The verbal order must include all the following elements:

(A) Client's name; and

(B) Name of the practitioner; and

(C) Description of the item; and

(D) Start date of the order; and

(E) Primary ICD-9 diagnosis code for the equipment/supplies requested.

(c) For items that are dispensed based on a verbal order, the provider must obtain a written order that meets the requirements outlined below for written orders.

(4) For an item requiring a written order prior to delivery, Medicare criteria must be met.

(5) The DMEPOS provider must have on file a written order, information from the treating practitioner concerning the client's diagnosis and medical condition, and any additional information required in a specific rule.

(6) OMAP accepts any of the following forms of orders and Certificates of Medical Necessity (CMN): a photocopy, facsimile image, electronically maintained or original "pen and ink" document.

(a) An electronically maintained document is one which has been created, modified, and stored via electronic means such as commercially available software packages and servers;

(b) It is the provider's responsibility to ensure the authenticity/validity of a facsimile image, electronically maintained or photocopied order;

(c) A provider must also ensure the security and integrity of all electronically maintained orders and/or certificates of medical necessity;

(d) The written order may serve as the order to dispense the item if the written order is obtained before the item is dispensed.

(7) A written order must be legible and contain the following elements:

(a) Client's name; and

(b) Detailed description of the item that can either be a narrative description (e.g., lightweight wheelchair base) or a brand name/model number including medically appropriate options or additional features; and

(c) The detailed description of the item may be completed by someone other than the practitioner. However, the treating practitioner must review the detailed description and personally indicate agreement by his signature and the date that the order is signed;

(d) Primary ICD-9 diagnosis code for the equipment/supplies requested;

(8) A provider is responsible to obtain as much documentation from the client's medical record as necessary for assurance that OMAP coverage criteria for an item(s) is met.

(9) Certain items require one or more of the following additional elements in the written order:

(a) For accessories or supplies that will be provided on a periodic basis:

(A) Quantity used;

(B) Specific frequency of change or use — "as needed" or "prn" orders are not acceptable;

(C) Number of units;

(D) Length of need: Example: An order for surgical dressings might specify one 4" x 4" hydrocolloid dressing which is changed one to two times per week for one month or until the ulcer heals.

(b) For orthoses: If a custom-fabricated orthosis is ordered by the physician, this must be clearly indicated on the written order;

(c) Length of need:

(A) If the coverage criteria in a rule specifies length of need; or,

(B) If the order is for a rental item.

(d) Any other medical documentation required by rule.

(10) For repairs: Labor for repairs, parts for DME repairs and replacement parts for DME (e.g., batteries) do not require a written order.

(11) A new order is required:

(a) When required by Medicare (for a Medicare covered service) (www.cignamedicare.com); or,

(b) When there is a change in the original order for an item; or,

(c) When an item is permanently replaced; or,

(d) When indicated by the treating practitioner.

(A) A new order is required when an item is being replaced because the item is worn or the client's condition has changed; and

(B) The provider's records should also include client-specific information regarding the need for the replacement item; and

(C) This information should be maintained in the provider's files and be available to OMAP on request; and

(D) A new order is required before replacing lost, stolen or irreparably damaged items to reaffirm the medical appropriateness of the item.

(e) When there is a change of DMEPOS provider: In cases where two or more providers merge, the resultant provider should make all reasonable attempts to secure copies of all active CMN's and written orders from the provider(s) purchased. This document should be kept on file by the resultant provider for future presentation to OMAP, if requested.

(f) On a regular or specific basis (even if there is no change in the order) only if it is so specified in a particular rule.

(12) A provider is required to maintain and provide (when required by a particular rule) legible copies of facsimile image and electronic transmissions of orders.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: AFS 41-1982, f. 4-29-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 in the North Salem, Woodburn, McMinnville, Lebanon, Albany and Corvallis branch offices, ef. 6-30-82 in the balance of the state; AFS 20-1983, f. 5-5-83, ef. 6-1-83; AFS 49-1987, f. 10-16-87, ef. 11-1-87; AFS 48-1989, f. & cert. ef. 8-24-89; HR 13-1991, f. & cert. ef. 3-1-91; Renumbered from 461-024-0004; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 17-1996, f. & cert. ef. 8-1-96; OMAP 13-1999, f. & cert. ef. 4-1-99; 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 72-2002(Temp), f. & cert. ef. 12-24-02 thru 5-15-03; OMAP 36-2003, f. & cert. ef. 5-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0080**
**Coverage and Exclusions**

(1) Durable medical equipment, prosthetics, orthotics and medical-supplies (DMEPOS) may be covered for payment by the Office of Medical Assistance Programs (OMAP) when the item:

(a) Has been approved for marketing by the Food and Drug Administration (FDA) and is otherwise generally considered to be safe and effective for the purpose intended; and

(b) Is reasonable and medically appropriate for the individual client; and

(c) Is primarily and customarily used to serve a medical purpose; and

(d) Is generally not useful to a person in the absence of illness or injury; and

(e) Is appropriate for use in a client's home; and

(f) Specifically, for durable medical equipment, can withstand repeated use; i.e., could normally be rented, and used by successive clients; and

(g) Meets the coverage criteria as specified in this rulebook.

(2) When Medicare is the primary payer for a covered service and when OMAP coverage criteria differs from Medicare coverage criteria, OMAP coverage criteria are waived.

(3) DMEPOS are not covered when the item is:

(a) Not primarily medical in nature; or,

(b) For personal comfort or convenience of client or caregiver; or,

(c) Inappropriate or unsuitable for home use; or,

(d) A self-help device; or,

(e) Not therapeutic or diagnostic in nature.

(4) Reimbursement:

(a) OMAP reimburses for the lowest level of service, which meets medical appropriateness. See OAR 410-120-1280 (Billing) and 410-120-1340 (Payment) for clients with Medicare, third party resource (TPR) or alternate resource, coverage;

(b) Reimbursement is based on OMAP's maximum allowable rate, manufacturer's suggested retail price or usual charge, whichever is the lowest.

(5) Equipment and supplies are not covered under some benefit packages (see OAR 410-120-1210).

(6) Buy-ups are prohibited. Advanced Beneficiary Notices (ABN) constitute a buy-up and are prohibited. Refer to the OMAP General Rules for specific language on buy-ups.

(7) Equipment purchased by OMAP is the property of the client.

(8) Rental charges, starting with the initial date of service, regardless of payer, apply to the purchase price.

(9) Before renting, purchase should be considered for long-term requirements.

(10) Medical supplies are not separately payable to a DMEPOS provider while a client with Medicare Part A coverage is under a home health plan of care and covered home health care services.

(11) Medical supplies are not separately payable while a client is under a hospice plan of care and the supplies are included as part of the written plan of care and for which payment may otherwise be made by Medicare, OMAP or other carrier.

(12) Table 122-0080: Items not covered by OMAP, include, but are not limited to, those listed in this table. [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.: AFS 3-1982, f. 1-20-82, ef. 2-1-82; AFS 6-1989(Temp), f. 2-9-89, cert. ef. 3-1-89; AFS 48-1989, f. & cert. ef. 8-24-89; HR 24-1990(Temp), f. & cert. ef. 7-27-90; HR 6-1991, f. & cert. ef. 1-18-91; Renumbered from 461-024-0020; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 26-1994, f. & cert. ef. 7-1-94; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 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 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 46-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0184**
**Repairs, Maintenance, Replacement and Delivery**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically appropriate, covered durable medical equipment, prosthetics and orthotics, including those items purchased or in use before the client enrolled with the Office of Medical Assistance Programs (OMAP).

(2) Repairs:

(a) To repair means to fix or mend and to put the equipment back in good condition after damage or wear;

(b) If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment will be made for the amount of the excess;

(c) Payment for repairs is not covered when:

(A) The skill of a technician is not required; or

(B) The equipment has been previously denied; or

(C) Equipment is being rented, including separately itemized charges for repair; or

(D) Parts and labor are covered under a manufacturer's or supplier's warranty.

(d) Code E1340 must not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate.

(3) Maintenance:

(a) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking of the client's equipment is not covered. However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, may be covered as repairs for medically appropriate client-owned equipment. For example, this might include, breaking down sealed components and performing tests which require specialized testing equipment not available to the client;

(b) Payment for maintenance/service is not covered for rented equipment, unless it is a capped rental item. OMAP may authorize payment for maintenance and servicing capped rental items after six months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of maintenance and servicing at no more than the rental fee schedule allowable amount;

(c) Up to one month's rental will be reimbursed at the level of either the equipment provided; or, the equipment being repaired, whichever is less costly;

(d) Maintenance that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered.

(4) Replacement — Replacement refers to the provision of an identical or nearly identical item:

(a) Temporary Replacement: K0462 may be appropriate for temporary replacement of covered client-owned equipment such as a wheelchair being repaired. The equipment in need of repair must be unavailable for use for more than one day. For example, the repair takes more than one day or a part has to be ordered and the wheelchair is non-functional;

(b) Permanent Replacement: Situations involving the provision of a different item because of a change in medical condition must meet the specific coverage criteria identified in this rulebook;

(c) Equipment which the client owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment.

(d) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered.

(5) Delivery:

(a) Payment for pick-up and delivery charges of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) whether rented or purchased, including travel time, is included in the allowable rate for the item;

(b) Providers may deliver directly to the client or the designee (person authorized to sign and accept delivery of DMEPOS on behalf of the client);

(c) Providers, their employees, or anyone else having a financial interest in the delivery of an item are prohibited from signing and accepting an item on behalf of a client;

(d) A provider may deliver DMEPOS to a client in a hospital or nursing facility for the purpose of fitting or training the client in its proper use. This may be done up to two days prior to the client's anticipated discharge to home. Bill the date of service on the claim as the date of discharge and use the client's home as the Place of Service (POS). The item must be for subsequent use in the client's home;

(e) A provider may deliver DMEPOS to a client's home in anticipation of a discharge from a hospital or nursing facility. The provider may arrange for actual delivery approximately two days prior to the client's anticipated discharge to home. Bill the date of service on the claim as the date of discharge and use the client's home as the POS;

(f) Payment is not covered for training, fitting, or use of DMEPOS with a date of service prior to the client's discharge from a:

(A) Hospital;

(B) Nursing facility; or

(C) Medicare Part A nursing facility.

(g) Shipping and handling charges are not covered.

(6) Documentation Requirements:

(a) A new Certificate of Medical Necessity (CMN) and/or physician's order is not required;

(b) Submit the following documentation with the prior authorization request:

(A) For Repairs/Maintenance:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Itemized statement of parts needed for repair including product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and labor time; and

(iii) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair.

(B) For Temporary Replacement:

(i) Narrative description, manufacturer and brand name/model name and number, serial number and original date of purchase for the covered equipment in need of repair; and

(ii) Narrative description, manufacturer and brand name/model name and number of the replacement equipment; and

(iii) Itemized statement of parts needed for repair including product name, part number, manufacturer's suggested retail price or manufacturer's invoice price and labor time; and

(iv) Justification of the client's medical need for the item and statement that client owns the equipment in need of repair; and

(v) Description of why repair takes more than one day to complete.

(C) For Permanent Replacement: See specific coverage criteria in this rulebook for more information.

(7) Procedure Codes:

(a) Replacement parts for wheelchair repair are billed using the specific Healthcare Common Procedure Coding System (HCPCS) code, if one exists, or code K0108 (other accessories);

(b) E1340:

(A) Repair or non-routine service requiring the skill of a technician, labor component, per 15 minutes;

(B) This code is used for services not covered by other codes or combination of codes in reference to the repairs of DMEPOS.

(c) K0462 — Temporary replacement for client-owned equipment being repaired, any type — Prior authorization (PA) required – PA;

(d) K0108 — Other wheelchair accessories (see OAR 410-122-0186) — PA.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0186**
**Reimbursement and Prior Authorization Requirements for Codes E1399 and K0108**

(1) Reimbursement for codes E1399 and K0108 is capped as follows:

(a) E1399 — $6000.00;

(b) K0108 — $12,000.00.

(2) Reimbursement for codes E1399 and K0108 is determined as either:

(a) 80% of the Manufacturer's Suggested Retail Price (MSRP); or

(b) If the MSRP is not available, the lowest amount of the following, plus 20percent:

(A) Manufacturer's invoice; or

(B) Manufacturer's wholesale price; or

(C) Acquisition cost; or

(D) Manufacturer's bill to provider.

(c) If (2) (a) or (b) are not available, reimbursement will be the "estimated price" plus 20percent. An "estimated price" is the price the provider expects the manufacturer to charge.

(3) When requesting prior authorization (PA) for items billed at or above $100, the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider:

(a) Must submit a copy of:

(A) The items from (2)(a-c) that will be used to bill; and

(B) Name of the manufacturer, description of the item, including product name/model name and number and technical specifications. .

(b) May be required to submit a picture of the item.

(4) The DMEPOS provider must submit verification for items billed under code E1399 when no specific Healthcare Common Procedure Coding System (HCPCS) code is available and an item category is not specified in chapter 410 division 122 rules. Verification can come from an organization such as:

(a) Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC); or

(b) American Orthotic and Prosthetic Association (AOPA).

(5) The Office of Medical Assistance Programs (OMAP) may review items that exceed the maximum allowable/cap on a case-by-case basis. For these situations, the provider must submit the following documentation:

(a) Documentation that supports the client meets all of the coverage criteria for the less costly alternative; and

(b) A comprehensive evaluation by a licensed clinician (who is not an employee of or otherwise paid by a provider) which clearly explains why the less costly alternative is not sufficient to meet the client's medical needs; and

(c) The expected hours of usage per day; and

(d) The expected outcome or change in client's condition.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0190**
**Miscellaneous Durable Medical Equipment and Supplies**

(1) When necessary, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) providers must contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) Healthcare Common Procedure Coding System (HCPCS) Unit to obtain proper billing codes for DMEPOS items.

(2) A HCPCS code identifies the durable medical equipment, prosthetics, orthotics, and/or supplies (DMEPOS) being billed.

(3) Documentation must support that HCPCS codes are correct.

(4) Proper HCPCS codes must be used regardless of fee schedule allowables.

(5) Coverage criteria for code E1399:

(a) Code E1399 includes but is not limited to use for the following:

(A) Walker gliders — Not covered for clients in a nursing facility (NF);

(B) Oxymiser cannula — Not covered for clients in a NF;

(C) Hydraulic bathtub lift — Not covered for clients in a NF;

(D) Heavy-duty or extra-wide rehab shower/commode chair — Not covered for clients in a NF.

(b) Code E1399 may be used for gait belts when the:

(A) Client is 60 pounds or greater, and;

(B) Care provider is trained in the proper use, and;

(C) Client meets one of the following criteria:

(i) The client may be able to walk independently, but needs a minor correction of ambulation, or;

(ii) The client needs minimal or standby assistance to walk alone, or;

(iii) The client requires assistance with transfer.

(c) Documentation of medical appropriateness from the prescribing practitioner must:

(A) Be kept on file by the DMEPOS provider; and

(B) Include documentation that the care provider is trained in proper use.

(6) **Table 122-0190.**

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 9-1993, f. & cert. ef. 4-1-93; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 54-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0202**
**Continuous Positive Airway Pressure (CPAP) System**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness(a) Initial Coverage:

(A) A single-level continuous positive airway pressure (CPAP) device (E0601) may be covered when the client has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (i or ii):

(i) The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour; or,

(ii) The AHI is from 5 to 14 events per hour with documented symptoms of:

(I) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,

(II) Hypertension, ischemic heart disease, or history of stroke.

(B) A three-month rental period is required for CPAP prior to purchase.

(b) Continued coverage of an E0601 beyond the first three months of therapy: Ongoing rental beyond the first three months is an option in lieu of purchase if medically appropriate and cost effective;

(c) For a client using a CPAP prior to Medicaid enrollment, and, with recent, supportive documentation from the treating practitioner indicative of effective treatment with a CPAP device, coverage criteria in this rule may be waived;

(d) Payment Authorization: A CPAP device and related accessories may be dispensed without prior authorization. The provider is still responsible to ensure all rule requirements are met. Payment authorization is required prior to submitting claims and will be given once all required documentation has been received and any other applicable rule requirements have been met. Payment authorization is obtained from the same authorizing authority as specified in 410-122-0040.

(2) Guidelines:

(a) A continuous positive airway pressure (CPAP) device delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs;

(b) A respiratory cycle is defined as an inspiration, followed by an expiration;

(c) Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include

sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). It must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment;

(d) For the purpose of this rule, polysomnographic studies must be performed in an attended, facility-based sleep study laboratory, and not in the home or in a mobile facility. These labs must be qualified providers of Medicare services and comply with all applicable state regulatory requirements; and

(e) The diagnostic portion of the polysomnogram recording must be a minimum of two hours;

(f) Polysomnographic studies must not be performed by a durable medical equipment (DME) provider;

(g) The apnea-hypopnea index (AHI) is defined as the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected;

(h) Apnea is defined as the cessation of airflow for at least 10 seconds documented on a polysomnogram;

(i) Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation;

(j) The AHI calculation must be based on the sleep time (in hours) within the two hours (or more) of recorded time.

(3) Documentation Requirements:

(a) Initial Coverage: Prior to the third date of service, submit the following documentation:

(A) A facility-based polysomnogram report that supports a diagnosis of obstructive sleep apnea (OSA); and if applicable

(B) Any other medical documentation that supports indications of coverage.

(b) Continued coverage beyond the first three months of therapy: No sooner than the 61st day after initiating therapy and prior to the fourth date of service, submit documentation from the treating physician that indicates the client is continuing to effectively comply (time spent at the effective pressure) with CPAP treatment. This means that the client is continuing to use the CPAP at the effective pressure for at least four hours in a 24-hour continuous period at least 80 percent of the time.

(4) Accessories:

(a) Accessories used with an E0601 device are covered when the coverage criteria for the device are met;

(b) Accessories are separately reimbursable at the time of initial issue and when replaced;

(c) Either a non-heated (E0561) or heated (E0562) humidifier is covered when ordered by the treating physician for use with a covered E0601 device;

(d) The following represents the usual maximum amount of accessories expected to be medically appropriate:

(A) A7030 — 1 per 6 months
(B) A7031 — 1 per 6 months
(C) A7032 — 2 per 1 month
(D) A7033 — 2 per 1 month
(E) A7034 — 1 per 3 months
(F) A7035 — 1 per 6 months
(G) A7036 — 1 per 6 months
(H) A7037 — 1 per 1 month
(I) A7038 — 2 per 1 month
(J) A7039 — 1 per 6 months

(5) Miscellaneous:

(a) It is the provider's responsibility to monitor appropriate and effective use of the device as ordered by the treating physician. When the equipment is not being used as prescribed, the provider must stop billing for the equipment and related accessories and supplies.

(b) For auto-titrating CPAP devices, use HCPCS code E0601.

(c) Products must be coded as published by SADMERC's Product Classification List for CPAP Systems and Respiratory Assist Devices.

(6) Table 122-0202. [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.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 46-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 76-2004, f. 9-30-04, cert. ef. 10-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0205**
**Respiratory Assist Devices**

(1) As referenced in this policy, non-invasive positive pressure respiratory assistance (NPPRA) is the administration of positive air pressure, using a nasal and/or oral mask interface which creates a seal, avoiding the use of more invasive airway access (e.g., tracheostomy).

(2) Indications and Coverage — General:

(a) The "treating prescribing practitioner" must be one who is qualified by virtue of experience and training in non-invasive respiratory assistance, to order and monitor the use of respiratory assist devices (RAD);

(b) For the purpose of this policy, polysomnographic studies must be performed in a sleep study laboratory, and not in the home or in a mobile facility. The sleep study laboratory must comply with all applicable state regulatory requirements;

(c) For the purpose of this policy, arterial blood gas, sleep oximetry and polysomnographic studies may not be performed by a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider. For purposes of this policy's coverage and payment guidelines,a DMEPOS provider is not considered a qualified provider or supplier of these tests.(d) If there is discontinuation of usage of E0470 or E0471 device at any time, the provider is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

(3) Coverage criteria for E0470 and E0471 devices – Table 122-0205-1.

(4) Documentation:

(a) The following documentation must be submitted with the request for prior authorization (PA) and the original kept on file by the provider:

(A) An order for all equipment and accessories including the client's diagnosis, an ICD-9-CM code signed and dated by the treating prescribing practitioner;

(B) Summary of events from the polysomnogram, if required in this rule under the indications and coverage section or Table 122-0205-1;

(C) Arterial blood gas results, if required under the indications and coverage section or Table 122-0205-1;

(D) Sleep oximetry results, if required under the indications and coverage section or Table 122-0205-1; [Table not included. See ED. NOTE.]

(E) Treating prescribing practitioner statement regarding medical symptoms characteristic of sleep-associated hypoventilation, including, but not limited to daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, and dyspnea;

(F) Other treatments that have been tried and failed. To be submitted in addition to the above at the fourth month review.

(b) A copy of the Evaluation of Respiratory Assist Device (OMAP 2461) completed and signed by the client, family member or caregiver;

(c) Clients currently using BiPapS and BiPap ST are not subject to the new criteria;

(5) Procedure Codes — Table 122-0205-2. [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.: OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0320**
**Manual Wheelchair Base**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The purchase, rental, repair, maintenance or modification of a client's primary wheelchair may be covered by the Office of Medical Assistance Programs (OMAP) when all of the following criteria are met:

(A) The client's condition is such that without the use of a wheelchair, the client would be bed or chair confined; and

(B) The client is not functionally ambulatory and the wheelchair is necessary to function within the home.

(b) When a client's current wheelchair is no longer medically appropriate or repair to the wheelchair exceeds replacement cost, a new wheelchair may be authorized;

(c) If a client has a medically appropriate wheelchair regardless of payer, OMAP does not reimburse for another wheelchair;

(d) One month's rental of a wheelchair may be payable if a covered client-owned wheelchair is in need of repair (see OAR 410-122-0184 Repairs, Maintenance, Replacement and Delivery).

(e) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. OMAP does not reimburse for adapting living quarters;

(f) Backup wheelchairs,backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, and any other upgrades to primarily allow performance of leisure or recreational activities are not covered.

(g) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair as well as support services such as emergency services, delivery, set-up, education, and ongoing assistance with the use of the wheelchair; .

(h) An adult tilt-in-space wheelchair (E1161) may be covered when a client:

(A) Is dependent for transfers; and

(B) Spends a minimum of four hours a day continuously in a wheelchair; and

(C) The plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(D) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting.

(i) A standard hemi (low seat) wheelchair (K0002) may be covered when a client requires a lower seat height (17" to 18") because of short stature or needs assistance to place his/her feet on the ground for propulsion;

(j) A lightweight wheelchair (K0003) may be covered when a client:

(A) Cannot self-propel in a standard wheelchair using arms and/or legs; and

(B) Can and does self-propel in a lightweight wheelchair.

(k) A high strength lightweight wheelchair (K0004) may be covered when a client:

(A) Self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair, and/or;

(B) Requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair;

(C) A high strength lightweight wheelchair is rarely medically appropriate if the expected duration of need is less than three months (e.g., post-operative recovery).

(l) An ultralightweight wheelchair (K0005) may be covered when a client has medical needs that require determination on an individual consideration basis;

(m) A heavy-duty wheelchair (K0006) may be covered when a client weighs more than 250 pounds or has severe spasticity;

(n) An extra heavy-duty wheelchair (K0007) may be covered when a client weighs more than 300 pounds;

(o) A manual wheelchair may be covered for a client residing in a nursing facility only when:

(A) Coverage criteria for a customized seat cushion and a customized back cushion are met (see 410-122-0340 Wheelchair Options/Accessories);

(B) When a manual wheelchair base is requested other than K0001, coverage criteria for the requested base must be met.

(p) For more information on coverage criteria regarding repairs and maintenance, see 410-122-0184, Repairs, Maintenance, Replacement and Delivery.

(2) Coding Guidelines:

(a) Adult manual wheelchairs (K0001-K0007, K0009, E1161) are those which have a seat width and a seat depth of 15" or greater.

(b) For codes K0001-K0007 and K0009, the wheels must be large enough and positioned such that the wheelchair could be propelled by the user.

(c) In addition, specific codes are defined by the following characteristics:

(A) Adult tilt-in-space wheelchair (E1161):

(i) Ability to tilt the frame of the wheelchair greater than or equal to 45 degrees from horizontal while maintaining the same back to seat angle; and

(ii) Lifetime warranty: On side frames and crossbraces.

(B) Standard wheelchair (K0001):

(i) Weight: greater than 36 lbs; and

(ii) Seat height: 19" or greater; and

(iii) Weight capacity: 250 pounds or less.

(C) Standard hemi (low seat) wheelchair (K0002):

(i) Weight: greater than 36 lbs; and

(ii) Seat height: Less than 19"; and

(iii) Weight capacity: 250 pounds or less.

(D) Lightweight wheelchair (K0003):

(i) Weight: 34-36 lbs; and

(ii) Weight capacity: 250 pounds or less.

(E) High strength, lightweight wheelchair (K0004):

(i) Weight: Less than 34 lbs; and

(ii) Lifetime warranty on side frames and crossbraces.

(F) Ultralightweight wheelchair (K0005):

(i) Weight: less than 30 lbs; and

(ii) Adjustable rear axle position; and

(iii) Lifetime warranty on side frames and crossbraces.

(G) Heavy duty wheelchair (K0006) has a weight capacity greater than 250 pounds.

(H) Extra heavy duty wheelchair (K0007) has a weight capacity greater than 300 pounds.

(d) The following features are included in the allowance for all adult manual wheelchairs:

(A) Seat width: 15" — 19"; and

(B) Seat depth: 15" — 19"; and

(C) Arm style: fixed, swingaway, or detachable; fixed height; and

(D) Footrests: fixed, swingaway, or detachable.

(e) Codes K0003-K0007 and E1161 include any seat height;

(f) Wheelchairs with individualized features which meet the needs of a particular client are billed by selecting the correct code for the wheelchair base and then using appropriate codes for wheelchair options and accessories (see 410-122-0340 Wheelchair Options/Accessories);

(g) If the frame of the wheelchair is modified in a unique way to accommodate the client, submit the code for the wheelchair base and submit the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(h) Wheelchair "poundage" (lbs.) represents the weight of the usual configuration of the wheelchair with a seat and back but without front riggings;

(i) A manual wheelchair with a seat width and/or depth of 14" or less is considered a pediatric size wheelchair and is billed with codes E1231-E1238 or E1229 (see 410-122-0720 Pediatric Wheelchairs);

(j) Refer to 410-122-0340 on Wheelchair Options/Accessories for information on other features included in the allowance for the wheelchair base.

(k) Contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on correct coding.

(3) Documentation Requirements: Submit the following documentation with the prior authorization (PA) request:

(a) For purchase and modifications, either the Wheelchair and Seating Prescription and Justification form (OMAP 3125) (found in the DME and Medical Supplies Supplemental Information on OMAP's website) or reasonable facsimile which includes, but is not limited to, the following information (not required for K0001, K0002 or K0003 unless modifications are being requested):

(A) Completion of the form or reasonable facsimile by a physical therapist, occupational therapist or treating physician, including signature and date; and

(B) Completion of the form or reasonable facsimile by an individual who has no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider; and

(C) Signature and date by the treating physician; and

(D) Information that specifically indicates the client's functional ambulation status in his or her customary environment; and

(E) Most cost effective equipment recommended to meet the client's medical needs and that person completing the form is in agreement with the DMEPOS provider's recommendations (include manufacturer, product name, model number, standard features, specifications, dimensions and options); and

(F) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable.

(b) Documentation that a physical environment assessment, that includes the client's living quarters as well as the most common places of service for use of the equipment, has been performed by the DMEPOS provider or a health care clinician. This assessment must support that these environments can accommodate and allow for the effective use of the equipment, including, but not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps, etc.), electrical service, etc.; and

(c) All Healthcare Common Procedure Coding System (HCPCS) codes to be billed on this claim (both codes that require authorization and those that do not require authorization)

(d) For purchase of K0001, K0002 or K0003 (without modifications):

(A) Information that specifically indicates the client's functional ambulation status in his or her customary environment; and

(B) Most cost effective equipment recommended to meet the client's medical needs and that person completing the form is in agreement with the durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) provider's recommendations (include manufacturer, product name, model number, standard features, specifications, dimensions and options); and

(C) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable.

(e) For a K0005 wheelchair, the documentation must include a description of the client's routine activities. This may include what types of activities the client frequently encounters and whether the client is fully independent in the use of the wheelchair. Describe the features of the K0005 base which are needed compared to the K0004 base.

(f) When code K0009 requested, all information that justifies the medical appropriateness for the item.

(g) Documentation for individual consideration might include information on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency, and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.

(h) For a nursing facility client, submit medical justification that corroborates the need for customized seat and back cushions (see 410-122-0340 Wheelchair Options/Accessories), including dated and clear photographs and body contour measurements.

(i) Any additional documentation that supports indications of coverage are met as specified in this policy.

(j) The above documentation must be kept on file by the DMEPOS provider and made available to OMAP upon request.

(4) Table 122-0320. [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 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993 f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 18-1994(Temp), f. & cert. ef. 4-1-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30- 94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0325**
**Motorized/Power Wheelchair Base**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The purchase, rental, repair, maintenance or modification of a client's primary wheelchair may be covered when all of the following criteria are met:

(A) The client's condition is such that without the use of a wheelchair the client would be bed or chair confined; and

(B) The client's condition is such that a wheelchair is medically appropriate and the client is unable to operate a wheelchair manually; and

(C) The client is capable of safely operating the controls for the power wheelchair.

(b) A client who requires a power wheelchair usually is totally nonambulatory and has severe weakness of the upper extremities due to a neurological, muscular, or cardiopulmonary disease/condition;

(c) The client's condition is such that the requirement for a power wheelchair is long-term (at least six months);

(d) When a client's current wheelchair is no longer medically appropriate or repair to the wheelchair exceeds replacement costs, a new wheelchair may be authorized;

(e) If a client has a medically appropriate wheelchair regardless of payer, OMAP does not reimburse for another wheelchair;

(f) One month's rental of a wheelchair may be payable if a covered client-owned wheelchair is in need of repair (see OAR 410-122-0184 Repairs, Maintenance, Replacement and Delivery);

(g) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. OMAP does not reimburse for adapting the living quarters;

(h) Backup wheelchairs,backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, head lights, tail lights, and any other upgrades to primarily allow performance of leisure or recreational activities are not covered;

(i) Reimbursement for the wheelchair codes includes all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also includes support services such as emergency services, delivery, set-up, education and on-going assistance with use of the wheelchair;

(j) Motorized/power wheelchair bases K0010, K0011, K0012, and K0014 are characterized by a seat width and a seat depth of 15" or greater;

(k) In addition, a lightweight power wheelchair (K0012) is characterized by:

(A) Weight less than 80 lbs. with back and seat but without frontriggings or battery; and

(B) Folding back or collapsible frame.

(l) Code K0014 is used for a power wheelchair base if it has a client weight capacity of greater than or equal to 350 pounds and has programmable controls;

(m) A power wheelchair with a seat width or depth of 14" or less is considered a pediatric power wheelchair base and is coded E1239;

(n) The following features are included in the allowance for K0010-K0012 and K0014 power wheelchair bases:

(A) Seat Width: 15"-19";

(B) Seat Depth: 15"-19";

(C) Arm Style: Fixed, swingaway, or detachable; fixed height;

(D) Footrests: Fixed, swingaway, or detachable.

(o) Wheelchairs with individualized features which meet the needs of a particular patient are billed by selecting the correct code for the wheelchair base and then using appropriate codes for wheelchair options and accessories. (Refer to the Wheelchair Options and Accessories policy.) If the frame of the wheelchair is modified in a unique way to accommodate the patient, bill the code for the wheelchair base and bill the modification with code K0108 (wheelchair component or accessory, not otherwise specified);

(p) Codes K0010 — K0014 are not used for manual wheelchairs with add-on power packs. Use the appropriate code for the manual wheelchair base provided (K0001 — K0009) and code E0983.

(2) Documentation Requirements: Submit the following documentation with the prior authorization (PA) request:

(a) For purchase and modifications, the Wheelchair and Seating Prescription and Justification form (OMAP 3125-see DME and Medical Supplies Supplemental Information) or reasonable facsimile which includes, but is not limited to, the following information:

(A) Completion of the form or reasonable facsimile by a physical therapist, occupational therapist or treating physician, including signature and date; and

(B) Completion of the form or reasonable facsimile by an individual who has no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) provider; and

(C) Signature and date by the treating physician; and

(D) Information that specifically indicates the client's functional ambulation status in his or her customary environment; and

(E) Most cost effective equipment recommended to meet the client's medical needs and that person completing the form is in agreement with the DMEPOS provider's recommendations (include manufacturer, product name, model number, standard features, specifications, dimensions and options); and

(F) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable.

(b) Documentation that a physical environment assessment that includes the client's living quarters as well as the most common places of service for use of the equipment, has been performed by the DMEPOS

provider or a health care clinician. This assessment must support that these environments can accommodate and allow for the effective use of the equipment, including, but not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps, etc.), electrical service, etc.; and

(c) All Healthcare Common Procedure Coding System codes (HCPCS) to be billed on this claim (both codes that require authorization and those that do not require authorization);

(d) Any additional documentation that supports indications of coverage are met as specified in this policy;

(e) The above documentation must be kept on file by the DMEPOS provider and made available to OMAP on request.

(3) Table 122-0325. Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
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Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0340**
**Wheelchair Options/Accessories**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) Options and accessories for covered wheelchairs may be payable when the following criteria are met:

(A) For an adult, the client has a wheelchair that meets Medicare coverage criteria (www.cignamedicare.com); and

(B) The client's condition is such that without the use of a wheelchair, would otherwise be bed or chair confined (an individual may qualify for a wheelchair and still be considered bed confined); and

(C) The options/accessories are necessary for the client to perform one or more of the following activities:

(i) Function in the home;

(ii) Perform instrumental activities of daily living.

(b) An option/accessory that is beneficial primarily in allowing the client to perform leisure or recreational activities is noncovered;

(c) Arm of Chair: Adjustable arm height option (E0973, K0017, K0018, K0020) may be covered when the client:

(A) Requires an arm height that is different than what is available using nonadjustable arms; and

(B) Spends at least two hours per day in the wheelchair;

(C) An arm trough (K0106) is covered if the client has quadriplegia, hemiplegia, or uncontrolled arm movements.

(d) Footrest/Legrest: Elevating legrests (E0990, K0046, K0047, K0053, K0195) may be covered when:

(A) The client has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee; or

(B) The client has significant edema of the lower extremities that requires having an elevating leg rest; or

(C) The client meets the criteria for and has a reclining back on the wheelchair;

(D) Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded E0990. This code is per leg rest;

(E) Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests.

(e) Nonstandard Seat Frame Dimensions:

(A) For all adult wheelchairs (E1161, K0001-K0007, K0009, K0010-K0012, K0014), payment for seat widths and/or seat depths of 15-19 inches are included in the payment for the base code;

(B) These seat dimensions should not be separately billed;

(C) Codes E2201-E2204 and E2340-E2343 describe seat widths and/or depths of 20 inches or more for manual or power wheelchairs;

(D) A nonstandard seat width and/or depth (E2201-E2204, E2340-E2343) is covered only if the patient's dimensions justify the need.

(f) Rear Wheels for Manual Wheelchairs:

(A) A push-rim activated power assist (E0986) is an option for a manual wheelchair in which sensors in specially designed wheels determine the force that is exerted by the patient on the wheel;

(B) Additional propulsive and/or braking force is then provided by motors in each wheel;

(C) Batteries are included;

(D) Code K0064 (flat free insert) is used to describe either:

(i) A removable ring of firm material that is placed inside of a pneumatic tire to allow the wheelchair to continue to move if the pneumatic tire is punctured; or

(ii) Nonremovable foam material in a foam filled rubber tire;

(iii) K0064 is not used for a solid self-skinning polyurethane tire.

(g) Batteries/Chargers:

(A) Up to two batteries (E2360-E2365) at any one time are allowed if required for a power wheelchair;

(B) Batteries/chargers for motorized/power wheelchairs are separately payable from the purchased wheelchair base.

(h) Seating:

(A) A general use seat cushion and a general use wheelchair back cushion may be covered for a client who has a wheelchair which meets OMAP coverage criteria;

(B) A skin protection seat cushion may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets OMAP coverage criteria; and

(ii) The client has either of the following:

(I) Current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or

(II) Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis), post polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease.

(C) A positioning seat cushion, positioning back cushion, and positioning accessory (E0955-E0957, E0960) may be covered for a client who meets both of the following criteria:

(i) The client has a wheelchair that meets OMAP coverage criteria; and

(ii) The client has any significant postural asymmetries due to one of the diagnoses listed in criterion (h)(A)(ii)(II) or to one of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease.

(j) A combination skin protection and positioning seat cushion may be covered when a client meets the criteria for both a skin protection seat cushion and a positioning seat cushion;

(k) Separate payment is allowed for a seat cushion solid support base (E2618) with mounting hardware when it is used on an adult manual wheelchair (K0001-K0009, E1161) or lightweight power wheelchair (K0012). There is no separate payment when this is used with other types of power wheelchairs (K0010, K0011, K0014) because those wheelchairs include a solid support base;

(l) There is no separate payment for a solid insert (E0992) that is used with a seat or back cushion because a solid base is included in the allowance for a wheelchair seat or back cushion;

(m) There is no separate payment for mounting hardware for a seat or back cushion;

(n) There is no separate payment for a headrest (E0955, E0966) on a captain's seat on a power wheelchair;

(o) A custom fabricated seat cushion (E2609) and a custom fabricated back cushion (E2617) are cushions that are individually made for a specific patient starting with basic materials including:

(A) Liquid foam or a block of foam; and

(B) Sheets of fabric or liquid coating material;

(C) The cushion must be fabricated using molded-to-patient-model technique, direct molded-to-patient technique, CAD-CAM technology, or detailed measurements of the patient used to create a configured cushion;

(D) The cushion must have structural features that significantly exceed the minimum requirements for a seat or back positioning cushion;

(E) The cushion must have a removable vapor permeable or waterproof cover or it must have a waterproof surface;

(F) A custom fabricated cushion may include certain prefabricated components (e.g., gel or multi-cellular air inserts); these components must not be billed separately;

(G) If a custom fabricated seat and back are integrated into a one-piece cushion, code as E2609 plus E2617;

(H) If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual client, the cushion must be billed as a prefabricated cushion, not custom fabricated;

(I) A custom fabricated seat cushion may be covered if criteria (i) and (iii) are met. A custom fabricated back cushion may be covered if criteria (ii) and (iii) are met:

(i) Client meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion;

(ii) Client meets all of the criteria for a prefabricated positioning back cushion;

(iii) There is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs.

(J) A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion which has not received a written coding verification from the Statistical Analysis DME Regional Carrier SADMERC or which does not meet the criteria stated in this rule is not covered.

(p) A headrest extension (E0966) is a sling support for the head. Code E0955 describes any type of cushioned headrest;(q) The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, that is an integral part of the cushion;

(r) A solid insert (E0992) is a separate rigid piece of wood or plastic which is inserted in the cover of a cushion to provide additional support and is included in the allowance for a seat cushion;

(s) A solid support base for a seat cushion is a rigid piece of plastic or other material which is attached with hardware to the seat frame of a wheelchair in place of a sling seat. A cushion is placed on top of the support base. Use code E2618 for this solid support base;

(t) The only products which may be billed using codes E2601-E2608, E2611-E2616, E2620, and E2621 and the only brand name products that may be billed using codes E2609 or E2617 and the only wheelchair cushions that may be billed with code K0108 are those products for which a written coding verification has been made by the SADMERC. Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Request can be found on the SADMERC web site or by contacting the SADMERC. A Product Classification List with products which have received a coding verification can be found on the SADMERC web site;

(u) Code E1028 (swingaway or removable mounting hardware upgrade) may be billed in addition to codes E0955-E0957. It must not be billed in addition to code E0960. It must not be used for mounting hardware related to a wheelchair seat cushion or back cushion code;

(v) Power seating systems:

(A) A power tilt seating system (E1002) includes all the following:

(i) A solid seat platform and a solid back; any frame width and depth;

(ii) Detachable or flip-up fixed height or adjustable height armrests;

(iii) Fixed or swingaway detachable leg rests;

(iv) Fixed or flip-up footplates;

(v) Motor and related electronics with or without variable speed programmability;

(vi) Switch control which is independent of the power wheelchair drive control interface;

(vii) Any hardware that is needed to attach the seating system to the wheelchair base;

(viii) It does not include a headrest;

(ix) It must have the following features:

(I) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability for the supplier to adjust the seat to back angle;

(IV) Ability to support patient weight of at least 250 pounds.

(B) A power recline seating system (E1003-E1005) includes all the following:

(i) A solid seat platform and a solid back;

(ii) Any frame width and depth;

(iii) Detachable or flip-up fixed height or adjustable height arm rests;

(iv) Fixed or swingaway detachable leg rests;

(v) Fixed or flip-up footplates;

(vi) A motor and related electronics with or without variable speed programmability;

(vii) A switch control which is independent of the power wheelchair drive control interface;

(viii) Any hardware that is needed to attach the seating system to the wheelchair base;

(ix) It does not include a headrest;

(y) It must have the following features:

(I) Ability to recline to greater than or equal to 150 degrees from horizontal;

(II) Back height of at least 20 inches;

(III) Ability to support patient weight of at least 250 pounds.

(C) A power tilt and recline seating system (E1006-E1008) includes:

(i) A solid seat platform and a solid back;

(ii) Any frame width and depth; detachable or flip-up fixed height or adjustable height armrests;

(iii) Fixed or swingaway detachable leg rests; fixed or flip-up footplates;

(iv) Two motors and related electronics with or without variable speed programmability;

(v) Switch control which is independent of the power wheelchair drive control interface;

(vi) Any hardware that is needed to attach the seating system to the wheelchair base;

(vii) It does not include a headrest;

(viii) It must have the following features:

(ix) Ability to tilt to greater than or equal to 45 degrees from horizontal;

(x) Ability to recline to greater than or equal to 150 degrees from horizontal;

(xi) Back height of at least 20 inches; ability to support patient weight of at least 250 pounds.

(D) A mechanical shear reduction feature (E1004 and E1007) consists of two separate back panels. As the posterior back panel reclines or raises there is a mechanical linkage between the two panels which allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(E) A power shear reduction feature (E1005 and E1008) consists of two separate back panels. As the posterior back panel reclines or raises there is a separate motor which controls the linkage between the two panels and allows the client's back to stay in contact with the anterior panel without sliding along that panel;

(F) A power leg elevation feature (E1010) involves a dedicated motor and related electronics with or without variable speed programmability which allows the leg rest to be raised and lowered independently of the recline and/or tilt of the seating system. It includes a switch control which may or may not be integrated with the power tilt and/or recline control(s);

(G) Codes E2310 and E2311:

(i) Describe the electronic components that allow the client to control two or more of the following motors from a single interface (e.g., proportional joystick, touchpad, or nonproportional interface): power wheelchair drive, power tilt, power recline, power shear reduction, power leg elevation, power seat elevation, power standing;

(ii) Include a function selection switch which allows the client to select the motor that is being controlled and an indicator feature to visually show which function has been selected;

(iii) When the wheelchair drive function has been selected, the indicator feature may also show the direction that has been selected (forward, reverse, left, right). This indicator feature may be in a separate display box or may be integrated into the wheelchair interface;

(iv) Payment for the code includes an allowance for fixed mounting hardware for the control box and for the display box (if present);

(v) When a switch is medically appropriate and a client has adequate hand motor skills, a switch would be considered the least costly alternative;

(vi) E2310 or E2311 may be considered for coverage when a client does not have hand motor skills or presents with cognitive deficits, contractures or limitation of movement patterns that prevents operation of a switch;

(vii) In addition, an alternate switching system must be medically appropriate and not hand controlled (not running through a joystick).

(viii) If a wheelchair has an electrical connection device described by code E2310 or E2311 and if the sole function of the connection is for a power seat elevation or power standing feature, it is not covered.

(w) Power Wheelchair Drive Control Systems:

(A) The term interface in the code narrative and definitions describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc;

(B) A proportional interface is one in which the direction and amount of movement by the client controls the direction and speed of the wheelchair. One example of a proportional interface is a standard joystick;

(C) A nonproportional interface is one which involves a number of switches. Selecting a particular switch determines the direction of the wheelchair, but the speed is pre-programmed. One example of a nonproportional interface is a sip-and-puff mechanism;

(D) The term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other

drive control interface) and convert that input into power output to the motor and gears in the power wheelchair base;

(E) A switch is an electronic device which turns power to a particular function either "on" or "off". The external component of a switch may be either mechanical or nonmechanical. Mechanical switches involve physical contact in order to be activated. Examples of the external components of mechanical switches include, but are not limited to, toggle, button, ribbon, etc. Examples of the external components of nonmechanical switches include, but are not limited to, proximity, infrared, etc. Some of the codes include multiple switches. In those situations, each functional switch may have its own external component or multiple functional switches may be integrated into a single external switch component or multiple functional switches may be integrated into the wheelchair control interface without having a distinct external switch component;

(F) A stop switch allows for an emergency stop when a wheelchair with a nonproportional interface is operating in the latched mode. (Latched mode is when the wheelchair continues to move without the patient having to continually activate the interface.) This switch is sometimes referred to as a kill switch;

(G) A direction change switch allows the client to change the direction that is controlled by another separate switch or by a mechanical proportional head control interface. For example, it allows a switch to initiate forward movement one time and backward movement another time;

(H) A function selection switch allows the client to determine what operation is being controlled by the interface at any particular time. Operations may include, but are not limited to, drive forward, drive backward, tilt forward, recline backward, etc.;

(I) An integrated proportional joystick and controller is an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair;

(J) The interfaces described by codes E2320-E2322, E2325, and E2327-E2330 must have programmable control parameters for speed adjustment, tremor dampening, acceleration control, and braking;

(K) A remote joystick (E2320, E2321) is one in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. These codes include remote joysticks that are used for hand control as well as joysticks that are used for chin control. Code E2320 includes any type of proportional remote joystick stick including, but not limited to standard, mini-proportional, compact, and short throw remote joysticks;

(L) When code E2320 or E2321 is used for a chin control interface, the chin cup is billed separately with code E2324;

(M) Code E2320 also describes a touchpad which is an interface similar to the pad-type mouse found on portable computers;

(N) Code E2322 describes a system of 3-5 mechanical switches which are activated by the client touching the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch, if provided, are included in the allowance for the code;

(O) Code E2323 includes prefabricated joystick handles that have shapes other than a straight stick – e.g., U shape or T shape – or that have some other nonstandard feature – e.g., flexible shaft;

(P) A sip and puff interface (E2325) is a nonproportional interface in which the client holds a tube in their mouth and controls the wheelchair by either sucking in (sip) or blowing out (puff). A mechanical stop switch is included in the allowance for the code. E2325 does not include the breath tube kit which is described by code E2326;

(Q) A proportional, mechanical head control interface (E2327) is one in which a headrest is attached to a joystick-like device. The direction and amount of movement of the client's head pressing on the headrest control the direction and speed of the wheelchair. A mechanical direction control switch is included in the code;

(R) A proportional, electronic head control interface (E2328) is one in which a client's head movements are sensed by a box placed behind the client's head. The direction and amount of movement of the client's head (which does not come in contact with the box) control the direction and speed of the wheelchair. A proportional, electronic extremity control interface (E2328) is one in which the direction and amount of movement of the client's arm or leg control the direction and speed of the wheelchair;

(S) A nonproportional, contact switch head control interface (E2329) is one in which a client activates one of three mechanical switches placed around the back and sides of their head. These switches are activated by pressure of the head against the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(T) A nonproportional, proximity switch head control interface (E2330) is one in which a client activates one of three switches placed around the back and sides of their head. These switches are activated by movement of the head toward the switch, though the head does not touch the switch. The switch that is selected determines the direction of the wheelchair. A mechanical stop switch and a mechanical direction change switch are included in the allowance for the code;

(U) Code E2399 (not otherwise classified interface) is appropriately used in the following situations:

(i) An integrated proportional joystick and controller box are being replaced due to damage; or

(ii) The item being replaced is a remote joystick box only (without the controller); or

(iii) The item being replaced is another type of interface, e.g. sip and puff, head control without the controller); or

(iv) The item being replaced is the controller box only (without the remote joystick or other type of interface); or

(v) There is no specific E code which describes the type of drive control interface system which is provided. In this situation, E2399 would be used at the time of initial issue or if the item was being provided as a replacement.

(V) The KC modifier (replacement of special power wheelchair interface) is used in the following situations:

(i) Due to a change in the client's condition an integrated joystick and controller is being replaced by another drive control interface — e.g., remote joystick, head control, sip and puff, etc.; or

(ii) The client has a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage.

(iii) The KC modifier is never used at the time of initial issue of a wheelchair.

(iv) The KC modifier specifically states replacement, therefore, the RP modifier is not required. The KC modifier is not used when billing code E2399.

(x) Other Power Wheelchair Accessories: An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface may be covered if the client has a covered speech generating device. (See Division 129, Speech-Language Pathology, Audiology and Hearing Aid Services.);

(y) Miscellaneous Accessories:

(A) Anti-rollback device (E0974) is covered if the client propels himself/herself and needs the device because of ramps;

(B) A safety belt/pelvic strap (E0978) is covered if the client has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning;

(C) One example (not all-inclusive) of a covered indication for swing-away, retractable, or removable hardware (E1028) would be to move the component out of the way so that a client could perform a slide transfer to a chair or bed;

(D) A fully reclining back option (E1226) is covered if the client spends at least 2 hours per day in the wheelchair and has one or more of the following conditions/needs:

(i) Quadriplegia;

(ii) Fixed hip angle;

(iii) Trunk or lower extremity casts/braces that require the reclining back feature for positioning;

(iv) Excess extensor tone of the trunk muscles; and/or

(v) The need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult.

(2) Documentation Requirements: Submit applicable documentation as follows with the prior authorization (PA) request:

(a) A Certificate of Medical Necessity (CMN) or reasonable facsimile for E0973, E0990, K0017, K0018, K0020, E1226, K0046, K0047, K0053, and K0195. For these items, the CMN may act as a substitute for a written order if it contains all of the required elements of an order. Depending on the type of wheelchair, the CMN for these options/accessories is either CMS Form 843 (power wheelchairs) or CMS Form 844 (manual wheelchairs;

(b) When code K0108 is billed, a narrative description of the item, the manufacturer, the model name or number (if applicable), and information justifying the medical appropriateness for the item;

(c) Options/accessories for individual consideration might include documentation on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, past experience using similar equipment;

(d) For a custom fabricated seat cushion:

(A) A comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a DMEPOS provider) which clearly explains why a prefabricated seating system is not sufficient to meet the client's seating and positioning needs; and

(B) Diagnostic reports that support the medical condition;

(e) Any additional documentation that supports indications of coverage are met as specified in this rule;

(f) Above documentation must be kept on file by the DMEPOS provider, documented in the client's medical record and made available to OMAP on request.

(3) Table 122-0340. [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 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 32-1992, f. & cert. ef. 10-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 26-1994, f. & cert. ef. 7-1-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0500**
**Transcutaneous Electrical Nerve Stimulator (TENS)**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: transcutaneous electrical nerve stimulator (TENS) (E0720, E0730) is a device which utilizes electrical current delivered through electrodes placed on the surface of the skin. A TENS unit decreases the client's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves.

(2) A TENS unit may be covered for the treatment of:

(a) Acute post-operative pain:

(A) Coverage is usually limited to 30 days from the day of surgery; and

(B) Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the attending physician; and

(C) Payment is made only as a rental; and

(D) Acute pain (less than three months duration) other than post-operative pain is not covered; or

(b) Chronic, intractable pain:

(A) The pain has been present for at least three months; and

(B) Other appropriate treatment modalities have been tried and failed; and

(C) The presumed etiology of the pain is a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be medically appropriate are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain; and

(D) The TENS unit must be used by the client on a trial basis for a minimum of one month (30 days), but not to exceed two months. The trial period is paid as a rental. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain;

(E) For coverage of a purchase, the physician must determine that the client is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a reevaluation of the client at the end of the trial period, must indicate how often the client used the TENS unit, the typical duration of use each time, and the results.

(2) Documentation Requirements: Submit the following documentation from the attending or consulting physician with the prior authorization (PA) request:

(a) For both acute post-operative pain and chronic, intractable pain:

(A) A signed and dated order by the treating physician. The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit; and

(B) Documentation of multiple medications and/or therapies that have been tried and failed; and

(C) A new order, when purchase is requested (after the required trial period). The initial date on this order must not overlap the dates of the trial period.

(b) In addition, for a client with acute post-operative pain: date of surgery resulting in acute post-operative pain;

(c) In addition, for a client with chronic, intractable pain: location of the pain, the duration of time the client has had the pain, and the presumed etiology of the pain;

(d) For authorization of quantities of supplies greater than those described in this policy as the usual maximum amounts:

(A) Each request must include documentation supporting the medical appropriateness for the higher utilization; and

(B) There must be clear documentation in the client's medical records corroborating the medical appropriateness of this amount.

(e) When ordering a 4 lead TENS unit, the client's medical record must document why 2 leads are insufficient to meet the client's needs;

(f) OMAP may request copies of the client's medical records that corroborate the order and any additional documentation that pertains to the medical appropriateness of items and quantities requested.

(3) Rental Guidelines: During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc.

(4) Purchase Guidelines: If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.

(5) Coding Guidelines:

(a) Separate allowance may be made for replacement supplies when they are medically appropriate and are used with a TENS unit that has been purchased and/or approved by OMAP;

(b) If 2 TENS leads are medically appropriate, then a maximum of one unit of Code A4595 would be allowed per month; if 4 TENS leads are necessary, a maximum of two units per month would be allowed;

(c) If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally;

(d) There is no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit;

(e) Codes A4556 (Electrodes, e.g., apnea monitor per pair), A4558 (Conductive paste or gel), and A4630 (Replacement batteries, medically appropriate TENS owned by the client) are not valid for prior authorization. A4595 should be used instead;

(f) For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service;

(g) Replacement of lead wires (A4557) will be covered when they are inoperative due to damage and the TENS unit is still medically appropriate. Replacement more often than every 12 months is rarely medically appropriate;

(h) A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used);

(i) Other supplies, including but not limited to the following, are not separately payable: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

(j) Providers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

(k) Table 122-0500. [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 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 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 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0560**
**Urological Services**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) Urinary catheters and external urinary collection devices are covered when used to drain or collect urine for a client who has permanent urinary incontinence or permanent urinary retention;

(b) Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within three months. A determination that there is no possibility that the client's condition may improve sometime in the future is not required. If the medical record, including the judgement of the attending treating physician, indicates the condition is of long and indefinite duration (ordinarily at least three months), the test of permanence is considered met;

(c) For adults, Medicare coverage criteria must be met (see Medicare's website for coverage criteria);

(d) Supplies for intermittent irrigation of indwelling catheters may be covered when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter;

(e) Supplies for continuous irrigation of indwelling catheters may be covered if there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically necessary catheter changes;

(f) Reimbursement for more than 200 pairs of non-sterile gloves (A4927) per month is not payable by the Office of Medical Assistance Programs (OMAP).

(2) Documentation Requirements:

(a) Documentation of medical appropriateness which has been reviewed and signed by the treating physician must be kept on file by the durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) provider;

(b) Medical appropriateness for use of a greater quantity of supplies than the amounts specified in this policy must be documented in the client's medical record and kept on file by the DMEPOS provider;

(c) Documentation required in this policy must be available to OMAP on request.

(3) Table 122-0560. [Table not included. See ED. NOTE.]

[ED. NOTE: Tables referenced rule are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 13-1991, f. & cert. ef. 3-1-91; HR 10-1992, f. & cert. ef. 4-1-92; HR 9-1993, f. & cert. ef. 4-1-93; HR 10-1994, f. & cert. ef. 2-15-94; HR 41-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1996, f. & cert. ef. 8-1-96; HR 7-1997, f. 2-28-97, cert. ef. 3-1-97; OMAP 11-1998, f. & cert. ef. 4-1-98; OMAP 13-1999, f. & cert. ef. 4-1-99; OMAP 1-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 4-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 8-2002, f. & cert. ef. 4-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 25-2004, f. & cert. ef. 4-1-04; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0590**
**Patient Lifts**

(1) Indications and Coverage — A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the client would be bed confined.

(2) A sling or seat for a client lift may be covered as an accessory when ordered as a replacement for the original equipment item.

(3) E0621 is included in the allowance for E0630 when provided at the same time.

(4) Procedure Codes:

(a) E0621 — Sling or seat, client lift, canvas or nylon — the Office of Medical Assistance Programs (OMAP) will purchase — Prior authorization (PA) required;

(b) E0630 — Client lift, hydraulic with seat or sling (considered purchased after 13 months of rental) — OMAP will purchase, rent or repair — PA required.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0630**
**Incontinent Supplies**

(1) Incontinent supplies may be covered for urinary or fecal incontinence as follows:

(a) Category I Incontinent Supplies:

(b) For up to 220 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity.

(c) Category II Incontinent Supplies:

(A) For up to 100 units (any code or product combination in this category) per month when;

(i) A documented bowel and bladder retraining program is present; and

(ii) A client has partial ability to be continent; and

(iii) Treatment failure with other, less-expensive products is documented; or

(B) For autism with tactile aversion; or

(C) For other medically appropriate reasons;

(D) Category II Incontinent Supplies are not separately payable with any other incontinent supplies.

(d) Category III Underpads:

(A) Disposable underpads:(T4541 and T4542) For up to 100 units (any combination of T4541 and T4542) per month, unless documentation supports the medical appropriateness for a higher quantity, up to a maximum of 150 units per month;

(B) Reusable/washable underpads: (T4537 and T4540) For up to eight units (any combination of T4537 and T4540) in a 12 month period;

(C) Category III Underpads are separately payable only with Category I Incontinent Supplies;

(D) T4541 and T4542 are not separately payable with T4537 and T4540 for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for eight reusable/washable underpads on a given date of service, a client would not be eligible for disposable underpads for the subsequent 12 months.

(e) Category IV Washable Protective Underwear: For up to 12 units in a 12 month period. Category IV Washable Protective Underwear is not separately payable with Category I Incontinent Supplies for the same dates of service or anticipated coverage period. For example, if a provider bills and is paid for 12 units of T4536 on a given date of service, a client would not be eligible for Category I Incontinent Supplies for the subsequent 12 months.

(2) Incontinent supplies are not covered:

(a) For nocturnal enuresis; or

(b) For children under the age of three.

(3) A provider may only submit A4335 when there is no definitive Healthcare Common Procedure Coding System (HCPCS) code that meets the product description.

(4) Documentation requirements: Submit the following documentation for review:

(a) For all categories, the medical reason for incontinence; and

(b) In addition, for Category II Incontinent Supplies only:

(A) Bowel and bladder retraining program (this can be in the form of a care plan); and

(B) Medical proof that other products have been tried and failed; and

(C) Documented progress of achieving or maintaining goals of bowel and bladder training program.

(5) Quantity specification:

(a) For prior authorization (PA) and reimbursement purposes, a unit count for Category I – IV codes is considered as single or individual piece of an item and not as multiple quantity;

(b) If an item quantity is listed as number of boxes, cases or cartons, the total number of individual pieces of that item contained within that respective measurement (box, case or carton) must be specified in the unit column on the PA request. See table 122-0630-2;

(c) For gloves (Category V Miscellaneous), 100 gloves equal one unit.

(9) Table 122-0630-1.

(10) Table 122-0630-2.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 37-2000, f. 9-29-00, cert. ef. 10-1-00; OMAP 32-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 64-2001, f. 12-28-01, cert.ef. 1-1-02; OMAP 47-2002, f. & cert. ef. 10-1-02; OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 76-2003, f. & cert. ef. 10-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 11-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

**410-122-0720**
**Pediatric Wheelchairs**

(1) Indications and Limitations of Coverage and/or Medical Appropriateness:

(a) The purchase, rental, repair, maintenance or modification of a client's primary wheelchair may be covered by the Office of Medical Assistance Programs (OMAP) when all of the following criteria are met:

(A) The client's condition is such that without the use of a wheelchair, the client would be bed or chair confined; and

(B) The client is not functionally ambulatory and the wheelchair is necessary to function within the home.

(b) When a client's current wheelchair is no longer medically appropriate or repair to the wheelchair exceeds replacement cost, a new wheelchair may be authorized;

(c) If a client has a medically appropriate wheelchair regardless of payer, OMAP does not reimburse for another wheelchair;

(d) One month's rental of a wheelchair may be payable if a covered client-owned wheelchair is in need of repair (see OAR 410-122-0184 Repairs, Maintenance, Replacement and Delivery);

(e) The client's living quarters must be able to accommodate and allow for the effective use of the requested wheelchair. OMAP does not reimburse for adapting living quarters;

(f) Backup wheelchairs, backpacks, accessory bags, clothing guards, awnings, additional positioning equipment if wheelchair meets the same need, custom colors, wheelchair gloves, and any other upgrades to primarily allow performance of leisure or recreational activities are not covered;

(g) Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair as well as support services such as emergency services,delivery, set-up, education and ongoing assistance with the use of the wheelchair.;

(h) A pediatric tilt-in space wheelchair (E123 — E1234) may be covered when a client:

(A) Is dependent for transfers; and

(B) Spends a minimum of four hours a day continuously in a wheelchair; and

(C) The plan of care addresses the need to change position at frequent intervals and the client is not left in the tilt position most of the time; and

(D) Has one of the following:

(i) High risk of skin breakdown;

(ii) Poor postural control, especially of the head and trunk;

(iii) Hyper/hypotonia;

(iv) Need for frequent changes in position and has poor upright sitting.

(i) A manual wheelchair may be covered for a client residing in a nursing facility only when coverage criteria for a customized seat cushion and a customized back cushion are met (see 410-122-0340 Wheelchair Options/Accessories);

(j) Pediatric seating system codes E2291 — E2294 may only be billed with pediatric wheelchair base codes;

(k) For other pediatric size positioning accessories, use the codes described in 410-122-0340 (Wheelchair Options/Accessories).

(2) Documentation Requirements: Submit the following documentation with the prior authorization (PA) request):

(a) For purchase and modifications, the Wheelchair and Seating Prescription and Justification form (OMAP 3125 — see DME and Medical Supplies Supplemental Information) or reasonable facsimile which includes, but is not limited to, the following information):

(A) Completion of the form or reasonable facsimile by a physical therapist, occupational therapist or treating physician, including signature and date; and

(B) Completion of the form or reasonable facsimile by an individual who has no direct or indirect financial relationship, agreement or contract with the durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider; and

(C) Signature and date by the treating physician; and

(D) Information that specifically indicates the client's functional ambulation status in their customary environment; and

(E) Most cost effective equipment recommended to meet the client's medical needs and that person completing the form is in agreement with the DMEPOS provider's recommendations (include manufacturer, product name, model number, standard features, specifications, dimensions and options); and

(F) Detailed information about client-owned equipment (including serial numbers) as well as any other equipment being used or available to meet the client's medical needs, including the age of the equipment and why it can't be grown or modified, if applicable.

(b) Documentation that a physical environment assessment, that includes the client's living quarters as well as the most common places of service for use of the equipment, has been performed by the DMEPOS provider or a health care clinician. This assessment must support that these environments can accommodate and allow for the effective use of the equipment, including, but not limited to, evaluation of door widths, counter/table height, accessibility (e.g., ramps, etc.), electrical service, etc.; and

(c) All Healthcare Common Procedure Coding System codes (HCPCS) to be billed on this claim (both codes that require authorization and those that do not require authorization);

(d) Documentation for individual consideration might include information on the client's diagnosis, the client's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency, and nature of the activities the client performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment;

(e) For a nursing facility client, submit medical justification that corroborates the need for customized seat and back cushions (see 410-122-0340 Wheelchair Options/Accessories), including dated and clear photographs and body contour measurements;

(f) Any additional documentation that supports indications of coverage are met as specified in this policy;

(g) The above documentation must be kept on file by the DMEPOS provider and made available to OMAP upon request.

(3) Table 122-0720.

[ED. NOTE: Tables referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: OMAP 21-2003, f. 3-26-03, cert. ef. 4-1-03; OMAP 44-2004, f. & cert. ef. 7-1-04; OMAP 94-2004, f. 12-30-04, cert. ef. 1-1-05; OMAP 44-2005, f. 9-9-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 45-2005
**Filed with Sec. of State:** 9-9-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 410-130-0220, 410-130-0255, 410-130-0585, 410-130-0587
**Subject:** The Medical-Surgical Services program rules govern payment for the Office of Medical Assistance Programs' (OMAP) payments for services provided to clients. OMAP amended the following OARs: 410-130-0220 to reflect CPT and HCPC code additions and deletions, add Physical Therapy codes no longer covered, add group education as not covered, and remove intranasal flu vaccine as not covered; 410-130-0255 to add vaccines covered by the Vaccines for Children's Program; 410-130-0585 to add language on services included in family planning; 410-130-0587 to clarify Family Planning Clinics must be enrolled with the Office of Family Health and to bill all supplies at acquisition cost. OMAP also amended these rules to take care of necessary housekeeping corrections.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-130-0220**
**Not Covered/BundledServices**

(1) Refer to the Oregon Health Plan Administrative Rules (chapter 410, division141) 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.

(2) 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.

(3) 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).

Table 130-0220-1

[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; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05

**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) VFC Program:

(a) Under this federal program, vaccine serums are free for clients ages 0 through 18. The Office of Medical Assistance Programs (OMAP) will not reimburse the cost of privately purchased vaccines that are covered through the VFC Program, but will reimburse for the administration of vaccines;

(b) Only providers enrolled in the VFC Program can receive free vaccine serums. To enroll as a VFC provider, contact the Department of Human Services Immunization Program. For contact information, see the Medical-Surgical Supplemental Information;

(c) Refer to Table 130-0255-1 for immunization codes covered through the VFC Program;

(d) Use the following procedures when billing for the administration of a VFC vaccine:

(A) When the sole purpose of the visit is to administer a VFC vaccine, the provider should bill the appropriate vaccine procedure code with modifier -26 or -SL for each injection. Do not bill CPT code 90465-90474 or 99211;

(B) When the vaccine 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.Table 130-0255-1.

[ED. NOTE: Tables referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
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; OMAP 58-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05

**410-130-0585**
**Family Planning Services**

(1) Family planning services are those intended to prevent or delay pregnancy, or otherwise control family size.

(2) Family planning services are covered for clients of childbearing age (including minors who are considered to be sexually active).

(3) Family Planning services include:

(a) Annual exams;

(b) Contraceptive education and counseling to address reproductive health issues;

(c) Laboratory tests;

(d) Radiology services;

(e) Medical and surgical procedures, including tubal ligations and vasectomies;

(f) Pharmaceutical supplies and devices.

(4) Clients may seek family planning services from any provider enrolled with the Office of Medical Assistance Programs (OMAP), even if the client is enrolled in a Prepaid Health Plan (PHP). Reimbursement for family planning services is made either by the client's PHP or OMAP. If the provider is:

(a) A participating provider with the client's PHP, bill the PHP;

(b) An enrolled OMAP provider, but is not a participating provider with the client's PHP, bill OMAP and mark the family planning box (24H) on the CMS-1500 claim form.

(5) Family planning methods include natural family planning, abstinence, intrauterine device, cervical cap, prescriptions, sub-dermal implants, condoms, and diaphragms.

(6) Bill all family planning services with the most appropriate ICD-9-CM diagnosis code in the V25 series (Contraceptive Management), the most appropriate CPT or HCPCS code and add modifier – FP.

(7) For annual family planning visits use the appropriate CPT code in the Preventative Medicine series (9938X-9939X). These codes include comprehensive contraceptive counseling.

(8) When comprehensive contraceptive counseling is the only service provided at the encounter, use a CPT code from the Preventative Medicine, Individual Counseling series (99401-99404).

(9) Bill contraceptive supplies with the most appropriate HCPCS codes.

(10) Where there are no specific CPT or HCPCS codes, use an appropriate unlisted code and add modifier -FP. Bill supplies 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; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05

**410-130-0587**
**Family Planning Clinic Services**

(1) This rule pertains only to Family Planning Clinics.

(2) To enroll with the Office of Medical Assistance Programs (OMAP) as a Family Planning Clinic, a provider must also be enrolled with the Office of Family Health as a Family Planning Expansion Project (FPEP) provider.

(3) Family Planning Clinics must follow all applicable FPEP and OMAP rules.

(4) Family Planning Clinics will be reimbursed an encounter rate only when the primary purpose of the visit is for family planning.

(5) 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 contraceptive medications;

(F) Contraceptive injections.

(b) Do not bill procedures, such as IUD insertions, diaphragm fittings or injections, with CPT or 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.

(6) Reimbursement for T1015 does not include payment for FP supplies and medications:

(a) Bill contraceptive supplies and contraceptive medications separately using HCPCS codes. Where there are no specific HCPCS codes, use an appropriate unspecified HCPCS code:

(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) Bill all contraceptive supplies and contraceptive medications at acquisition cost;

(c) Add modifier -FP after all codes for contraceptive services, supplies and medications;

(d) Non-contraceptive medications are not billable under this program;

(7) Reimbursement for T1015 does not include payment for 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.

(8) Encounters where the primary purpose of the visit is not contraceptive in nature, use appropriate CPT codes and do not add modifier -FP.

(9) 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; OMAP 8-2005, f. 3-9-05, cert. ef. 4-1-05; OMAP 45-2005, f. 9-9-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 46-2005
**Filed with Sec. of State:** 9-9-2005
**Certified to be Effective:** 10-1-05
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**Rules Amended:** 410-141-0000, 410-141-0020, 410-141-0060, 410-141-0080, 410-141-0180, 410-141-0220, 410-141-0263, 410-141-0300, 410-141-0420
**Subject:** The Oregon Health Plan (OHP) administrative rules govern Office of Medical Assistance Programs' (OMAP) payments for products and services provided to certain clients. OMAP permanently amended as follows: 410-141-0020 to clarify language and intent and to make rule precedence consistent; 410-141-0060 and 410-141-0080 to clarify psychiatric residential treatment services; and, 410-141-0000, 410-141-0180, 410-141-0220, 410-141-0263, 410-141-0300, and 410-141-0420 to take care of necessary housekeeping corrections.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-141-0000**
**Definitions**

(1) Action — In the case of a Prepaid Health Plan (PHP):

(a) The denial or limited authorization of a requested covered service, including the type or level of service;

(b) The reduction, suspension or termination of a previously authorized service;

(c) The denial in whole or in part, of payment for a service;

(d) The failure to provide services in a timely manner, as defined by OMAP;

(e) The failure of a PHP to act within the timeframes provided in 42 CFR 438.408(b); or

(f) For an OMAP Member in a single Fully Capitated Health Plan (FCHP) or Mental Health Organization (MHO) Service Area, the denial of a request to obtain covered services outside of the FCHP or MHO's Participating Provider panel pursuant to OAR 410-141-0160 and 410-141-0220.

(2) Administrative Hearing — A DHS hearing related to an Action, including a denial, reduction, or termination of benefits, which is held when requested by the OHP Client or OMAP Member. A hearing may also be held when requested by an OHP Client or OMAP Member who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(3) Advance Directive — A form that allows a person to have another person make health care decisions when he/she cannot make the decision and tells a doctor that the person does not want any life sustaining help if he/she is near death.

(4) Aged — Individuals who meet eligibility criteria established by DHS Seniors and People with Disabilities for receipt of medical assistance because of age.

(5) Americans with Disabilities Act (ADA) — Federal law promoting the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(6) Alternative Care Settings — Sites or groups of practitioners, which provide care to OMAP Members under contract with the PHP. Alternative Care Settings include but are not limited to urgent care centers, hospice, birthing centers, out-placed medical teams in community or mobile health care facilities, outpatient surgicenters.

(7) Ancillary Services — Those medical services under the Oregon Health Plan not identified in the definition of a Condition/Treatment Pair under the OHP Benefit Package, but Medically Appropriate to support a service covered under the OHP benefit package. A list of ancillary services and limitations is identified in OAR 410-141-0520, Prioritized List of Health Services, or specified in the Ancillary Services Criteria Guide.

(8) Appeal — A request for review of an "Action" as defined in this section.

(9) Automated Information System (AIS) — A computer system that provides information on the current eligibility status for clients under the Medical Assistance Program.

(10) Blind — Individuals who meet eligibility criteria established by DHS Seniors and People with Disabilities for receipt of medical assistance because of a condition or disease that causes or has caused blindness.

(11) Capitated Services — Those Covered Services that a PHP or Primary Care Manager agrees to provide for a Capitation Payment under an OMAP Oregon Health Plan contract or agreement.

(12) Capitation Payment:

(a) Monthly prepayment to a PHP for the provision of all Capitated Services needed by OHP Clients who are enrolled with the PHP;

(b) Monthly prepayment to a Primary Care Manager to provide Primary Care Management Services for an OHP Client who is enrolled with the PCM. Payment is made on a per OHP Client, per month basis.

(13) Centers for Medicare and Medicaid Services (CMS). The federal agency under the Department of Health and Human Services, responsible for approving the waiver request to operate the Oregon Health Plan Medicaid Demonstration Project.

(14) CFR- Code of Federal Regulations.

(15) Chemical Dependency Services — Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

(16) Chemical Dependency Organization (CDO) — a Prepaid Health Plan that provides and coordinates chemical dependency outpatient, intensive outpatient and opiate substitution treatment services as Capitated Services under the Oregon Health Plan. All chemical dependency services covered under the Oregon Health Plan are covered as Capitated Services by the CDO.

(17) Chemical Dependency Services — Assessment, treatment and rehabilitation on a regularly scheduled basis, or in response to crisis for alcohol and/or other drug abusing or dependent clients and their family members or significant others, consistent with Level I and/or Level II of the "Chemical Dependency Placement, Continued Stay, and Discharge Criteria."

(18) Children's Health Insurance Program (CHIP) — A Federal and State funded portion of the Medical Assistance Program established by Title XXI of the Social Security Act and administered in Oregon by the Department of Human Services, Office of Medical Assistance Programs (see Medical Assistance).

(19) Children Receiving CAF Child Welfare or OYA Services — Individuals who are receiving medical assistance under ORS 414.025(2)(f), (i), (j), (k) and (o), 418.034, and 418.187 to 418.970. These individuals are generally children in the care and/or custody of Children, Adults and Families Services, Department of Human Services or Oregon Youth Authority who are in placement outside of their homes.

(20) Claim — (1) A bill for services, (2) a line item of a service, or (3) all services for one recipient within a bill.

(21) Clinical Record — The Clinical Record includes the medical, dental, or mental health records of an OHP Client or OMAP Member. These records include the PCP's record, the inpatient and outpatient hospital records and the ENCC, Complaint and Disenrollment for cause records, which may reside in the PHP's administrative offices.

(22) Cold Call Marketing — Any unsolicited personal contact by a PHP with a Potential Member for the purpose of Marketing as defined in this rule.

(23) Comfort Care — The provision of medical services or items that give comfort and/or pain relief to an individual who has a Terminal Illness. Comfort care includes the combination of medical and related services designed to make it possible for an individual with Terminal Illness to die with dignity and respect and with as much comfort as is possible given the nature of the illness. Comfort Care includes but is not limited to care provided through a hospice program (see Hospice rules), pain medication, and palliative services including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. Comfort Care includes nutrition, hydration and medication for

disabled infants with life-threatening conditions that are not covered under Condition/Treatment Pairs. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable Comfort Care is provided consistent with Section 4751 OBRA 1990 — Patient Self-Determination Act and ORS 127 relating to health care decisions as amended by the Sixty-Seventh Oregon Legislative Assembly, 1993. Comfort Care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(24) Community Mental Health Program (CMHP) — The organization of all services for persons with mental or emotional disorders and developmental disabilities operated by, or contractually affiliated with, a local Mental Health Authority, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the DHS Office of Mental Health and Addiction Services.

(25) Comorbid Condition — A medical condition/diagnosis (i.e., illness, disease and/or disability) coexisting with one or more other current and existing conditions/diagnoses in the same patient.

(26) Complaint — An OMAP Member's or OMAP Member's Representative's expression of dissatisfaction to a PHP or Participating Provider about any matter other than an Action, as "Action" is defined in this Section.

(27) Community Standard — Typical expectations for access to the health care delivery system in the OMAP Member's or PCM Member's community of residence. Except where the Community Standard is less than sufficient to ensure quality of care, OMAP requires that the health care delivery system available to OMAP Members in Prepaid Health Plans and to PCM Members with Primary Care Managers take into consideration the Community Standard and be adequate to meet the needs of OMAP and PCM Members.

(28) Condition/Treatment Pair — Diagnoses described in the International Classification of Diseases Clinical Modifications, 9th edition (ICD-9 CM), the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV), and treatments described in the Current Procedural Terminology, 4th edition (CPT-4) or American Dental Association Codes (CDT-2), or the DHS Office of Mental Health and Addiction Services Medicaid Procedure Codes and Reimbursement Rates, which, when paired by the Health Services Commission, constitute the line items in the Prioritized List of Health Services. Condition/Treatment Pairs may contain many diagnoses and treatments. The Condition/Treatment Pairs are listed in OAR 410-141-0520, Prioritized List of Health Services.

(29) Continuing Treatment Benefit — A benefit for OHP Clients who meet criteria for having services covered that were either in a course of treatment or were scheduled for treatment on the day immediately prior to the date of conversion to the OHP Benefit Package of covered services and that treatment is not covered under the OHP Benefit Package of covered services.

(30) Co-payment — The portion of a covered service that an OMAP Member must pay to a provider or a facility. This is usually a fixed amount that is paid at the time one or more services are rendered.

(31) Contract — The contract between the State of Oregon, acting by and through its Department of Human Services (DHS), Office of Medical Assistance Programs (OMAP) and a Fully Capitated Health Plan (FCHP), Dental Care Organization (DCO), Physician Care Organization (PCO), or a Chemical Dependency Organization (CDO), or between the Office of Mental Health and Addiction Services (OMHAS) and a Mental Health Organization (MHO) for the provision of covered services to eligible OMAP Members for a Capitation Payment. Also referred to as a Service Agreement.

(32) Covered Services — are Medically Appropriate health services that are funded by the Legislature and described in ORS 414.705 to 414.750; OAR 410-120-1210, Medical Assistance Benefit Packages and Delivery System; OAR 410-141-0120, Oregon Health Plan Prepaid Health Plan Provision of Health Care Services; OAR 410-141-0520, Prioritized List of Health Services; and OAR 410-141-0480, Oregon Health Plan Plus Benefit Package of Covered Services; except as excluded or limited under OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients and OAR 410 Division 120.

(33) Dentally Appropriate — Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

(a) Consistent with the symptoms of a dental condition or treatment of a dental condition;

(b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of the Oregon Health Plan Member or a provider of the service;

(d) The most cost effective of the alternative levels of dental services that can be safely provided to an OMAP Member.

(34) Dental Care Organization (DCO) — A Prepaid Health Plan that provides and coordinates capitated dental services. All dental services covered under the Oregon Health Plan are covered as Capitated Services by the DCO; no dental services are paid by OMAP on a fee-for-service basis for Oregon Health Plan Clients enrolled with a DCO provider.

(35) Dental Case Management Services — Services provided to ensure that eligible OMAP Members obtain dental services including a comprehensive, ongoing assessment of the dental and medical needs related to dental care of the Member plus the development and implementation of a plan to ensure that eligible OMAP Members obtain Capitated Services.

(36) Dental Emergency Services — Dental services may include but are not limited to severe tooth pain, unusual swelling of the face or gums, and an avulsed tooth.

(37) Dental Practitioner — A practitioner who provides dental services to OMAP Members under an agreement with a DCO, or is a Fee-For-Service Health Care Practitioner. Dental practitioners are licensed and/or certified by the state in which they practice, as applicable, to provide services within a defined scope of practice.

(38) Department of Human Services (DHS) — DHS is made up of three program areas: Children, Adults and Families; Health Services; and Seniors and People with Disabilities. They are supported by the Director's Office; Administrative Services; and Finance and Policy Analysis. The Office of Medical Assistance Programs and the Office of Mental Health and Addiction Services are part of the Health Services Cluster.

(39) Diagnostic Services — Those services required to diagnose a condition, including but not limited to radiology, ultrasound, other diagnostic imaging, electrocardiograms, laboratory and pathology examinations, and physician or other professional diagnostic or evaluative services.

(40) Disabled — Individuals who meet eligibility criteria established by the DHS Seniors and People with Disabilities for receipt of Medical Assistance because of a disability.

(41) Disenrollment — The act of discharging an Oregon Health Plan Client from a Prepaid Health Plan's or Primary Care Manager's responsibility. After the effective date of Disenrollment an Oregon Health Plan Client is no longer required to obtain Capitated Services from the Prepaid Health Plan or Primary Care Manager, nor be referred by the Prepaid Health Plan for Medical Case Managed Services or by the Primary Care Manager for PCM Case Managed Services.

(42) Dual Eligible — OHP Clients who are receiving both Medicaid and Medicare benefits.

(43) Emergency Medical Condition – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson (rather than a Health Care Professional) and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

(44) Emergency Services — Covered Services furnished by a provider that is qualified to furnish these services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(45) Enrollment — Oregon Health Plan Clients, subject to OAR 410-141-0060 — Oregon Health Plan Managed Care Enrollment Requirements, become OMAP Members of a Prepaid Health Plan or PCM Members of a Primary Care Manager that contracts with OMAP to provide Capitated Services. An OHP Client's Enrollment with a PHP indicates that the OMAP Member must obtain or be referred by the PHP for all Capitated Services and referred by the PHP for all Medical Case Managed Services subsequent to the effective date of Enrollment. An Oregon Health Plan Client's Enrollment with a Primary Care Manager indicates that the PCM Member must obtain or be referred by the Primary Care Manager for preventive and primary care and referred by the Primary Care Manager for all PCM Case Managed Services subsequent to the effective date of Enrollment.

(46) Enrollment Area — Client enrollment is based on the client's residential address and zip code. The address is automatically assigned a coun-

ty code or Federal Information Processing Standard (FIPS) code by the system, which indicates to the DHS worker that Plan(s) are in the area.

(47) Enrollment Year — A twelve-month period beginning the first day of the month of Enrollment of the Oregon Health Plan Client in a PHP and, for any subsequent year(s) of continuous Enrollment, beginning that same day in each such year(s). The Enrollment Year of Oregon Health Plan Clients who re-enroll within a calendar month of Disenrollment shall be counted as if there were no break in Enrollment.

(48) End Stage Renal Disease (ESRD) — End stage renal disease is defined as that stage of kidney impairment that appears irreversible and requires a regular course of dialysis or kidney transplantation to maintain life. In general, 5% or less of normal kidney function remains. If the person is 36 or more months post-transplant, the individual is no longer considered to have ESRD.

(49) Exceptional Needs Care Coordination (ENCC) — A specialized case management service provided by Fully Capitated Health Plans to OMAP Members who are Aged, Blind or Disabled, consistent with OAR 410-141-0405, Oregon Health Plan Prepaid Health Plan Exceptional Needs Care Coordination (ENCC). ENCC includes:

(a) Early identification of those OMAP Members who are Aged, Blind or Disabled who have disabilities or complex medical needs;

(b) Assistance to ensure timely access to providers and Capitated Services;

(c) Coordination with providers to ensure consideration is given to unique needs in treatment planning;

(d) Assistance to providers with coordination of Capitated Services and discharge planning; and

(e) Aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.

(50) Family Health Insurance Assistance Program (FHIAP) — A program in which the State subsidizes premiums in the commercial market for uninsured individuals and families with income below 185% of the FPL. FHIAP is funded with federal and states funds through either Title XIX, XXI or both.

(51) Family Planning Services — Services for clients of childbearing age (including minors who can be considered to be sexually active) who desire such services and which are intended to prevent pregnancy or otherwise limit family size.

(52) Fee-for-Service Health Care Providers — Health care providers who bill for each service provided and are paid by OMAP for services as described in OMAP provider rules. Certain services are covered but are not provided by Prepaid Health Plans or by Primary Care Managers. The client may seek such services from an appropriate Fee-For-Service provider. Primary Care Managers provide primary care services on a fee-for-service basis and might also refer PCM Members to specialists and other providers for fee-for-service care. In some parts of the state, the State may not enter into contracts with any managed care providers. OHP Clients in these areas will receive all services from Fee-For-Service providers.

(53) FPL – Federal Poverty Level.

(54) Free-Standing Mental Health Organization (MHO) — The single MHO in each county that provides only mental health services and is not affiliated with a Fully Capitated Health Plan for that service area. In most cases this “carve-out” MHO is a county Community Mental Health Program or a consortium of Community Mental Health Programs, but may be a private behavioral health care company.

(55) Fully Capitated Health Plan (FCHP) — Prepaid Health Plans that contract with OMAP to provide capitated services under the Oregon Health Plan. The distinguishing characteristic of FCHPs is the coverage of hospital inpatient services.

(56) Grievance System–The overall system that includes Complaints and Appeals handled at the PHP level and access to the state fair hearing process. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the OMAP Member’s rights.)

(57) Health Care Professionals — Persons with current and appropriate licensure, certification, or accreditation in a medical, mental health or dental profession, which include but are not limited to: Medical Doctors (including Psychiatrists), Dentists, Osteopathic Physicians, Psychologists, Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, Certified Medical Assistants, Licensed Physicians Assistants, Qualified Mental Health Professionals (QMHPs), and Qualified Mental Health Associates (QMHAs), Dental Hygienists, Denturists, and Certified Dental Assistants. These professionals may conduct health, mental health or dental assessments of OMAP members and provide Screening Services to OHP Clients within their scope of practice, licensure or certification.

(58) Health Insurance Portability and Accountability Act (HIPAA) of 1996 — HIPAA is a federal law (Public Law 104-191, August 21, 1996) with the legislative objective to assure health insurance portability, reduce health care fraud and abuse, enforce standards for health information and guarantee security and privacy of health information.

(59) Health Maintenance Unit (HMU) — The OMAP unit responsible for adjustments to enrollments, retroactive Disenrollment and enrollment of newborns.

(60) Health Plan New/Noncategorical Client (HPN) — A person who is 19 years of age or older, is not pregnant, is not receiving Medicaid through another program and who must meet eligibility requirements in OAR 461-136-1100(2), in addition to all other OHP eligibility requirements to become an Oregon Health Plan Client.

(61) Health Services Commission — An eleven member commission that is charged with reporting to the Governor the ranking of health benefits from most to least important, and representing the comparable benefits of each service to the entire population to be served.

(62) Hospice Services — A public agency or private organization or subdivision of either that is primarily engaged in providing care to terminally ill individuals, is certified for Medicare and/or accredited by the Oregon Hospice Association, is listed in the Hospice Program Registry, and has a valid provider agreement.

(63) Hospital Hold — A hospital hold is a process that allows a hospital to assist an individual who is admitted to the hospital for an inpatient hospital stay to secure a date of request when the individual is unable to apply for the Oregon Health Plan due to inpatient hospitalization. OHP clients shall be exempted from mandatory enrollment with an FCHP, if clients become eligible through a hospital hold process and are placed in the Adults/Couples category.

(64) Line Items — Condition/Treatment Pairs or categories of services included at specific lines in the Prioritized List of Services developed by the Health Services Commission for the Oregon Health Plan Medicaid Demonstration Project.

(65) Local and Regional Allied Agencies include the following: local Mental Health Authority; Community Mental Health Programs; local DHS offices; Commission on Children and Families; Oregon Youth Authority; Department of Corrections; Housing Authorities; local health departments, including WIC Programs; local schools; special education programs; law enforcement agencies; adult and juvenile criminal justices; developmental disability services; chemical dependency providers; residential providers; state hospitals, and other PHPs.

(66) Marketing — Any communication from a PHP to a Medicaid recipient who is not enrolled in that PHP which can reasonably be interpreted as an attempt to influence the recipient:

(a) To enroll in that particular PHP;

(b)To either Disenroll or not to enroll with another PHP.

(67) Marketing Materials — Any medium produced by, or on behalf of, a PHP that can reasonably be interpreted as intended for Marketing as defined in this rule.

(68) Medicaid — A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department of Human Services.

(69) Medical Assistance Program — A program for payment of health care provided to eligible Oregonians. Oregon’s Medical Assistance Program includes Medicaid services including the OHP Medicaid Demonstration, and the Children’s Health Insurance Program (CHIP). The Medical Assistance Program is administered by the Office of Medical Assistance Programs (OMAP), of the Department of Human Services. Coordination of the Medical Assistance Program is the responsibility of the Office of Medical Assistance Programs.

(70) Medical Care Identification — The preferred term for what is commonly called the “medical card.” It is a letter-sized document issued monthly to Medical Assistance Program clients to verify their eligibility for services and enrollment in PHPs.

(71) Medical Case Management Services — Services provided to ensure that OMAP Members obtain health care services necessary to maintain physical and emotional development and health. Medical Case Management Services include a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are Capitated Services or non-capitated services, and follow-up, as appropriate, to assess the impact of care.

(72) Medically Appropriate — Services and medical supplies that are required for prevention, diagnosis or treatment of a health condition which encompasses physical or mental conditions, or injuries, and which are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of an Oregon Health Plan Client or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to an OMAP Member or PCM Member in the PHP's or Primary Care Manager's judgment.

(73) Medicare — The federal health insurance program for the Aged and Disabled administered by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act.

(74) Medicare HMO — A capitated health plan that meets specific referralines and contracts with CMS to provide Medicare benefits to Medicare enrollees.

(75) Mental Health Assessment — The determination of an OMAP Member's need for mental health services. A Qualified Mental Health Professional collects and evaluates data pertinent to a Member's mental status, psychosocial history and current problems through interview, observation and testing.

(76) Mental Health Case Management — Services provided to OMAP Members who require assistance to ensure access to benefits and services from local, regional or state allied agencies or other service providers. Services provided may include: advocating for the OMAP Member's treatment needs; providing assistance in obtaining entitlements based on mental or emotional disability; referring OMAP Members to needed services or supports; accessing housing or residential programs; coordinating services, including educational or vocational activities; and establishing alternatives to inpatient psychiatric services. ENCC Services are separate and distinct from Mental Health Case Management.

(77) Mental Health Organization (MHO) — A Prepaid Health Plan under contract with the Office of Mental Health and Addiction Services that provides mental health services as capitated services under the Oregon Health Plan. MHOs can be Fully Capitated Health Plans, community mental health programs or private behavioral organizations or combinations thereof.

(78) Non-Capitated Services — Those OHP-covered services that are paid for on a fee-for-service basis and for which a capitation payment has not been made to a PHP.

(79) Non-covered services — Services or items for which the Medical Assistance Program is not responsible for payment. Services may be covered under the Oregon Medical Assistance Program, but not covered under the Oregon Health Plan. Non-covered services for the Oregon Health Plan are identified in:

(a) OAR 410-141-0500, Excluded Services and Limitations for Oregon Health Plan Clients;

(b) Exclusions and limitations described in OAR 410-120-1200; and

(c) The individual provider administrative rules.

(80) Non-Participating Provider — A provider who does not have a contractual relationship with the Prepaid Health Plan, i.e. is not on their panel of providers.

(81) Office of Medical Assistance Programs (OMAP) — The Office of the Department of Human Services responsible for coordinating Medical Assistance Programs, including the OHP Medicaid Demonstration, in Oregon and the Children's Health Insurance Program (CHIP). OMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of client eligibility and processes and pays OMAP providers.

(82) Office of Mental Health and Addiction Services (OMHAS) — The Department of Human Services office responsible for the administration of the state's policy and programs for mental health, chemical dependency prevention, intervention, and treatment services.

(83) OMAP Member — An Oregon Health Plan Client enrolled with a Prepaid Health Plan.

(84) Ombudsman Services — Services provided by DHS to Aged, Blind and Disabled Oregon Health Plan Clients by DHS Ombudsman Staff who may serve as the Oregon Health Plan Client's advocate whenever the Oregon Health Plan Client, Representative, a physician or other medical personnel, or other personal advocate serving the Oregon Health Plan Client, is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider under the Oregon Health Plan. Ombudsman Services include response to individual complaints about access to care, quality of care or limits to care; and response to complaints about Oregon Health Plan systems.

(85) Oregon Health Plan (OHP) — The Medicaid demonstration project that expands Medicaid eligibility to eligible Oregon Health Plan Clients. The Oregon Health Plan relies substantially upon prioritization of health services and managed care to achieve the public policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(86) Oregon Health Plan (OHP) Plus Benefit Package — A benefit package available to eligible Oregon Health Plan clients as described in OAR 410-120-1210, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-120-0520, Prioritized List of Health Services.

(87) Oregon Health Plan (OHP) Standard Benefit Package — A benefit package available to eligible Oregon Health Plan clients who are not otherwise eligible for Medicaid (including families, adults and couples) as described in OAR 410-120-1210, Medical Assistance Benefits: Excluded Services and Limitations and in OAR 410-141-0520, Prioritized List of Health Services.

(88) Oregon Health Plan Client — An individual found eligible by DHS to receive services under the Oregon Health Plan. Clients in the following OHP categories eligible to enroll in PHPs defined as follows:

(a) Temporary Assistance to Needy Families (TANF) recipients are eligible with income under current Children, Adults and Families (CAF) eligibility rules;

(b) Children's Health Insurance Program (CHIP) — children under one year of age who have income under 185% FPL and do not meet one of the other eligibility classifications;

(c) Poverty Level Medical (PLM) Adults under 100% Federal Poverty Level (FPL) are OHP recipients who are pregnant women with income under 100% of FPL as defined by CAF;

(d) PLM Adults over 100% FPL are OHP recipients who are pregnant women with income between 100% and 185% of the FPL;

(e) PLM children under one year of age have family income under 133% FPL or were born to mothers who were eligible as PLM Adults at the time of the child's birth;

(f) PLM or CHIP children one through five years of age who have family income under 185% FPL and do not meet one of the other eligibility classifications;

(g) PLM or CHIP children six through eighteen years of age who have family income under 185% FPL and do not meet one of the other eligibility classifications;

(h) OHP Adults and Couples are OHP Clients aged 19 or over and not Medicare eligible, with income below 100% FPL who do not meet one of the other eligibility classifications, and do not have an unborn child or a child under age 19 in the household;

(i) OHP Families are OHP Clients, aged 19 or over and not Medicare eligible, with income below 100% of FPL who do not meet one of the other eligibility classifications, and have an unborn child or a child under the age of 19 in the household;

(j) General Assistance (GA) Recipients are OHP Clients who are eligible by virtue of their eligibility under the Oregon General Assistance program, ORS 411.710 et seq.;

(k) Assistance to Blind and Disabled (AB/AD) with Medicare are OHP Clients with concurrent Medicare eligibility with income under current eligibility rules;

(l) AB/AD without Medicare are OHP Clients without Medicare with income under current eligibility rules;

(m) Old Age Assistance (OAA) with Medicare are OHP Clients with concurrent Medicare Part A or Medicare Parts A & B eligibility with income under current eligibility rules;

(n) OAA with Medicare Part B only are OAA eligibles with concurrent Medicare Part B only income under current eligibility rules;

(o) OAA without Medicare Eligibles are OHP Clients without Medicare with income under current eligibility rules;

(p) CAF Children are OHP recipients who are children with medical eligibility determined by Children, Adults and Families or the Oregon Youth Authority receiving OHP under ORS 414.025(2)(f), (I), (j), (k) and (o), 418.034 and 418.187 to 418.970. These individuals are generally in the care and/or custody of the Children, Adults and Families or the Oregon Youth Authority who are in placement outside of their homes.

(89) Oregon Youth Authority — The state department charged with the management and administration of youth correction facilities, state parole and probation services and other functions related to state programs for youth corrections.

(90) Participating Provider — An individual, facility, corporate entity, or other organization which supplies medical, dental, chemical dependency services, or mental health services or medical and dental items and that has agreed to provide those services or items to OMAP Members under an agreement or contract with a PHP and to bill in accordance with the signed agreement or contract with a PHP.

(91) PCM Case Managed Services include the following: Preventive Services, primary care services and specialty services, including those provided by physicians, nurse practitioners, physician assistants, naturopaths, chiropractors, podiatrists, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics and Tribal Health Clinics, Community Mental Health Programs, Mental Health Organizations; inpatient hospital services; and outpatient hospital services except laboratory, X-ray, and maternity management services.

(92) PCM Member — An Oregon Health Plan Client enrolled with a Primary Care Manager.

(93) PHP Coordinator – the DHS OMAP employee designated by OMAP as the liaison between OMAP and the PHP.

(94) Physician Care Organization (PCO) — Prepaid Health Plan that contracts with OMAP to provide partially capitated health services under the Oregon Health Plan. The distinguishing characteristic of a PCO is the exclusion of inpatient hospital services.

(95) Post Hospital Extended Care Benefit — A 20 day benefit for non-Medicare OMAP Members enrolled in a FCHP who meet Medicare criteria for a post-hospital skilled nursing placement.

(96) Post Stabilization Services — covered services, related to an Emergency Medical Condition that are provided after an OMAP Member is stabilized in order to maintain the stabilized condition or to improve or resolve the OMAP Member's condition.

(97) Potential OMAP Member — An OHP client who is subject to mandatory enrollment in managed care, or may voluntarily elect to enroll in a managed care program, but is not yet enrolled with a specific PHP.

(98) Practitioner — A person licensed pursuant to State law to engage in the provision of health care services within the scope of the practitioner's license and/or certification.

(99) Prepaid Health Plan (PHP) — A managed health, dental, chemical dependency, physician care organization, or mental health care organization that contracts with OMAP and/or OMHAS on a case managed, prepaid, capitated basis under the Oregon Health Plan. Prepaid Health Plans may be Dental Care Organizations (DCOs), Fully Capitated Health Plans (FCHPs), Mental Health Organizations (MHOs), Physician Care Organizations (PCOs) or Chemical Dependency Organizations (CDOs).

(100) Preventive Services — Those services as defined under Expanded Definition of Preventive Services for Oregon Health Plan clients in OAR 410-141-0480, The Oregon Health Plan Benefit Package of covered services, and OAR 410-141-0520, Prioritized List of Health Services.

(101) Primary Care Management Services — Primary Care Management Services are services provided to ensure PCM Members obtain health care services necessary to maintain physical and emotional development and health. Primary Care Management Services include a comprehensive, ongoing assessment of medical needs plus the development, and implementation of a plan to obtain needed medical services that are preventive or primary care services or PCM Case Managed Services and follow-up, as appropriate, to assess the impact of care.

(102) Primary Care Manager (PCM) — A physician (MD or DO), nurse practitioner, physician assistant; or naturopath with physician backups, who agrees to provide Primary Care Management Services as defined in rule to PCM Members. Primary Care Managers may also be hospital primary care clinics, Rural Health Clinics, Migrant and Community Health Clinics, Federally Qualified Health Centers, County Health Departments, Indian Health Service Clinics or Tribal Health Clinics. The PCM provides Primary Care Management Services to PCM Members for a Capitation Payment. The PCM provides preventive and primary care services on a fee-for-service basis.

(103) Primary Care Dentist (PCD) – A Dental Practitioner who is responsible for supervising, coordinating initial and primary dental care within their scope of practice for OMAP Members. Primary Care Dentists initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of appropriate dental or medical care.

(104) Primary Care Provider (PCP) — A practitioner who has responsibility for supervising, coordinating initial and primary care within their scope of practice for OMAP Members, Primary care providers initiate referrals for care outside their scope of practice, consultations and specialist care, and assure the continuity of medically or dental appropriate care.

(105) Prioritized List of Health Services — The listing of condition and treatment pairs developed by the Health Services Commission for the purpose of implementing the Oregon Health Plan Demonstration Project. See OAR 410-141-0520, Prioritized List of Health Services, for the listing of condition and treatment pairs.

(106) Proof of Indian Heritage — Proof of Native American and/or Alaska Native descent as evidenced by written identification that shows status as an "Indian" in accordance with the Indian Health Care Improvement Act (P.L. 94-437, as amended). This written proof supports his/her eligibility for services under programs of the Indian Health Service — services provided by Indian Health Service facilities, tribal health clinics/programs or urban clinics. Written proof may be a tribal identification card, a certificate of degree of Indian blood, or a letter from the Indian Health Service verifying eligibility for health care through programs of the Indian Health Service.

(107) Provider — An individual, facility, institution, corporate entity, or other organization which supplies medical, dental or mental health services or medical and dental items.

(108) Quality Improvement — Quality improvement is the effort to improve the level of performance of a key process or processes in health services or health care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement (as used in these rules) includes the goals of quality assurance, quality control, quality planning and quality management in health care where "quality of care is the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge."

(109) Representative — A person who can make Oregon Health Plan related decisions for Oregon Health Plan Clients who are not able to make such decisions themselves. A Representative may be, in the following order of priority, a person who is designated as the Oregon Health Plan Client's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the Oregon Health Plan client, the Individual Service Plan Team (for developmentally disabled clients), a DHS case manager or other DHS designee.

(110) Rural — A geographic area 10 or more map miles from a population center of 30,000 people or less.

(111) Seniors and People with Disabilities (SPD) — The Cluster within DHS responsible for providing services such as:

(a) Assistance with the cost of long-term care through the Medicaid Long Term Care Program and the Oregon Project Independence (OPI) Program;

(b) Cash assistance grants for persons with long-term disabilities through General Assistance and the Oregon Supplemental Income Program (OSIP); and

(c) Administration of the federal Older Americans Act.

(112) Service Area — The geographic area in which the PHP has identified in their Contract or Agreement with DHS to provide services under the Oregon Health Plan.

(113) Stabilize — no material deterioration of the Emergency Medical Condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

(114) Terminal Illness — An illness or injury in which death is imminent irrespective of treatment, where the application of life-sustaining procedures or the artificial administration of nutrition and hydration serves only to postpone the moment of death.

(115) Triage — Evaluations conducted to determine whether or not an emergency condition exists, and to direct the OMAP Member to the most appropriate setting for Medically Appropriate care.

(116) Urban — A geographic area less than 10 map miles from a population center of 30,000 people or more.

(117) Urgent Care Services — Covered Services that are Medically Appropriate and immediately required in order to prevent a serious deterioration of an OMAP Member's health that results from an unforeseen illness or an injury. Services that can be foreseen by the individual are not considered Urgent Services

(118) Valid Claim — An invoice received by the PHP for payment of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules; and

(c) A Valid Claim means a Claim received by a PHP for payment of Covered Services rendered to an OMAP client which (1) Can be processed without obtaining additional information from the Provider of the service or from a third party; and (2) Has been received within the time limitations prescribed in OHP Rules. A Valid Claim does not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Appropriateness. A Valid Claim is synonymous with the federal definition of a Clean Claim as defined in 42 CFR 447.45(b).

(119) Valid Pre-Authorization — A request received by the PHP for approval of the provision of covered health care services rendered to an eligible client which:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party; and

(b) Has been received within the time limitations prescribed in these Rules.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000. f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 13-2002, f. & cert. ef. 4-1-02; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 14-2003, f. 2-28-03, cert. ef. 3-1-03; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0020**
**Administration of Oregon Health Plan Regulation and Rule Precedence**

(1) The Department of Human Services (DHS) and its Office of Medical Assistance Programs (OMAP) may adopt reasonable and lawful policies, procedures, rules and interpretations to promote the orderly and efficient administration of medical assistance programs including the Oregon Health Plan pursuant to ORS 414.065 (generally, fee-for-service), 414.725 (Prepaid Health Plans), and 414.115 to 414.145 (services contracts) subject to the rulemaking requirements of Oregon Revised Statutes and Oregon Administrative Rule (OAR) procedures.

(2) In applying its policies, procedures, rules and interpretations, OMAP will construe them as much as possible to be complementary. In the event that OMAP policies, procedures, rules and interpretations may not be complementary, OMAP will apply the following order of precedence to guide its interpretation:

(a) For purposes of the provision of covered medical assistance to OMAP Clients, including but not limited to authorization and delivery of service, or denials of authorization or services, OMAP, Clients, enrolled Providers and the Prepaid Health Plans will apply the following order of precedence:

(A) Those federal laws and regulations governing the operation of the medical assistance program and any waivers granted OMAP by the Centers for Medicare and Medicaid Services to operate medical assistance programs including the Oregon Health Plan;

(B) Oregon Revised Statutes governing medical assistance programs;

(C) Generally for Prepaid Health Plans, requirements applicable to the provision of covered medical assistance to OMAP Clients are provided in OAR 410-141-0000 through 410-141-0860, Oregon Health Plan Administrative Rules for Prepaid Health Plans, inclusive, and where applicable, OMAP General Rules, OAR 410-120-0000 through 410-120-1980, and the provider rules applicable to the category of medical service;

(D) Generally for enrolled fee-for-service providers or other contractors, requirements applicable to the provision of covered medical assistance to OMAP Clients are provided in OMAP General Rules, OAR 410-120-0000 through 410-120-1980, the Prioritized List and program coverage described in OAR 410-141-0480 to 410-141-0520,and the provider rules applicable to the category of medical service; and

(E) Any other applicable duly promulgated rules issued by OMAP and other offices or units within the Department of Human Services necessary to administer the State of Oregon's medical assistance programs.

(b) For purposes of contract administration solely as between OMAP and its Prepaid Health Plans, the terms of the applicable contract and the requirements in subsection (2)(a) of this rule applicable to the provision of covered medical assistance to OMAP Clients:

(A) Nothing in this rule shall be deemed to incorporate into contracts provisions of law not expressly incorporated into such contracts, nor shall this rule be deemed to supercede any rules of construction of such contracts that may be provided for in such contracts.

(B) Nothing in this rule gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly or indirectly or otherwise, to any person or entity unless such person or entity is identified by name as a named party to the contract.;

Stat. Auth.: ORS 409
Stats. Implemented: 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0060**
**Oregon Health Plan Managed Care Enrollment Requirements**

(1) Enrollment of an Oregon Health Plan (OHP) Client, excluding the New/Noncategorical Client (HPN) and Children's Health Insurance Program (CHIP) clients in Prepaid Health Plans (PHPs) shall be mandatory unless exempted from Enrollment by the Department of Human Services (DHS), or unless the OHP Client resides in a Service Area where there is inadequate capacity to provide access to Capitated Services for all OHP Clients through PHPs or Primary Care Managers (PCMs). PHPs include Fully Capitated Health Plans (FCHPs), Dental Care Organizations (DCOs) and Mental Health Organizations (MHOs), Physician Care Organizations (PCOs), and Chemical Dependency Organizations (CDOs).

(2) Enrollment of the New/Noncategorical Client (HPN) and Children's Health Insurance Program (CHIP) Client in PHPs shall be mandatory unless exempted from Enrollment by DHS under the term in 410-141- 0060(4). Selection of PHPs in accordance with this rule is a condition of eligibility for HPN and CHIP Clients. If, upon reapplication, an HPN and CHIP Clients do not select PHPs in accordance with this rule, PHPs will be selected for the HPN and CHIP Client by DHS. This selection will be made based on the PHPs in which the HPN and CHIP Clients were previously enrolled.

(3) OHP Clients, except the HPN and CHIP Clients shall be enrolled with PHPs or PCMs according to the following criteria:

(a) Areas with sufficient physical health service capacity through a combination of FCHPs, PCOs, and PCMs shall be called mandatory FCHP/PCO/PCM Service Areas. An OHP Client shall select a FCHP or PCO unless exempted from Enrollment in a FCHP and PCO, in which case they shall choose a PCM in a mandatory FCHP/PCO/PCM Service Area;

(b) Service areas with sufficient physical health service capacity through PCMs alone shall be called mandatory PCM Service Areas. An OHP Client shall select a PCM in a mandatory PCM Service Area;

(c) Service Areas without sufficient physical health service capacity through FCHPs, PCOs and PCMs shall be called voluntary FCHP/PCO/PCM Service Areas. An OHP Client may choose to select a FCHP, PCO or PCM in voluntary FCHP/PCO/PCM Service Areas if the FCHP. PCO or PCM is open for Enrollment, or may choose to remain in the Medicaid Fee-for-Service (FFS) physical health care delivery system;

(d) Service Areas with sufficient dental care service capacity through DCOs shall be called mandatory DCO Service Areas. An OHP Client shall select a DCO in a mandatory DCO Service Area;

(e) Service Areas without sufficient dental care service capacity through DCOs shall be called voluntary DCO Service Areas. An OHP Client may choose to select a DCO in a voluntary DCO Service Area if the DCO is open for Enrollment, or may choose to remain in the Medicaid FFS dental care delivery system;

(f) Service Areas with sufficient mental health service capacity through MHOs shall be called mandatory MHO Service Areas. An OHP Client shall select an MHO in a mandatory MHO Service Area;

(g) Service Areas without sufficient mental health service capacity through MHOs shall be called voluntary MHO Service Areas. An OHP Client may choose to select an MHO in voluntary MHO Service Areas if the MHO is open for Enrollment, or may choose to remain in the Medicaid FFS mental health care delivery system;

(h) When a Service Area changes from mandatory to voluntary, the OMAP Member will remain with their PHP for the remainder of their eligibility period, unless the OMAP Member meets the criteria stated in OAR 410- 141-0060(4), or as provided by OAR 410-141-0080.

(4) The following are exemptions to mandatory Enrollment in PHPs, which allow OHP Clients, including HPN and CHIP Clients, to enroll with a PCM or remain in the Medicaid FFS delivery systems for physical, dental and/or mental health care:

(a) The OHP Client is covered under a major medical insurance policy, such as a Medicare supplemental policy, Medicare employer group policy or other third party resource (TPR) which covers the cost of services to be provided by a PHP, (excluding dental insurance. An OHP Client shall be enrolled with a DCO even if they have a dental TPR). The OHP Client shall enroll with a PCM if the insurance policy is not a private HMO;

(b) The OHP Client has an established relationship with an OMAP enrolled Practitioner who is not a member of the PHP's Participating

Provider panel the OHP Client would be enrolled in, and the PHP cannot negotiate a treatment plan or reimbursement arrangement with the Practitioner that is consistent with the PHP's contracting practices to provide for continuity of care, and it would be detrimental to the health of the OHP Client as determined by DHS to change Practitioners:

(A) When the Practitioner is a Primary Care Practitioner (PCP) enrolled with OMAP as a PCM, the OHP Client shall enroll with this Practitioner as a PCM Member;

(B) Exemptions from mandatory Enrollment in PHPs for this reason may be granted for a period of four months. Extensions may be granted by DHS upon request, subject to review of unique circumstances. A 12-month exemption may be granted if the reason for the exemption is not likely to change or is due to a chronic or permanent condition or disability;

(C) OHP clients shall be exempted from mandatory Enrollment with an FCHP or PCO, if the OHP Client became eligible through a hospital hold process and are placed in the Adults/Couples category. The OHP Client shall remain FFS for the first six (6) months of eligibility unless a change occurs with their eligibility or the category. At which time, the exemption shall be removed and the OHP Client shall be enrolled into an open FCHP or PCO. The exemption shall not effect the mandatory Enrollment requirement into a DCO or MHO.

(c) The OHP Client is a Native American or Alaska Native with Proof of Indian Heritage and chooses to receive services from an Indian Health Service facility or tribal health clinic;

(d) The OHP Client is a child in the legal custody of either the Oregon Youth Authority (OYA) or Children, Adults and Families Services (CAFS) (SOSCF services), and the child is expected to be in a substitute care placement for less than 30 calendar days, unless one of the following conditions exist:

(A) There is no fee-for-service access; or

(B) There is continuity of care issues.

(e) The OHP Client is in the third trimester of her pregnancy when first determined eligible for OHP, or at redetermination, and she wishes to continue obtaining maternity services from a Practitioner who is not a Participating Provider with an FCHP or PCO in the Service Area:

(A) In order to qualify for such exemption at the time of redetermination, the OHP Client must not have been enrolled with an FCHP or PCO during the three months preceding redetermination;

(B) If the OMAP Member moves out of the PHP's Service Area during the third trimester, the OMAP Member may be exempted from Enrollment in the new Service Area for continuity of care if the OMAP Member wants to continue Obstetric care with her previous physician, and that physician is within the travel time or distance indicated in 410-141-0220(1)(a) Oregon Health Plan PHP Accessibility;

(C) If the Practitioner is a PCM; the OMAP Member shall enroll with that Practitioner as a PCM Member;

(D) If the Practitioner is not enrolled with OMAP as a PCM, then the OMAP Member may remain in the Medicaid FFS delivery system until 60 days after the birth of her child. After the 60-day period, the OHP Client must enroll in a FCHP or PCO.

(f) The OHP Client has End Stage Renal Disease (ESRD). The OHP Client shall not enroll in an FCHP or PCO but shall enroll with a PCM unless exempt for some other reason listed in section (4) of this rule;

(g) The OHP Client has been accepted by the Medically Fragile Children's Unit of the Office of Mental Health and Addiction Services (OMHAS);

(h) The OHP Client is a Medicare beneficiary and is in a hospice program shall not enroll in an FCHP or PCO that is also a Medicare Cost HMO. The OHP Client may enroll in either an FCHP or PCO that does not have a Medicare Cost HMO or with a PCM unless exempt for some other reason listed in section (4) of this rule;

(i) The OHP Client is enrolled in Medicare and the only FCHP or PCO in the Service Area is a Medicare HMO. The OHP Client may be exempted from Enrollment in the FCHP or PCO if the OHP Client chooses not to enroll;

(j) If an OMAP Member is enrolled in a program participating in the Intensive Treatment Service Pilot Project, the OMAP Member shall remain enrolled in the MHO he/she was enrolled in prior to the placement;

(k) Other just causes as determined by DHS, at its sole discretion, which include the following factors:

(A) The cause is beyond the control of the OHP Client;

(B) The cause is in existence at the time that the OHP Client first becomes eligible for OHP;

(C) Enrollment would pose a serious health risk; and

(D) The lack of reasonable alternatives.

(l) A woman eligible for the Breast and Cervical Cancer Medical (BCCM) Program, (refer to BCCM rules established by Children, Adult and Families Services), shall not enroll in an FCHP, PCO, DCO or MHO. A woman in the BCCM Program shall remain in the Medicaid fee-for-service delivery system.

(5) The primary person in the household group and benefit group as defined in OAR 461-110-0110, 461-110-0210, and 461-110- 0720, respectively, shall select PHPs or PCMs on behalf of all OHP Clients in the benefit group. PHP or PCM selection shall occur at the time of application for the OHP in accordance with section (1) of this rule: (a) All OHP Clients in the benefit group shall enroll in the same PHP for each benefit type (physical, dental or mental health care) unless exempted under the conditions stated above in section (4). If PCM selection is an option, OHP Clients in the benefit group may select different PCMs;

(b) If the OHP Client is not able to choose PHPs or PCMs on his or her own, the Representative of the OHP Client shall make the selection. The hierarchy used for making Enrollment decisions shall be in descending order as defined under Representative:

(A) If the OHP form 7208M, Medicare+Choice election form is signed by someone other than the OHP Client, the OHP Client's Representative must complete and sign an Addendum. The Addendum is incorporated as part of the 7208M and is located on page four (4) of the form:

(i) If the FCHP or PCO does not receive the 7208M within 10 calendar days after the date of Enrollment, the FCHP or PCO shall send a letter to the OMAP Member with a copy sent to the Seniors and People with Disabilities (SPD) branch manager. The letter shall:

(I) Explain the need for the completion of the 7208M;

(II) Notify the OMAP Member, if the 7208M is not received within 30 days, the FCHP or PCO shall request Disenrollment; and

(III) Instruct the OMAP Member to contact their caseworker for other coverage alternatives.

(ii) If the FCHP or PCO has not received the 7208M at the end of 30 days, the FCHP or PCO shall notify OMAP's Health Management Unit (HMU). HMU shall disenroll the OMAP Member effective the end of the month following the notification and notify the OMAP Member of the Disenrollment. HMU shall provide SPD with the OHP Client Disenrollment list.

(B) If the OHP Client is a Medicare beneficiary who is capable of making Enrollment decisions, the Representative shall not have authority to select FCHPs or PCOs that have corresponding Medicare HMO components.

(c) CAF or OYA shall select PHPs or a PCM for a child receiving CAF (SOSCF services) or OYA Services, with the exception of children in subsidized adoptions;

(d) Enrollment in a FCHP or PCO of an OHP Client who is receiving Medicare and who resides in a Service Area served by PHPs or PCMs shall be as follows:

(A) If the OHP Client selects a FCHP or PCO that has a corresponding Medicare HMO, the OHP Client shall also enroll in the Medicare HMO;

(B) If the OHP Client is enrolled as a private member of a Medicare HMO, the OHP Client may choose to remain enrolled as a private member or to enroll in the FCHP or PCO that corresponds to the Medicare HMO:

(i) If the OHP Client chooses to remain as a private member in the Medicare HMO, the OHP Client shall remain in the Medicaid FFS delivery system for physical health care services but shall select a DCO and MHO where available;

(ii) If the OHP Client chooses to discontinue the Medicare HMO enrollment and then, within 60 calendar days of disenrollment from the Medicare HMO, chooses the FCHP or PCO that corresponds to the Medicare HMO that was discontinued, the OHP Client shall be allowed to enroll in the FCHP or PCO even if the FCHP or PCO is not open for Enrollment to other OHP Clients;

(iii) A Dual Eligible (DE) OHP Client who has been exempted from Enrollment in an MHO shall not be enrolled in a FCHP or PCO that has a corresponding Medicare HMO unless the exemption was done for a provider who is on the FCHP's or PCO's panel.

(e) MHO Enrollment options shall be based on the OHP Client's county of residence, the FCHP or PCO selected by the OHP Client, and whether the FCHP or PCO selected serves as a MHO:

(A) If the OHP Client selects a FCHP or PCO that is not a MHO, then the OHP Client shall enroll in the MHO designated as the freestanding MHO for that county;

(B) If the OHP Client selects a FCHP or PCO that is a MHO, then the OHP Client shall receive the OHP mental health benefit through that FCHP or PCO.

(6) If the OHP Client resides in a mandatory Service Area and fails to select a DCO, MHO, PCO and/or FCHP or a PCM at the time of application for the OHP, OMAP may enroll the OHP Client with a DCO, MHO, PCO and/or FCHP or a PCM:

(a) The OHP Client shall be assigned to and enrolled with a DCO, MHO, and FCHP, PCO or PCM which meet the following requirements:

(A) Is open for Enrollment;

(B) Serves the county in which the OHP Client resides;

(C) Has Practitioners located within the Community Standard distance for average travel time for the OHP Client.

(b) Assignment shall be made first to a FCHP or PCO and second to a PCM;

(c) DHS shall send a notice to the OHP Client informing the OHP Client of the assignments and the right to change assignments within 30 calendar days of Enrollment. A change in assignment shall be honored if there is another DCO, MHO, and FCHP, PCO or PCM open for Enrollment in the county in which the OHP Client resides;

(d) Enrollments resulting from assignments shall be effective the first of the month or week after DHS enrolls the OHP Client and notifies the OHP Client of Enrollment and the name of the PHP or PCM: If Enrollment is initiated by a DHS worker on or before Wednesday, the date of Enrollment shall be the following Monday. If Enrollment is initiated by a DHS worker after Wednesday, the date of Enrollment shall be one week from the following Monday. Monthly Enrollment in a mandatory Service Area where there is only one FCHP, PCO, MHO or DCO shall be initiated by an auto-Enrollment program of DHS with effective dates the first of the month following the month-end cutoff. Monthly Enrollment in Service Areas where there is a choice of PHPs, shall be auto-Enrolled by computer algorithm.

(7) The provision of Capitated Services to an OMAP Member enrolled with a PHP or a PCM shall begin on the first day of Enrollment with the PHP or a PCM except for:

(a) A newborn whose mother was enrolled at the time of birth. The date of Enrollment shall be the newborn's date of birth;

(b) Persons, other than newborns, who are hospitalized on the date enrolled. The date of Enrollment with a FCHP, PCO or MHO shall be the first possible Enrollment date after the date the OHP Client is discharged from inpatient hospital services and the date of Enrollment with a PCM shall be the first of the month for which Capitation Payment is made;

(c) For OMAP Members who are re-enrolled within 30 calendar days of Disenrollment. The date of Enrollment shall be the date specified by DHS that may be retroactive to the date of Disenrollment;

(d) Adopted children or children placed in an adoptive placement. The date of Enrollment shall be the date specified by DHS; or

(e) For children or adolescents enrolled into an MHO on the day of admission to Psychiatric Residential Treatment Services (PRTS), the MHO shall be responsible for said services. If the OMAP Member is enrolled after the first day of admission to the PRTS, the OMAP Member shall be Disenrolled and the date of the enrollment shall be the first day of the month following discharge from the PRTS.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; HR 8-1994(Temp), f. & cert. ef. 2-1-94; DEQ 24-1994, f. 5-31-94, cert. ef. 6-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 29-1996(Temp), f. 12-31-96, cert. ef. 1-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 12-2002, f. & cert. ef. 4-1-02; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0080**

**Oregon Health Plan (OHP) Disenrollment from Prepaid Health Plans (PHPs)**

(1) Office of Medical Assistance Programs (OMAP) Member Requests for Disenrollment:

(a) All Oregon Health Plan (OHP) OMAP Member-initiated requests for Disenrollment from a Prepaid Health Plan (PHP) must be initiated, orally or in writing, by the primary person in the benefit group enrolled with a PHP, where primary person and benefit group are defined in OAR 461-110-0110 and 461-110-0720, respectively. For OMAP Members who are not able to request Disenrollment on their own, the request may be initiated by the OMAP Member's Representative;

(b) Primary person or Representative requests for Disenrollment shall be honored:

(A) Without cause:

(i) After six months of OMAP Member's Enrollment. The effective date of Disenrollment shall be the first of the month following the Department's approval of Disenrollment;

(ii)Whenever an OMAP Member's eligibility is redetermined by the Department of Human Services (DHS) and the primary person requests Disenrollment without cause. The effective date of Disenrollment shall be the first of the month following the date that the OMAP Member's eligibility is redetermined by the Department;

(B) With cause:

(i) At any time;

(ii) OMAP Members who disenroll from a Medicare Health Maintenance Organization (HMO) shall also be Disenrolled from the corresponding Fully Capitated Health Plan (FCHP) or Physician Care Organization (PCO). The effective date of Disenrollment shall be the first of the month that the OMAP Member's Medicare HMO Disenrollment is effective;

(iii) OMAP Members who are receiving Medicare and who are enrolled in a FCHP or PCO that has a corresponding Medicare HMO/Medicare+Choice (M+C) component may disenroll from the FCHP or PCO at any time if they also request Disenrollment from the Medicare HMO. The effective date of Disenrollment from the FCHP or PCO shall be the first of the month following the date of request for Disenrollment;

(iv) PHP does not, because of moral or religious objections, cover the service the OMAP Member seeks;

(v) The OMAP Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the OMAP Members' Primary Care Provider or another Provider determines that receiving the services separately would subject the OMAP Member to unnecessary risk; or

(vi) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of access to Participating Providers experienced in dealing with the OMAP Member's health care needs. Examples of sufficient cause include but are not limited to:

(l) The OMAP Member moves out of the PHP's Service Area;

(ll) It would be detrimental to the OMAP Member's health to remain enrolled in the PHP;

(lll) The OMAP Member is a Native American or Alaskan Native with Proof of Indian Heritage who wishes to obtain primary care services from his or her Indian Health Service facility, tribal health clinic/program or urban clinic and the Fee-For-Service (FFS) delivery system;

(IV) Continuity of care that is not in conflict with any section of 410-141-0060 or 410-141-0080.

(C) If the following conditions are met:

(i) The applicant is in the third trimester of her pregnancy and has just been determined eligible for OHP, or the OHP Client has just been re-determined eligible and was not enrolled in a FCHP or PCO within the past 3 months; and

(ii) The new FCHP or PCO the OMAP Member is enrolled with does not contract with the OMAP Member's current OB Provider and the OMAP Member wishes to continue obtaining maternity services from that Non-Participating OB Provider; and

(iii) The request to change FCHPs, PCOs or return to FFS is made prior to the date of delivery.

(c) In addition to the Disenrollment constraints listed in (b), above, OMAP Member Disenrollment requests are subject to the following requirements:

(A) The OMAP Member shall join another PHP, unless the OMAP Member resides in a Service Area where Enrollment is voluntary, or the OMAP Member meets the exemptions to Enrollment as stated in 410-141-0060(4);

(B) If the only PHP available in a mandatory Service Area is the PHP from which the OMAP Member wishes to disenroll, the OMAP Member may not disenroll without cause;

(C) The effective date of Disenrollment shall be the end of the month in which Disenrollment was requested unless retroactive Disenrollment is approved by OMAP;

(D) If the Department fails to make a Disenrollment determination by the first day of the second month following the month in which the OMAP Member files a request for Disenrollment, the Disenrollment is considered approved.

(2) Prepaid Health Plan requests for Disenrollment:

(a) Causes for Disenrollment:

(A) OMAP may Disenroll OMAP Members for cause when requested by the PHP subject to ADA requirements and approval by the Centers for Medicare and Medicaid Services (CMS), if a Medicare member Disenrolled in a FCHP's or PCO's Medicare HMO/M+C. Examples of cause include, but are not limited to the following:

(i) Missed appointments. The number of missed appointments is to be established by the Provider or PHP. The number must be the same as for commercial members or patients. The Provider must document they have attempted to ascertain the reasons for the missed appointments and to assist the OMAP Member in receiving services. This rule does not apply to Medicare members who are enrolled in a FCHP's or PCO's Medicare HMO/M+C;

(ii) OMAP Member's behavior is disruptive, unruly, or abusive to the point that his/her Enrollment seriously impairs the Provider's ability to furnish services to either the OMAP Member or other members, except as excluded in (b)(B)(vii);

(iii) OMAP Member commits or threatens an act of physical violence directed at a medical Provider or property, the Provider's staff, or other patients, or the PHP's staff;

(iv) OMAP Member commits fraudulent or illegal acts such as: permitting use of his/her medical ID card by others, altering a prescription, theft or other criminal acts committed in any Provider or PHP's premises. The PHP shall report any illegal acts to law enforcement authorities or to the office for Children, Adults and Families (CAF) Fraud Unit as appropriate;

(v) OHP Clients who have been exempted from mandatory Enrollment with a FCHP or PCO, due to the OHP Client's eligibility through a hospital hold process and placed in the Adults/Couples category as required under 410-141-0060(4)(b)(C);

(vi) OMAP Member fails to pay co-payment(s) for Covered Services as described in OAR 410-120-1230 and/or 410-120-1235.

(B) OMAP Members shall not be disenrolled solely for the following reasons:

(i) Because of a physical or mental disability;

(ii) Because of an adverse change in the OMAP Member's health;

(iii) Because of the OMAP Member's utilization of services, either excessive or lack thereof;

(iv) Because the OMAP Member requests a hearing;

(v) Because the OMAP Member has been diagnosed with End Stage Renal Disease (ESRD);

(vi) Because the OMAP Member exercises his/her option to make decisions regarding his/her medical care with which the PHP disagrees;

(vii) Because of uncooperative or disruptive behavior resulting from the OMAP Member's special needs (except when continued Enrollment seriously impairs the PHP's ability to furnish services to either this OMAP Member or other members.

(C) Requests by the PHP for Disenrollment of specific OMAP Members shall be submitted in writing to their PHP Coordinator for approval. The PHP must document the reasons for the request, provide written evidence to support the basis for the request, and document that attempts at intervention were made as described below. The procedures cited below must be followed prior to requesting Disenrollment of an OMAP Member (except in cases of threats or acts of physical violence, and fraudulent or illegal acts). In cases of threats or acts of physical violence, OMAP will consider an oral request for Disenrollment, with written documentation to follow: In cases of fraudulent or illegal acts, the PHP must submit written documentation for review by the OMAP PHP Coordinators:

(i) There shall be notification from the Provider to the PHP at the time the problem is identified. The notification must describe the problem and allow time for appropriate intervention by the PHP. Such notification shall be documented in the OMAP Member's Clinical Record. The PHP shall conduct Provider education regarding the need for early intervention and the services they can offer the Provider;

(ii) The PHP shall contact the OMAP Member either verbally or in writing, depending on the severity of the problem, to develop an agreement regarding the issue(s). If contact is verbal, it shall be documented in the OMAP Member's record. The PHP shall inform the OMAP Member that his/her continued behavior may result in Disenrollment from the PHP;

(iii) The PHP shall provide individual education, counseling, and/or other interventions in a serious effort to resolve the problem;

(iv) The PHP shall contact the OMAP Member's DHS caseworker regarding the problem and, if needed, involve the caseworker and other appropriate agencies' caseworkers in the resolution;

(v) If the severity of the problem and intervention warrants, the PHP shall develop a care plan that details how the problem is going to be addressed and/or coordinate a case conference. Involvement of Provider, caseworker, OMAP Member, family, and other appropriate agencies is encouraged. If necessary, the PHP shall obtain an authorization for release of information from the OMAP Member for the Providers and agencies in order to involve them in the resolution of the problem. If the release is verbal, it must be documented in the OMAP Member's record;

(vi) If a Primary Care Provider (PCP) terminates the Provider/patient relationship, the PHP shall attempt to locate another PCP on their panel who will accept the OMAP Member as their patient. If needed, the PHP shall obtain an authorization for release of information from the OMAP Member in order to share the information necessary for a new Provider to evaluate if they can treat the OMAP Member. All terminations of Provider/patient relationships shall be according to the PHP's policies and must be consistent with PHP or PCP's policies for commercial members.

(D) If the problem persists, the PHP may request Disenrollment of the OMAP Member by submitting a written request to Disenroll the OMAP Member to the PHP's OMAP PHP Coordinator, with a copy to the OMAP Member's caseworker. Documentation with the request shall include the following:

(i) The reason the PHP is requesting Disenrollment; a summary of the PHP's efforts to resolve the problem and other options attempted before requesting Disenrollment;

(ii) Documentation should be objective, with as much specific details and direct quotes as possible when problems involve disruptive, unruly, abusive or threatening behaviors;

(iii) Where appropriate, background documentation including a description of the OMAP Member's age, diagnosis, mental status (including their level of understanding of the problem and situation), functional status (their level of independence) and social support system;

(iv) Where appropriate, separate statements from PCPs, caseworker and other agencies, Providers or individuals involved;

(v) If reason for the request is related to the OMAP Member's substance abuse treatment, the PHP shall notify the OHP Coordinator in the Office of Mental Health and Addiction Services;

(vi) If the OMAP Member is disabled, the following documentation shall also be submitted as appropriate:

(I) A written assessment of the relationship of the behavior to the disability including: current medical knowledge or best available objective evidence to ascertain the nature, duration and severity of the risk to the health or safety of others; the probability that potential injury to others will actually occur; and whether reasonable modifications of policies, practices, or procedures will mitigate the risk to others;

(II) An interdisciplinary team review that includes a mental health professional and/or behavioral specialist to assess the behavior, the behavioral history, and previous history of efforts to manage behavior;

(III) If warranted, a clinical assessment that the behavior will not respond to reasonable clinical or social interventions;

(IV) Documentation of any accommodations that have been attempted;

(V) Any additional information or assessments requested by the OMAP PHP Coordinators.

(E) Requests will be reviewed according to the following process:

(i) If there is sufficient documentation, the request will be evaluated by a team of PHP Coordinators who may request additional information from Ombudsman, mental health or other agencies as needed;

(ii) If there is not sufficient documentation, the PHP Coordinator will notify the PHP what additional documentation is required before the request can be considered;

(iii) The PHP Coordinators will review the request and notify the PHP of the decision within ten working days of receipt. Written decisions, including reasons for denials, will be sent to the PHP within 15 working days from receipt of request;

(iv) If the request is approved, the Disenrollment date is 30 days after the date of approval, except as provided in (F) and (G) below. The PHP must send the OMAP Member a letter within 14 days after the request was approved, with a copy to the OMAP Member's DHS caseworker and OMAP's Health Management Unit (HMU), except in cases where the OMAP Member is also enrolled in a FCHP's or PCO's Medicare HMO/M+C. The letter must give the Disenrollment date, the reason for Disenrollment, and the notice of OMAP Member's right to file a Complaint (as specified in 410-141-0260 through 410-141-0266) and to request an Administrative Hearing;

(v) In cases where the OMAP Member is also enrolled in a FCHP's or PCO's Medicare HMO/M+C, the letter shall be sent after the approval by CMS and the date of Disenrollment shall be the date of Disenrollment as approved by CMS. If CMS does not approve the Disenrollment, the OMAP Member shall not be disenrolled from the PHP's OHP Plan;

(vi) If the OMAP Member requests a hearing, the OMAP Member will continue to be disenrolled until a hearing decision reversing that Disenrollment has been mailed to the OMAP Member and the PHP;

(vii) The PHP Coordinator will determine when Enrollment in another PHP or with a PCM is appropriate. The PHP Coordinator will contact the OMAP Member's DHS caseworker to arrange Enrollment;

(viii) When the Disenrollment date has been determined, HMU sends a letter to the OMAP Member with a copy to the OMAP Member's DHS caseworker and the PHP. The letter shall inform the OMAP Member of the requirement to be enrolled in another PHP.

(F) If the PHP Coordinator approves a PHP's request for Disenrollment because the OMAP Member threatens or commits an act of physical violence directed at a medical Provider, the Provider's staff, or other patients, the following procedures shall apply:

(i) OMAP shall inform the OMAP Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for Disenrollment;

(iii) All OMAP Members in the OMAP Member's benefit group, as defined in OAR 461-110-0720, may be Disenrolled if the PHP requests;

(iv) OMAP may require the OMAP Member and/or the benefit group to obtain services from FFS Providers or a PCM until such time as they can be enrolled in another PHP;

(v) At the time of Enrollment into another PHP, OMAP shall notify the new PHP that the OMAP Member and/or benefit group were previously Disenrolled from another PHP at that PHP's request.

(G) If the PHP Coordinator approves the PHP's request for Disenrollment because the OMAP Member commits fraudulent or illegal acts as stated in 410-141-0080(2)(a), the following procedures shall apply:

(i) The PHP shall inform the OMAP Member of the Disenrollment decision in writing, including the right to request an Administrative Hearing;

(ii) The OMAP Member shall be Disenrolled as of the date of the PHP's request for Disenrollment;

(iii) At the time of Enrollment into another PHP, OMAP shall notify the new PHP that the OMAP Member and/or benefit group were previously Disenrolled from another PHP at that PHP's request;

(iv) If an OMAP Member who has been Disenrolled for cause is reenrolled in the PHP, the PHP may request a Disenrollment review by the PHP's PHP Coordinator. An OMAP Member may not be Disenrolled from the same PHP for a period of more than 12 months. If the OMAP Member is reenrolled after the 12-month period and is again Disenrolled for cause, the Disenrollment will be reviewed by DHS for further action.

(b) Other reasons for the PHP's requests for Disenrollment include the following:

(A) If the OMAP Member is enrolled in the FCHP or MHO on the same day the OMAP Member is admitted to the hospital, the FCHP or MHO shall be responsible for said hospitalization. If the OMAP Member is enrolled after the first day of the inpatient stay, the OMAP Member shall be Disenrolled, and the date of Enrollment shall be the next available Enrollment date following discharge from inpatient hospital services;

(B) The OMAP Member has surgery scheduled at the time their Enrollment is effective with the PHP, the Provider is not on the PHP's Provider panel, and the OMAP Member wishes to have the services performed by that Provider;

(C) The Medicare member is enrolled in a Medicare Cost Plan and was receiving Hospice Services at the time of Enrollment in the PHP;

(D) The OMAP Member had End Stage Renal Disease at the time of Enrollment in the PHP;

(E) Excluding the DCO, the PHP determines that the OMAP Member has a third party insurer. If after contacting The Health Insurance Group, the Disenrollment is not effective the following month, PHP may contact HMU to request Disenrollment;

(F) If a PHP has knowledge of an OMAP Member's change of address, PHP shall notify DHS. DHS will verify the address information and Disenroll the OMAP Member from the PHP, if the OMAP Member no longer resides in the PHP's Service Area. OMAP Members shall be Disenrolled if out of the PHP's Service Area for more than three (3) months, unless previously arranged with the PHP. The effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment from the PHP;

(G) The OMAP Member is an inmate who is serving time for a criminal offense or confined involuntarily in a State or Federal prison, jail, detention facility, or other penal institution. This does not include OMAP Members on probation, house arrest, living voluntarily in a facility after their case has been adjudicated, infants living with an inmate, or inmates who become inpatients. The PHP is responsible for identifying the OMAP Members and providing sufficient proof of incarceration to HMU for review of the Disenrollment request. OMAP will approve requests for Disenrollment from PHPs for OMAP Members who have been incarcerated for at least fourteen (14) calendar days and are currently incarcerated. FCHPs are responsible for inpatient services only during the time an OMAP Member was an inmate;

(H) For children or adolescents enrolled into an MHO on the day of admission to Psychiatric Residential Treatment Services (PRTS), the MHO shall be responsible for said services. If the OMAP Member is enrolled after the first day of admission to the PRTS, OMAP Member shall be Disenrolled and the date of the enrollment shall be the first day of the month following discharge from the PRTS; or

(I) The OMAP Member is in a state psychiatric institution.

(3) OMAP Initiated Disenrollments:

(a) OMAP may initiate and Disenroll OMAP Members as follows:

(A) If OMAP determines that the OMAP Member has sufficient third party resources such that health care and services may be cost effectively provided on a FFS basis, OMAP may Disenroll the OMAP Member. The effective date of Disenrollment shall be the end of the month in which OMAP makes such a determination. OMAP may specify a retroactive effective date of Disenrollment if the OMAP Member's third party coverage is through the PHP, or in other situations agreed to by the PHP and OMAP;

(B) If the OMAP Member moves out of the PHP's Service Area(s), the effective date of Disenrollment shall be the date specified by OMAP and OMAP will recoup the balance of that month's Capitation Payment from the PHP;

(C) If the OMAP Member is no longer eligible under the Oregon Health Plan Medicaid Demonstration Project or Children's Health Insurance Program, the effective date of Disenrollment shall be the date specified by OMAP;

(D) If the OMAP Member dies, the effective date of Disenrollment shall be the end of the month following the date of death;

(E) When a non-Medicare contracting PHP is assumed by another PHP that is a Medicare HMO/M+C, OMAP Members with Medicare shall be Disenrolled from the existing PHP. The effective date of Disenrollment shall be the day prior to the month the new PHP assumes the existing PHP;

(F) If OMAP determines that Contractor's OMAP Member has enrolled with their Employer Sponsored Insurance (ESI) through FHIAP the effective date of the Disenrollment shall be the OMAP Member's effective date of coverage with FHIAP.

(b) Unless specified otherwise in these rules or in the OMAP notification of Disenrollment to the PHP, all Disenrollments are effective the end of the month after the request for Disenrollment is approved by OMAP;

(c) OMAP shall inform the OMAP Members of the Disenrollment decision in writing, including the right to request an Administrative Hearing. Oregon Health Plan Clients may request an OMAP hearing if they dispute a Disenrollment decision by OMAP;

(d) If the OHP Client requests a hearing, the OHP Client will continue to be Disenrolled until a hearing decision reversing that Disenrollment has been mailed to the OHP Client.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 33-1994, f. & cert. ef. 11-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 21-1996(Temp), f. & cert. ef. 11-1-96; HR 11-1997, f. 3-28-97, cert. ef. 4-1-97; HR 14-1997, f. & cert. ef. 7-1-97; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 49-1998(Temp), f. 12-31-98, cert. ef. 1-1-99 thru 6-30-99; Administrative correction 8-9-99; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 24-2003, f. 3-26-03 cert. ef. 4-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0180**
**Oregon Health Plan Prepaid Health Plan Record Keeping**

(1) Maintenance and Security: Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure maintenance of a record keeping system that includes maintaining the security of records as required

by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC § 1320-d et seq., and the federal regulations implementing the Act, and complete Clinical Records that document the care received by Office of Medical Assistance Programs (OMAP) Members from the PHP's primary care and referral providers. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures and take any corrective action necessary to ensure Participating Provider compliance. PHPs shall document all monitoring and corrective action activities. Such policies and procedures shall ensure that records are secured, safeguarded and stored in accordance with applicable Oregon Revised Statutes (ORS) and Oregon Administrative Rules (OAR).

(2) Confidentiality and Privacy: PHPs and PHP's Participating Provides shall have written policies and procedures to ensure that Clinical Records related to OMAP Member's Individual Identifiable Health Information and the receiving of services are kept confidential and protected from unauthorized use and disclosure consistent with the requirements of HIPAA and in accordance with ORS 179.505 through 179.507, 411.320, 433.045(3), 42 CFR Part 2, 42 CFR Part 431, Subpart F, 45 CFR 205.50 If the PHP is a public body within the meaning of the Oregon public records law, such policies and procedures shall ensure that OMAP Member privacy is maintained in accordance with ORS 192.502(2), 192.502(8) (Confidential under Oregon law) and 192.502(9) (Confidential under Federal law) or other relevant exemptions:

(a) PHPs and their Participating Providers shall not release or disclose any information concerning an OMAP Member for any purpose not directly connected with the administration of Title XIX of the Social Security Act except as directed by the OMAP Member;

(b) Except in an emergency, PHPs' Participating Providers shall obtain a written authorization for release of information from the OMAP Member or the legal guardian, or the legal Power of Attorney for Health Care Decisions of the OMAP Member before releasing information. The written authorization for release of information shall specify the type of information to be released and the recipient of the information, and shall be placed in the OMAP Member's record. In an emergency, release of service information shall be limited to the extent necessary to meet the emergency information needs and then only to those persons involved in providing emergency medical services to the OMAP Member;

(c) PHPs may consider an OMAP Member, age 14 or older competent to authorize or prevent disclosure of mental health and alcohol and drug treatment outpatient records until the custodial parent or legal guardian becomes involved in an outpatient treatment plan consistent with the OMAP Member's clinical treatment requirements.

(3) Access to Clinical Records:

(a) Provider Access to Clinical Records:

(A) PHPs shall release health service information requested by a Provider involved in the care of an OMAP Member within ten working days of receiving a signed authorization for release of information;

(B) Mental Health Organizations (MHOs) shall assure that directly operated and subcontracted service components, as well as other cooperating health service Providers, have access to the applicable contents of an OMAP Member's mental health record when necessary for use in the diagnosis or treatment of the OMAP Member. Such access is permitted under ORS 179.505(6).

(b) OMAP Member Access to Clinical Records: Except as provided in ORS 179.505(9), PHPs' Participating Providers shall upon request, provide the OMAP Member access to his/her own Clinical Record, allow for the record to be amended or corrected and provide copies within ten working days of the request. PHPs' Participating Providers may charge the OMAP Member for reasonable duplication costs;

(c) Third Party Access to Records: Except as otherwise provided in this rule, PHPs' Participating Providers shall upon receipt of a written authorization for release of information for the OMAP Member provide access to OMAP Member's Clinical Record. PHPs' Participating Providers may charge for reasonable duplication costs;

(d) DHS Access to Records: PHPs shall cooperate with OMAP, the Office of Mental Health and Addiction Services (OMHAS), the Medicaid Fraud Unit, and/or OMHAS representatives for the purposes of audits, inspection and examination of OMAP Members' Clinical and Administrative Records.

(4) Retention of Records: All Clinical Records shall be retained for seven years after the date of services for which claims are made. If an audit, litigation, research and evaluation, or other action involving the records is started before the end of the seven-year period, the Clinical Records must be retained until all issues arising out of the action are resolved.

(5) Requirements for Clinical Records: PHPs shall have policies and procedures that ensure maintenance of a Clinical Record keeping system that is consistent with state and federal regulations to which the PHP is subject. The system shall assure accessibility, uniformity and completeness of clinical information that fully documents the OMAP Member's condition, and the covered and non-covered services received from PHPs' Participating or referred Providers. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Provider compliance. PHPs shall document all monitoring and corrective action activities:

(a) A Clinical Record shall be maintained for each OMAP Member receiving services that documents all types of care needed or delivered in all settings whether such services are delivered during or after normal clinic hours;

(b) All entries in the Clinical Record shall be signed and dated;

(c) Errors to the Clinical Record shall be corrected as follows. Incorrect data shall be crossed through with a single line. Correct and legible data shall be added followed by the date corrected and initials of the person making the correction. Removal or obliteration of errors shall be prohibited

(d) The Clinical Record shall reflect a signed and dated authorization for treatment for the OMAP Member, his/her legal guardian or the Power of Attorney for Health Care Decisions for any invasive treatments;

(e) The PCP's or clinic's Clinical Record shall include data that forms the basis of the diagnostic impression of the OMAP Member's chief complaint sufficient to justify any further diagnostic procedures, treatments, recommendations for return visits, and referrals. The PCP or clinic's Clinical Record of the OMAP Members receiving services shall include the following information as applicable:

(A) OMAP Member's name, date of birth, sex, address, telephone number, and identifying number as applicable;

(B) Name, address and telephone number of next of kin, legal guardian, Power of Attorney for Health Care Decisions, or other responsible party;

(C) Medical, dental or psychosocial history as appropriate;

(D) Dates of service;

(E) Names and titles of persons performing the services;

(F) Physicians' orders;

(G) Pertinent findings on examination and diagnosis;

(H) Description of medical services provided, including medications administered or prescribed; tests ordered or performed and results;

(I) Goods or supplies dispensed or prescribed;

(J) Description of treatment given and progress made;

(K) Recommendations for additional treatments or consultations;

(L) Evidence of referrals and results of referrals;

(M) Copies of the following documents if applicable:

(i) Mental health, psychiatric, psychological, psychosocial or functional screenings, assessments, examinations or evaluations;

(ii) Plans of care including evidence that the OMAP Member was jointly involved in the development of his/her mental health treatment plan;

(iii) For inpatient and outpatient hospitalizations, history and physical, dictated consultations, and discharge summary;

(iv) Emergency department and screening services reports;

(v) Consultation reports;

(vi) Medical education and medical social services provided;

(N) Copies of signed authorizations for release of information forms;

(O) Copies of medical and/or mental health directives.

(f) Based on written policies and procedures, the Clinical Record keeping system developed and maintained by PHPs' Participating Providers shall include sufficient detail and clarity to permit internal and external clinical audit to validate encounter submissions and to assure Medically Appropriate services are provided consistent with the documented needs of the OMAP Member. The system shall conform to accepted professional practice and facilitate an adequate system for follow up treatment;

(g) The PCP or clinic shall have policies and procedures that accommodate OMAP Member's requesting to review and correct or amend their Clinical Record;

(h) Other Records: PHPs' shall maintain other records in either the Clinical Record or within the PHP's administrative offices. Such records shall include the following:

(A) Names and phone numbers of the OMAP Member's prepaid health plans, primary care physician or clinic, primary dentist and mental health Practitioner, if any in the MHO records;

(B) Copies of Client Process Monitoring System (CPMS) enrollment forms in the MHO's records;

(C) Copies of long term psychiatric care determination request forms in the MHO's records;

(D) Evidence that the OMAP Member has received a fee schedule for services not covered under the Capitation Payment in the MHO's records;

(E) Evidence that the OMAP Member has been informed of his or her rights and responsibilities in the MHO records;

(F) ENCC records in the FCHP's or PCO's records;

(G) Complaint and Appeal records;

(H) Disenrollment Requests for Cause and the supporting documentation.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0220**

**Oregon Health Plan Prepaid Health Plan Accessibility**

(1) Prepaid Health Plans (PHPs) shall have written policies and procedures that ensure access to all covered services for all Office of Medical Assistance Programs (OMAP) Members. PHPs shall communicate these policies and procedures to Participating Providers, regularly monitor Participating Providers' compliance with these policies and procedures, and take any corrective action necessary to ensure Participating Provider compliance. PHPs shall document all monitoring and corrective action activities. PHPs shall not discriminate between OMAP Members and non-OMAP members as it relates to benefits and covered services to which they are both entitled:

(a) PHPs shall have written policies and procedures which ensure that for 90% of their OMAP Members in each Service Area, routine travel time or distance to the location of the Primary Care Physician (PCP) does not exceed the Community Standard for accessing health care Participating Providers. The travel time or distance to PCPs shall not exceed the following, unless otherwise approved by OMAP:

(A) In urban areas — 30 miles, 30 minutes or the Community Standard, whichever is greater;

(B) In rural areas — 60 miles, 60 minutes or the Community Standard, whichever is greater.

(b) PHPs shall maintain and monitor a network of appropriate Participating Providers sufficient to ensure adequate service capacity to provide availability of, and timely access to, Medically Appropriate covered services for OMAP Members:

(A) PHPs shall have an access plan that establishes standards for access, outlines how capacity is determined and establishes procedures for monthly monitoring of capacity and access, and for improving access and managing risk in times of reduced Participating Provider capacity. The access plan shall also identify populations in need of interpreter services and populations in need of accommodation under the Americans with Disabilities Act;

(B) PHPs shall make the services it provides including: specialists, pharmacy, hospital, vision and ancillary services, as accessible to OMAP Members in terms of timeliness, amount, duration and scope as those services are to non-OMAP persons within the same Service Area. If the PHP is unable to provide those services locally, it must so demonstrate to OMAP and shall provide reasonable alternatives for OMAP Members to access care that must be approved by OMAP. PHPs shall have a monitoring system that will demonstrate to OMAP or OMHAS, as applicable, that the PHP has surveyed and monitored for equal access of OMAP Members to referral Providers pharmacy, hospital, vision and ancillary services;

(C) PHPs shall have written policies and procedures and a monitoring system to ensure that OMAP Members who are Aged, Blind, or Disabled or who are children receiving Children, Adults and Families (CAF) State Office of Services to Children and Families (SOSCF) services or Oregon Youth Authority (OYA) services have access to primary care, dental care, mental health Providers and referral, as applicable. These Providers shall have the expertise to treat, take into account and accommodate the full range of medical, dental or mental health conditions experienced by these OMAP Members, including emotional, disturbance and behavioral responses, and combined or multiple diagnoses.

(2) PHPs and Primary Care Managers (PCMs) Enrollment Standards:

(a) PHPs and PCMs shall remain open for Enrollment unless DHS has closed Enrollment because the PHP or PCM has exceeded their Enrollment limit or does not have sufficient capacity to provide access to services as mutually agreed upon by OMAP or Office of Mental Health and Addiction Services (OMHAS), as appropriate, and the PHP or PCM;

(b) PHPs Enrollment may also be closed by OMAP or OMHAS, as appropriate due to sanction provisions;

(c) PHPs and PCMs shall accept all OHP Clients, regardless of health status at the time of Enrollment, subject to the stipulations in Contracts/agreements with DHS to provide covered services or Primary Care management services;

(d) PHPs and PCMs may confirm the Enrollment status of an OHP Client by one of the following:

(A) The individual's name appears on the monthly or weekly Enrollment list produced by OMAP;

(B) The individual presents a valid Medical Care Identification that shows he or she is enrolled with the PHP or PCM;

(C) The Automated Information System (AIS) verifies that the individual is currently eligible and enrolled with the PHP or PCM;

(D) An appropriately authorized staff member of DHS states that the individual is currently eligible and enrolled with the PHP or PCM.

(e) PHPs shall have open Enrollment for 30 continuous calendar days during each twelve-month period of October through September, regardless of the PHP's Enrollment limit. The open Enrollment periods for consecutive years may not be more than 14 months apart.

(3) If a PHP is assumed by another PHP, OMAP Members shall be automatically enrolled in the succeeding PHP. The OMAP Member will have 30 calendar days to request Disenrollment from the succeeding PHP. If the succeeding PHP is a Medicare HMO, those OMAP Members who are Medicare beneficiaries shall not be automatically enrolled but shall be offered Enrollment in the succeeding PHP.

(4) If a PHP engages in an activity, such as the termination of a Participating Provider or Participating Provider group which has significant impact on access in that Service Area and necessitates either transferring OMAP Members to other Providers or the PHP withdrawing from part or all of a Service Area, the PHP shall provide DHS at least 90 calendar days written notice prior to the planned effective date of such activity:

(a) A PHP may provide less than the required 90 calendar days notice to DHS upon approval by DHS when the PHP must terminate a Participating Provider or Participating Provider group due to problems that could compromise OMAP Member care, or when such a Participating Provider or Participating Provider group terminates its contract with the PHP and refuses to provide the required 90 calendar days notice;

(b) If DHS must notify OMAP Members of a change in Participating Providers or PHPs, the PHP shall provide DHS with the name, prime number, and address label of the OMAP Members affected by such changes at least 30 calendar days prior to the planned effective date of such activity. The PHP shall provide OMAP Members with at least 30 calendar-days notice of such changes.

(5) PHPs shall have written policies and procedures that ensure scheduling and rescheduling of OMAP Member appointments are appropriate to the reasons for, and urgency of, the visit:

(a) PHPs shall have written policies and procedures and a monitoring system to assure that OMAP Members have access to appointments according to the following standards:

(A) FCHPs and PCOs:

(i) Emergency Care — The OMAP Member shall be seen immediately or referred to an emergency department depending on the OMAP Member's condition;

(ii) Urgent Care — The OMAP Member shall be seen within 48 hours; and

(iii) Well Care — The OMAP Member shall be seen within 4 weeks or within the Community Standard.

(B) DCOs:

(i) Emergency Care — The OMAP Member shall be seen or treated within 24-hours;

(ii) Urgent Care — The OMAP Member shall be seen within one to two weeks depending on OMAP Member's condition; and

(iii) Routine Care — The OMAP Member shall be seen for routine care within an average of eight (8) weeks and within twelve (12) weeks or the community standard, whichever is less, unless there is a documented special clinical reason which would make access longer than 12 weeks appropriate.

(C) MHOs and CDOs:

(i) Emergency Care — OMAP Member shall be seen within 24-hours or as indicated in initial screening;

(ii) Urgent Care — OMAP Member shall be seen within 48 hours or as indicated in initial screening;

(iii) Non-Urgent Care — OMAP Member shall be seen for an intake assessment within 2 weeks from date of request.

(b) PHPs shall have written policies and procedures to schedule patients and provide appropriate flow of OMAP Members through the office such that OMAP Members are not kept waiting longer than non-OMAP Member patients, under normal circumstances. If OMAP Members are kept waiting or if a wait of over 45 minutes from the time of a scheduled appointment is anticipated, OMAP Members shall be afforded the opportunity to reschedule the appointment. PHPs must monitor waiting time for clients at least through Complaint and Appeal reviews, OMAP termination reports, and OMAP Member surveys to determine if waiting times for clients in all settings are appropriate;

(c) PHPs shall have written procedures and a monitoring system for timely follow-up with OMAP Member(s) when Participating Providers have notified the PHP that the OMAP Member(s) have failed to keep scheduled appointments. The procedures shall address determining why appointments are not kept, the timely rescheduling of missed appointments, as deemed Medically or Dentally Appropriate, documentation in the Clinical Record or non-clinical record of missed appointments, recall or notification efforts, and outreach services. If failure to keep a scheduled appointment is a symptom of the OMAP Member's diagnosis or disability or is due to lack of transportation to the PHP's Participating Provider office or clinic, PHPs shall provide outreach services as Medically Appropriate;

(d) PHPs shall have policies and procedures that ensure Participating Providers will attempt to contact OMAP Members if there is a need to cancel or reschedule the OMAP Member's appointment and there is sufficient time and a telephone number available;

(e) PHPs shall have written policies and procedures to Triage the service needs of OMAP Members who walk to the PCP's office or clinic with medical, mental health or dental care needs. Such Triage services must be provided in accordance with OAR 410-141-0140, Oregon Health Plan Prepaid Health Plan Emergency and Urgent Care Services;

(f) OMAP Members with non-emergent conditions who walk into the PCP's office or clinic should be scheduled for an appointment as appropriate to the OMAP Member's needs or be evaluated for treatment within two hours by a medical, mental health or dental Provider.

(6) PHPs shall have written policies and procedures that ensure the maintenance of 24-hour telephone coverage (not a recording) either on site or through call sharing or an answering service, unless this requirement is waived in writing by OMAP and/or OMHAS because the PHP submits an alternative plan that will provide equal or improved telephone access:

(a) Such policies and procedures shall ensure that telephone coverage provides access to 24-hour care and shall address the standards for PCPs or clinics callback for emergency, urgent, and routine issues and the provision of interpretive services after office hours;

(b) FCHPs and PCOs shall have an adequate on-call PCP or clinic backup system covering internal medicine, family practice, OB/Gyn, and pediatrics, as an operative element of FCHP's and PCO's after-hours care;

(c) Such policies and procedures shall ensure that relevant information is entered into the appropriate Clinical Record of the OMAP Member regardless of who responds to the call or the time of day the call is received. PHPs shall monitor for compliance with this requirement;

(d) Such policies and procedures shall include a written protocol specifying when a medical, mental health or dental Provider must be consulted. When Medically Appropriate, all such calls shall be forwarded to the on-call PCP who shall respond immediately to calls which may be emergent in nature. Urgent calls shall be returned appropriate to the OMAP Member's condition, but in no event more than 30 minutes after receipt. If information is inadequate to determine if the call is urgent, the call shall be returned within 60 minutes;

(e) Such policies and procedures shall ensure that all persons answering the telephone (both for the PHP and the PHP's Participating Providers) have sufficient communication skills and training to reassure OMAP Members and encourage them to wait for a return call in appropriate situations. PHPs shall have written procedures and trained staff to communicate with hearing impaired OMAP Members via TDD/TTY;

(f) PHPs shall monitor compliance with the policies and procedures governing 24-hour telephone coverage and on-call PCP coverage, take corrective action as needed, and report findings to the PHP's Quality Improvement committee;

(g) PHPs shall monitor such arrangements to ensure that the arrangements provide access to 24-hour care. PHPs shall, in addition, have telephone coverage at PHP's administrative offices that will permit access to PHPs' administrative staff during normal office hours, including lunch hours.

(7) PHPs shall develop written policies and procedures for communicating with, and providing care to OMAP Members who have difficulty communicating due to a medical condition or who are living in a household where there is no adult available to communicate in English or where there is no telephone:

(a) Such policies and procedures shall address the provision of qualified interpreter services by phone, in person, in PHP administrative offices, especially those of OMAP Member services and Complaint and Grievance representatives and in emergency rooms of contracted hospitals;

(b) PHPs shall provide or ensure the provision of qualified interpreter services for covered medical, mental health or dental care visits, including home health visits, to interpret for OMAP Members with hearing impairment or in the primary language of non-English speaking OMAP Members. Such interpreters shall be linguistically appropriate and be capable of communicating in English and the primary language of the OMAP Member and be able to translate clinical information effectively. Interpreter services shall be sufficient for the Provider to be able to understand the OMAP Member's complaint; to make a diagnosis; respond to OMAP Member's questions and concerns; and to communicate instructions to the OMAP Member;

(c) PHPs shall ensure the provision of care and interpreter services, which are culturally appropriate, i.e., demonstrating both awareness for and sensitivity to cultural differences and similarities and the effect of those on the medical care of the OMAP Member;

(d) PHPs shall have written policies and procedures that ensure compliance with requirements of the Americans with Disabilities Act of 1990 in providing access to covered services for all OMAP Members and shall arrange for services to be provided by Non-Participating referral Providers when necessary:

(A) PHPs shall have a written plan for ensuring compliance with these requirements and shall monitor for compliance;

(B) Such a plan shall include procedures to determine whether OMAP Members are receiving accommodations for access and to determine what will be done to remove existing barriers and/or to accommodate the needs of OMAP Members;

(C) This plan shall include the assurance of appropriate physical access to obtain covered services for all OMAP Members including, but not limited to, the following:

(i) Street level access or accessible ramp into facility;

(ii) Wheelchair access to lavatory;

(iii) Wheelchair access to examination room; and

(iv) Doors with levered hardware or other special adaptations for wheelchair access.

(e) PHPs shall ensure that Participating Providers, their facilities and personnel are prepared to meet the special needs of OMAP Members who require accommodations because of a disability:

(A) PHPs shall have a written plan for meeting the needs of OMAP Members;

(B) PHPs shall monitor Participating Providers for compliance with the access plan and take corrective action, when necessary.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 38-1998, f. & cert. ef. 10-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0263**
**Notice of Action by a Prepaid Health Plan**

(1) When a PHP (or authorized Practitioner acting on behalf of the PHP) takes or intends to take any Action, including but not limited to denials or limiting prior authorizations of a requested covered service(s) in an amount, duration, or scope that is less than requested, or reductions, suspension, discontinuation or termination of a previously authorized service, or any other Action, the PHP (or authorized Practitioner acting on behalf of the PHP) shall mail a written client Notice of Action in accordance with section (2) of this rule to the OMAP Member within the timeframes specified in subsection (3) of this rule.

(2) The written client Notice of Action must be an OMAP approved format and it must be used for all denials of a requested covered service(s), reductions, discontinuations or terminations of previously authorized services, denials of claims payment, or other Action. The client Notice of Action must meet the language and format requirements of 42 CFR 438.10(c) and (d) and shall inform the OMAP Member of the following:

(a) Relevant information shall include, but is not limited to, the following:

(A) Date of client Notice of Action;

(B) PHP name;

(C) PCP/PCD name;

(D) OMAP Member's name and ID number;

(E) Date of service or item requested or provided;

(F) Who requested or provided the item or service; and

(G) Effective date of the Action.

(b) The Action the PHP or its Participating Provider has taken or intends to take;

(c) Reasons for the Action, including but not limited to the following reasons:

(A) Treatment is not covered;

(B) The item requires pre-authorization and it was not pre-authorized;

(C) The service is not Dentally or Medically Appropriate;

(D) The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard;

(E) The person was not an OMAP Member at the time of the service or is not an OMAP Member at the time of a requested service; and

(F) The Provider is not on the PHP's panel and prior approval was not obtained (if such prior authorization would be required under the Oregon Health Plan Rules).

(d) A reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Action pursuant to subsection (b) of this section, in compliance with the notice requirements in ORS 183.415(2)(c);

(e) The OMAP Member's right to file an Appeal with the PHP and how to exercise that right as required in OAR 410-141-0262;

(f) The circumstances under which expedited Appeal resolution is available and how to request it;

(g) The OMAP Member's right to have benefits continue pending resolution of the Appeal, how to request that benefit(s) be continued, and the circumstances under which the OMAP Member may be required to pay the costs of these services; and

(h) The telephone number to contact the PHP for additional information.

(3) The PHP or Practitioner(s) acting on behalf of the PHP must mail the Notice of Action within the following time frames:

(a) For termination, suspension, or reduction of previously authorized OHP covered services, the following time frames apply:

(A) The notice must be mailed at least 10 calendar days before the date of Action, except as permitted under subsections (B) or (C) of this section;

(B) The PHP (or authorized Practitioner acting on behalf of the PHP) may mail a notice not later than the date of Action if:

(i) The PHP or Practitioner receives a clear written statement signed by the OMAP Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information;

(ii) The OMAP Member has been admitted to an institution where he or she is ineligible for covered services from the PHP;

(iii) The OMAP Member's whereabouts are unknown and the post office returns PHP or Practitioner's mail directed to him or her indicating no forwarding address;

(iv) The PHP establishes the fact that another State, territory, or commonwealth has accepted the OMAP Member for Medicaid services;

(v) A change in the level of medical or dental care is prescribed by the OMAP Member's PCP or PCD; or

(vi) The date of Action will occur in less than 10 calendar days, in accordance with 42 CFR 483.12(a)(5)(ii), related to discharges or transfers and long-term care facilities.

(C) The PHP may shorten the period of advance notice to 5 calendar days before the date of the Action if the PHP has facts indicating that an Action should be taken because of probable fraud by the OMAP Member. Whenever possible, these facts should be verified through secondary sources.

(b) For denial of payment, at the time of any Action affecting the claim;

(c) For standard prior authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested, the PHP must provide Notice of Action as expeditiously as the OMAP Member's health condition requires and within 14 calendar days following receipt of the request for service, except that:

(A) The PHP may have a possible extension of up to 14 additional calendar days if the OMAP Member or the Provider requests the extension; or if the PHP justifies (to OMAP upon request) a need for additional information and how the extension is in the OMAP Member's interest;

(B) If the PHP extends the timeframe, in accordance with subsection (A) of this section, it must give the OMAP Member written notice of the reason for the decision to extend the timeframe and inform the OMAP Member of their right to file a Complaint if he or she disagrees with that decision. The PHP must issue and carry out its prior authorization determination as expeditiously as the OMAP Member's health condition requires and no later than the date the extension expires.

(d) For prior authorization decisions not reached within the timeframes specified in subsection (c) of this section, (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire;

(e) For expedited prior authorizations, within the timeframes specified in OAR 410-141-0265.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 35-2004, f. 5-26-04 cert. ef. 6-1-04; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0300**
**Oregon Health Plan Prepaid Health Plan Member Education**

CDO: Chemical Dependency Organization

DCO: Dental Care Organization

DHS: Department of Human Services

ENCC: Exceptional Needs Care Coordination

FCHP: Fully Capitated Health Plan

MHO: Mental Health Organization

PCD: Primary Care Dentist

PCO: Physican Care Organization

PCP: Primary Care Provider

PHP: Prepaid Health Plan (FCHP, PCO, DCO, CDO and MHO) OHP: Oregon Health Plan OMHAS: Office of Mental Health and Addiction Services OMAP: Office of Medical Assistance Programs

(1) PHPs shall have an ongoing process of OMAP Member education and information sharing that includes orientation to the PHP, a PHP OMAP Member handbook and health education. OMAP Member education shall include:

(a) The availability of ENCC through FCHPs and PCOs for OMAP Members with special health care needs, who are Aged, Blind or Disabled; and

(b) The appropriate use of the delivery system, including a proactive and effective education of OMAP Members on how to access Emergency Services and Urgent Care Services appropriately.

(2) PHPs shall offer PHP orientation to new OMAP Members by mail, phone, or in person within 30 days of Enrollment unless no address can be obtained, a telephone number is not provided by OMAP, and a DHS agency is unable to assist in delivering the information to the OMAP Member.

(3) PHP OMAP Member handbook materials:

(a) The PHP OMAP Member handbook shall be made available for new OMAP Members, as described in OAR 410-141-0280, Oregon Health Plan PHP Informational Requirements, and shall be distributed within 14 calendar days of the OMAP Member's effective date of coverage with PHP;

(b) At a minimum the information in the PHP OMAP Member handbook shall contain the following elements:

(A) Location(s), office hours and availability of physical access for OMAP Members with disabilities to PHP and PCP and PCD offices;

(B) Telephone number(s) (including TTY) for OMAP Members to call for more information and telephone numbers relating to information listed below;

(C) OMAP Member's choice and use of PCPs, PCDs and policies on changing PCPs, PCDs;

(D) Use of the PHP's appointment system;

(E) Use of the PHP's referral system, including procedures for obtaining benefits, including authorization requirements;

(F) How OMAP Members are to access Urgent Care Services and advice;

(G) How and when OMAP Members are to use Emergency Services including information on Post-Stabilization Care Services, related to an emergency medical condition that are provided after an OMAP Member is

stabilized in order to maintain the stabilized condition, or, under the circumstances to improve or resolve the OMAP Member's condition;

(H) Information on the PHP's Complaint process and information on fair hearing procedures;

(I) How OMAP Members are to access interpreter services including sign interpreters;

(J) Information on the OMAP Member's rights and responsibilities;

(K) Information on the OMAP Member's possible responsibility for charges including Medicare deductibles and coinsurances (if they go outside of PHP for non-emergent care), co-payments, and charges for non-covered services;

(L) The transitional procedures for new OMAP Members to obtain prescriptions, supplies and other necessary items and/or services in the first month of Enrollment with the PHP if they are unable to meet with a PCP, PCD, other prescribing Practitioner or obtain new orders during that period;

(M) What services can be self-referred to both Participating and Non-Participating Providers (FCHPs, PCOs and MHOs only);

(N) To adult OMAP Members written information on Advance Directive policies including:

(i) A description of applicable state law;

(ii) OMAP Member rights under Oregon law;

(iii) The contractor's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(O) How to request information on the PHP's Physician Incentives;

(P) The OMAP Members right to request and obtain copies of their Clinical Records (and that they may be charged a reasonable copying fee) and to request that the record be amended or corrected;

(Q) How OMAP Members are to obtain emergent and non-emergent ambulance services (FCHP and PCO only) and other medical transportation to appointments, as appropriate;

(R) Explanation of the amount, scope and duration of covered and Non-covered Services in sufficient detail to ensure that OMAP Members understand the benefits to which they are entitled;

(S) How OMAP Members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs (FCHPs and PCOs only);

(T) PHP's Confidentiality Policy;

(U) Name, locations, telephone numbers of, and non-English languages offered by current Participating Providers, including information on PHP's PCPs/PCDs that are not accepting new OMAP Members (not MHOs) including at a minimum, information on PCPs, specialists and hospitals in the OMAP Member's Service Area;

(V) The extent to which; and how, OMAP Members may obtain benefits, including family planning services, from out of network Providers;

(W) Any restrictions on the OMAP Member's freedom of choice among network Providers;

(X) Policies on referrals for specialty care and for other benefits not furnished by the OMAP Member's PCP;

(Y) How and where OMAP Members are to access any benefits that are available under OHP but are not covered under the PHPs' Contract, including any cost sharing, and how transportation is provided.

(c) If the PHP OMAP Member handbook is returned with a new address, the PHP shall re-mail the PHP OMAP Member handbook or use the telephone number provided by DHS to reach the OMAP Member. If the PHP is unable to reach the OMAP Member by either mail or telephone, the PHP shall retain the PHP OMAP Member handbook and have it available upon request for the OMAP Member;

(d) PHPs shall, at a minimum, annually and upon request provide the PHP OMAP Member handbook to OMAP Members, OMAP Member's Representative and to clinical offices for distribution to OMAP Members;

(e) The PHP OMAP Member handbook shall be reviewed by PHP for accuracy at least yearly and updated with new or corrected information as needed to reflect the PHP's internal changes and regulatory changes. If changes impact the OMAP Members' ability to use services or benefits, the updated materials shall be distributed to all OMAP Members;

(f) The DHS "Oregon Health Plan Client Handbook" is in addition to the PHP OMAP Member handbook and cannot be used to substitute for the PHP OMAP Member handbook.

(4) PHPs shall have written procedures and criteria for health education of OMAP Members. Health education shall include: information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. Health education may be provided by PHP's Practitioner(s) or other individual(s) or program(s) approved by the PHP. PHPs shall endeavor to provide health education in a culturally sensitive manner in order to communicate most effectively with individuals from non-dominant cultures: PHPs shall ensure development and maintenance of an individualized health educational plan for OMAP Members who have been identified by their Practitioner as requiring specific educational intervention. DHS may assist in developing materials that address specifically identified health education problems to the population in need.

(5) PHPs shall provide an identification card to OMAP Members, unless waived by OMAP and/or OMHAS, which contains simple, readable and usable information on how to access care in an urgent or emergency situation. Such identification cards shall confer no rights to services or other benefits under the Oregon Health Plan and are solely for the convenience of the PHP's, OMAP Members and Providers.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.725
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 39-1994, f. 12-30-94, cert. ef. 1-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 29-2001, f. 8-13-01, cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 50-2003, f. 7-31-03 cert. ef 8-1-03; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

**410-141-0420**

**Oregon Health Plan Prepaid Health Plan Billing and Payment Under the Oregon Health Plan**

(1) All billings for Oregon Health Plan Clients to Prepaid Health Plans (PHPs) and to Office of Medical Assistance Programs (OMAP) shall be submitted within four (4) months and twelve (12) months, respectively, of the date of service, subject to other applicable OMAP billing rules. Submissions shall be made to PHPs within the four (4) month time frame except in the following cases:

(a) Pregnancy;

(b) Eligibility issues such as retroactive deletions or retroactive Enrollments;

(c) Medicare is the primary payor;

(d) Other cases that could have delayed the initial billing to the PHP (which does not include failure of Provider to certify the OMAP Member's eligibility); or

(e)Third Party Resource (TPR). Pursuant to 42 CFR 36.61, subpart G: Indian Health Services and the amended Public Law 93-638 under the Memorandum of Agreement that Indian Health Service and 638 Tribal Facilities are the payor of last resort and is not considered an alternative resource or TPR.

(2) Providers must be enrolled with OMAP to be eligible for Fee-for-Service (FFS) payment by OMAP. Mental health Providers, except Federally Qualified Health Centers, must be approved by the Local Mental Health Authority (LMHA) and the Office of Mental Health and Addiction Services (OMHAS) before enrollment with OMAP. Providers may be retroactively enrolled, in accordance with OAR 410-120-1260, Provider enrollment.

(3) Providers, including mental health Providers, do not have to be enrolled with OMAP to be eligible for payment for services by PHPs except that Providers who have been excluded as Medicare/Medicaid Providers by OMAP, CMS or by lawful court orders are ineligible to receive payment for services by PHPs.

(4) Providers shall verify, before rendering services, that the OMAP Member is eligible for the Medical Assistance Program on the date of service and that the service to be rendered is covered under the Oregon Health Plan Benefit Package of Covered Services. Providers shall also identify the party responsible for covering the intended service and seek pre-authorizations from the appropriate payor before rendering services. Providers shall inform OMAP Members of any charges for non-covered services prior to the services being delivered.

(5) Capitated Services:

(a) PHPs receive a Capitation Payment to provide services to OMAP Members. These services are referred to as Capitated Services;

(b) PHPs are responsible for payment of all Capitated Services. Such services should be billed directly to the PHP, unless the PHP or OMAP specifies otherwise. PHPs may require Providers to obtain preauthorization to deliver certain Capitated Services.

(6) Payment by the PHP to Providers for Capitated Services is a matter between the PHP and the Provider, except as follows:

(a) Pre-authorizations:

(A) PHPs shall have written procedures for processing pre-authorization requests received from any Provider. The procedures shall specify time frames for:

(i) Date stamping pre-authorization requests when received;

(ii) Determining within a specific number of days from receipt whether a pre-authorization request is valid or non-valid;

(iii) The specific number of days allowed for follow up on pended preauthorization requests to obtain additional information;

(iv) The specific number of days following receipt of the additional information that a redetermination must be made;

(v) Providing services after office hours and on weekends that require preauthorization;

(vi) Sending notice of the decision with Appeal rights to the OMAP Member when the determination is made to deny the requested service as specified in 410-141-0263.

(B) PHPs shall make a determination on at least 95% of Valid Pre-Authorization requests, within two working days of receipt of a preauthorization or reauthorization request related to urgent services; alcohol and drug services; and/or care required while in a skilled nursing facility. Pre-authorizations for prescription drugs must be completed and the pharmacy notified within 24 hours. If a pre-authorization for a prescription cannot be completed within the 24 hours, the PHP must provide for the dispensing of at least a 72-hour supply if the medical need for the drug is immediate. PHP shall notify Providers of such determination within 2 working days of receipt of the request;

(C) For expedited prior authorization requests in which the Provider indicates, or the PHP determines, that following the standard timeframe could seriously jeopardize the OMAP Member's life or health or ability to attain, maintain, or regain maximum function:

(i) The PHP must make an expedited authorization decision and provide notice as expeditiously as the OMAP Member's health condition requires and no later than three working days after receipt of the request for service;

(ii) The PHP may extend the three working days time period by up to 14 calendar days if the OMAP Member requests an extension, or if the PHP justifies to OMAP a need for additional information and how the extension is in the OMAP Member's interest.

(D) For all other pre-authorization requests, PHPs shall notify Providers of an approval, a denial or a need for further information within 14 calendar days of receipt of the request. PHPs must make reasonable efforts to obtain the necessary information during that 14-day period. However, the PHP may use an additional 14 days to obtain follow-up information, if the PHP justifies the need for additional information and how the delay is in the interest of the OMAP Member. The PHP shall make a determination as the OMAP Member's health condition requires, but no later than the expiration of the extension. PHPs shall notify OMAP Members of a denial within five working days from the final determination using an OMAP or OMHAS approved client notice format.

(b) Claims Payment:

(A) PHPs shall have written procedures for processing claims submitted for payment from any source. The procedures shall specify time frames for:

(i) Date stamping claims when received;

(ii) Determining within a specific number of days from receipt whether a claim is valid or non-valid;

(iii) The specific number of days allowed for follow up of pended claims to obtain additional information;

(iv) The specific number of days following receipt of additional information that a determination must be made; and

(v) Sending notice of the decision with Appeal rights to the OMAP Member when the determination is made to deny the claim.

(B) PHPs shall pay or deny at least 90% of Valid Claims within 45 calendar days of receipt and at least 99% of Valid Claims within 60 calendars days of receipt. PHPs shall make an initial determination on 99% of all claims submitted within 60 calendar days of receipt;

(C) PHPs shall provide written notification of PHP determinations when such determinations result in a denial of payment for services, for which the OMAP Member may be financially responsible. Such notice shall be provided to the OMAP Member and the treating Provider within 14calendar days of the final determination. The notice to the OMAP Member shall be an OMAP or OMHAS approved notice format and shall include information on the PHPs internal appeals process, and the Notice of Hearing Rights (OMAP 3030) shall be attached. The notice to the Provider shall include the reason for the denial;

(D) PHPs shall not require Providers to delay billing to the PHP;

(E) PHPs shall not require Medicare be billed as the primary insurer for services or items not covered by Medicare, nor require non-Medicare approved Providers to bill Medicare;

(F) PHPs shall not deny payment of Valid Claims when the potential TPR is based only on a diagnosis, and no potential TPR has been documented in the OMAP Member's Clinical Record;

(G) PHPs shall not delay nor deny payments because a co-payment was not collected at the time of service.

(c) FCHPs, PCOs, and MHOs are responsible for payment of Medicare coinsurances and deductibles up to the Medicare or PHP's allowable for covered services the OMAP Member receives within the PHP, for authorized referral care, and for Urgent Care Services or Emergency Services the OMAP Member receives from non-contracted Providers. FCHPs, PCOs, and MHOs are not responsible for Medicare coinsurances and deductibles for non-urgent or non-emergent care OMAP Members receive from Non Participating Providers-;

(d) FCHPs and PCOs shall pay transportation, meals and lodging costs for the OMAP Member and any required attendant for out-of-state services (as defined in General Rules) that the FCHP and PCO has arranged and authorized when those services are available within the state, unless otherwise approved by OMAP;

(e) PHPs shall be responsible for payment of covered services provided by a Non-Participating Provider that were not pre-authorized if the following conditions exist:

(A) It can be verified that the Participating Provider ordered or directed the covered services to be delivered by a Non-Participating Provider; and

(B) The covered service was delivered in good faith without the preauthorization; and (C) It was a covered service that would have been pre-authorized with a Participating Provider if the PHP's referral protocols had been followed;

(D) The PHP shall be responsible for payment to Non-Participating Providers (Providers enrolled with OMAP that do not have a contract with the PHP) for covered services that are subject to reimbursement from the PHP, the amount specified in OAR 410-120-1295. This rule does not apply to Providers that are Type A or Type B hospitals, as they are paid in accordance with ORS 414.727.

(7) Other Services:

(a) OMAP Members enrolled with PHPs may receive certain services on an OMAP FFS basis. Such services are referred to as Non-Capitated Services;

(b) Certain services must be authorized by the PHP or the Community Mental Health Program (CMHP) for some mental health services, even though such services are then paid by OMAP on an OMAP FFS basis. Before providing services, Providers should contact the PHPs identified on the OMAP Member's Medical Care Identification or, for some mental health services, the CMHP. Alternatively, the Provider may call the OMAP Provider Services Unit to obtain information about coverage for a particular service and/or pre-authorization requirements;

(c) Services authorized by the PHP or CMHP are subject to the rules and limitations of the appropriate OMAP administrative rules and supplemental information, including rates and billing instructions;

(d) Providers shall bill OMAP directly for Non-Capitated Services in accordance with billing instructions contained in the OMAP administrative rules and supplemental information;

(e) OMAP shall pay at the Medicaid FFS rate in effect on the date the service is provided subject to the rules and limitations described in the relevant rules, contracts, billing instructions and OMAP administrative rules and supplemental information;

(f) OMAP will not pay a Provider for provision of services for which a PHP has received a Capitation Payment unless otherwise provided for in OAR 410-141-0120;

(g) When an item or service is included in the rate paid to a medical institution, a residential facility or foster home, provision of that item or service is not the responsibility of OMAP, OMHAS, nor a PHP except as provided for in OMAP administrative rules and supplemental information (e.g., Capitated Services that are not included in the nursing facility all-inclusive rate);

(h) FCHPs and PCOs that contract with non-public teaching hospitals will reimburse those hospitals for Graduate Medical Education (GME), if the hospitals are:

(A) Neither a type A nor type B hospitals;

(B) Not paid according to a type A or type B payment methodology; and,

(C) In remote areas greater than 60 miles from the nearest acute care hospital, with a graduate medical student teaching program.

(i) FCHPs and PCOs that contract with FQHCs and RHCs shall negotiate a rate of reimbursement that is not less than the level and amount of payment which the FCHP or PCO would make for the same service(s) furnished by a Provider, who is not an FQHC nor RHC, consistent with the requirements of BBA 4712(b)(2).

(8) Coverage of services through the Oregon Health Plan Benefit Package of Covered Services is limited by OAR 410-141-0500, Excluded Services and Limitations for OHP Clients.

(9) OHP Clients who are enrolled with a PCM receive services on a FFS basis:

(a) PCMs are paid a per client/per month payment to provide Primary Care Management Services, in accordance with OAR 410-141-0410, Primary Care Manager Medical Management;

(b) PCMs provide Primary Care access, and management services for Preventive Services, primary care services, referrals for specialty services, limited inpatient hospital services and outpatient hospital services. OMAP payment for these PCM managed services is contingent upon PCCM authorization;

(c) All PCM Managed Services are covered services that shall be billed directly to OMAP in accordance with billing instructions contained in the OMAP administrative rules and supplemental information;

(d) OMAP shall pay at the OMAP Fee-For-Service (FFS) rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate OMAP administrative rules and supplemental information.

(10) All OHP Clients who are enrolled with a PCO receive inpatient hospital services on an OMAP FFS basis:

(a) May receive services directly from any appropriately enrolled OMAP Provider;

(b) All services shall be billed directly to OMAP in accordance with FFS billing instructions contained in the OMAP administrative rules and supplemental information;

(c) OMAP shall pay at the OMAP FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate OMAP administrative rules and supplemental information.

(11) OHP Clients who are not enrolled with a PHP receive services on an OMAP FFS basis:

(a) Services may be received directly from any appropriate enrolled OMAP Provider;

(b) All services shall be billed directly to OMAP in accordance with billing instructions contained in the OMAP administrative rules and supplemental information;

(c) OMAP shall pay at the OMAP FFS rate in effect on the date the service is provided subject to the rules and limitations described in the appropriate OMAP administrative rules and supplemental information.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: HR 31-1993, f. 10-14-93, cert. ef. 2-1-94; HR 7-1994, f. & cert. ef. 2-1-94; HR 17-1995, f. 9-28-95, cert. ef. 10-1-95; HR 19-1996, f. & cert. ef. 10-1-96; HR 25-1997, f. & cert. ef. 10-1-97; OMAP 21-1998, f. & cert. ef. 7-1-98; OMAP 39-1999, f. & cert. ef. 10-1-99; OMAP 26-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 15-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 52-2001, f. & cert. ef. 10-1-01; OMAP 57-2002, f. & cert. ef. 10-1-02; OMAP 4-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 61-2003, 9-5-03, cert. ef. 10-1-03; OMAP 23-2004(Temp), f. & cert. ef. 3-23-04 thru 8-15-04; OMAP 33-2004, f. 5-26-04, cert. ef. 6-1-04; OMAP 37-2004(Temp), f. 5-27-04 cert. ef. 6-1-04 thru 11-15-04; OMAP 47-2004, f. 7-22-04 cert. ef. 8-1-04; OMAP 27-2005, f. 4-20-05, cert. ef. 5-1-05; OMAP 46-2005, f. 9-9-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 47-2005
**Filed with Sec. of State:** 9-9-2005
**Certified to be Effective:** 10-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 410-147-0000
**Subject:** The Federally Qualified Health Centers and Rural Health Clinics (FQHC/RHC) Services program rules govern the Office of Medical Assistance Programs' (OMAP) payments for services provided to certain clients. OMAP permanently amended 410-147-0000 to remove outdated and unnecessary information.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-147-0000**
**Foreword**

(1) The Office of Medical Assistance Programs (OMAP) Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) rules are designed to assist FQHCs and RHCs to deliver health care services and prepare health claims for clients with Medical Assistance Program coverage.

(2) The FQHC and RHC rules contain important information including general program policy, provider enrollment, and maintenance of financial records, special programs, and billing information.

(3) It is the clinic's responsibility to understand and follow all OMAP rules that are in effect on the date services are provided.

(4) Typically rules are modified twice a year, April for technical changes and October for technical and/or program changes. Technical changes refer to operational information. All provider rules can be found on OMAP's website.

(5) FQHCs and RHCs must use rules contained in the FQHC and RHC rules. Do not use other provider rules unless specifically directed in rules contained in the FQHC and RHC rules. OMAP General Rules and the Oregon Health Plan (OHP) Administrative Rules are intended to be used in conjunction with all program rules including the FQHC and RHC provider rules.

(6) The Health Services Commission's Prioritized List of Health Services is found in the OHP Administrative Rules (OAR 410-141-0520) and defines the services covered under OMAP.

(7) An FQHC is defined as a clinic that is recognized and certified by the Centers for Medicare and Medicaid Services (CMS) as meeting federal requirements as an FQHC.

(8) An RHC is defined as a clinic that is recognized and certified by CMS as meeting federal requirements for payment for RHC services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: Hist.: AFS 20-1988, f. 3-8-88, cert. ef. 4-1-88; AFS 16-1989(Temp), f. 3-31-89, cert. ef. 4-1-89; AFS 47-1989, f. & cert. ef. 8-24-89; HR 4-1991, f. 1-15-91, cert. ef. 2-1-91; HR 29-1991(Temp), f. & cert. ef. 7-1-91; HR 33-1991, f. & cert. ef. 8-16-91; Renumbered from 461-0014-415; HR 12-1992, f. & cert. ef. 4-1-92; HR 24-1992, f. & cert. ef. 7-3-92; HR 13-1996(Temp), f. & cert. ef. 7-1-96; HR 24-1996, f. 11-29-96, cert. ef. 12-1-96; OMAP 19-1999, f. & cert. ef. 4-1-99; OMAP 35-1999, f. & cert. ef. 10-1-99; OMAP 20-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 21-2000, f. 9-28-00, cert. ef 10-1-00;OMAP 37-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 42-2001, f. 9-24-01, cert. ef. 10-1-01; OMAP 62-2002, f. & cert. ef. 10-1-02, Renumbered from 410-128-0000; OMAP 63-2002, f. & cert. ef. 10-1-02, Renumbered from 410-135-0000; OMAP 63-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 47-2005, f. 9-9-05, cert. ef. 10-1-05

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**Adm. Order No.:** OMAP 48-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 9-15-05 thru 2-15-06
**Notice Publication Date:**
**Rules Amended:** 410-147-0365
**Subject:** The Federally Qualified Health Center and Rural Health Clinic program govern Office of Medical Assistance Programs' (OMAP) payments for products and services provided to clients. In May 2005, OMAP adopted OAR 410-147-0365 contingent on federal approval of the State Plan Amendment, to provide an alternate payment methodology (APM) for the obstetrical (OB) care portion of the Prospective Payment System provided by remote rural and frontier Rural Health Clinics. Based upon negotiations with the Centers for Medicare and Medicaid Services (CMS) that has resulted in substantial changes to the State Plan Amendment, OMAP temporarily amended OAR 410-147-0365 to change the APM calculation to a cost-based OB delivery encounter rate. Implementation remains contingent on final federal approval of the State Plan Amendment.
**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-147-0365**
**Independent Rural Health Clinic (RHC) Alternate Payment Methodology (APM) for Obstetrics (OB) Care Delivery Procedures**

(1) A Medicare certified independent RHC, as defined below, may be eligible for an obstetrics (OB) alternate payment methodology (APM) encounter rate for delivery procedures. The OB APM delivery encounter rate includes additional OB delivery-related costs incurred by a clinic as a cost-based payment in addition to the Prospective Payment System (PPS) medical encounter rate. The OB APM is contingent, and becomes effective, upon federal approval of the State Plan Amendment. The intent of the OB APM is to maintain access to OB care, including delivery services, in frontier and remote rural areas and to compensate eligible clinics for professional costs uniquely associated with OB care, not to exceed 100% of reasonable cost.

(2) To be eligible for the OB APM delivery encounter rate, a Medicare certified independent RHC must meet all Office of Medical Assistance

Programs (OMAP) requirements applicable to an RHC, qualify as either "frontier" or "remote rural" as defined in (a) and (b) below, be located in a service area with unmet medical need defined in (c) below, and must request to participate in writing pursuant to participation requirements specified in (3) and (5) below.

(a) Frontier RHC is defined as located in a frontier county as designated by the Oregon Office of Rural Health;

(b) Remote rural RHC is defined as located in a remote rural service area as designated by the Oregon Office of Rural Health;

(c) A frontier or remote rural RHC must be located in a service area of unmet medical need as determined by the Oregon Office of Rural Health for the year in which the written request for OB APM was made.

(3) If the frontier or remote rural RHC qualifies under (2) and other requirements outlined by OMAP, the clinic must provide OMAP all required documentation necessary to qualify for the OB APM delivery encounter rate.

(a) An eligible RHC must submit a written request to OMAP for the OB APM delivery encounter rate. The RHC is responsible for providing all documentation necessary for OMAP to conduct the calculations described in this rule. Failure to provide necessary documentation with the request to participate may result in a delay of the calculation and effective date of the OB APM delivery encounter rate.

(b) RHCs that meet the requirements in (2) prior to Federal approval of the State Plan Amendment (SPA) may bill, using the OB APM delivery encounter rate, effective the date of Federal approval of the SPA provided OMAP has determined the clinic's OB APM delivery encounter rate.

(c) RHCs that meet the requirements in (2) after the Federal approval date of the SPA may bill, using the OB APM delivery encounter rate, effective the date OMAP determines the clinic's OB APM delivery encounter rate.

(4) Care status changes:

(a) OMAP reserves the right to request periodic review of utilization, cost reporting and to re-evaluate OB care access including delivery services in a community to determine the continued need to pay an OB APM delivery encounter rate for frontier and remote rural RHCs;

(b) Prior to making any changes in the RHC's status and rates, OMAP will re-evaluate the following:

(A) If OB care access including delivery services in a community has changed;

(B) If the RHC no longer meets the requirements for the OB APM:

(i) An RHC's agreement with the Secretary of Health and Human Services, Center for Medicare and Medicaid Services is terminated; or

(ii) The location of an RHC does not qualify as an unmet medical need service area as determined by the Oregon Office of Rural Health for five consecutive years;

(iii) The stability of new providers supplying additional OB care access including delivery services;

(c) OMAP will give the RHC 90 days notice of change in status and rate;

(d) If OMAP determines that an RHC no longer meets the OB APM requirements, the RHC may request, within 30 days from notification, that OMAP review any additional supporting documentation regarding the determination.

(5) Determining OB APM Delivery Encounter Rate: The frontier or remote rural RHC requesting an OB APM delivery encounter rate, and meeting the OMAP requirements, will have an OB APM delivery encounter rate which is the sum of a clinic's PPS medical encounter rate and an OB cost-based payment. The OB payment is calculated from costs uniquely associated with OB delivery services and which were not used in the calculation of a clinic's PPS medical encounter rate as outlined in the State Plan, Attachment 4.19B:

(a) Qualification of the OB APM delivery encounter rate is not considered a change of scope.

(b) The Medicare Economic Index (MEI) adjustment, as required by the PPS, will apply to the OB APM delivery encounter rate once established.

(c) OMAP will use the information listed below to determine the eligible RHC's initial OB payment. With the written request for an OB APM delivery encounter rate, both an existing and new clinic must provide:

(A) Total number of delivery encounters;

(B) Malpractice premiums for all physicians and certified nurses performing OB deliveries for the current and next year; and

(C) On-call time coverage.

(d) Delivery encounters include vaginal and cesarean delivery professional services provided by the RHC:

(A) Clinics performing deliveries prior to written request for an OB APM delivery encounter rate must provide the most recent full year of claims data for deliveries; and

(B) Clinics that have not previously provided delivery services must provide a reasonable projection of delivery encounters for the forecasted year.

(C) Clinics with actual or projected delivery encounters less than 100, will have their OB payment calculated using a base number of 100 OB delivery encounters.

(e) OMAP will calculate an additional projected cost of malpractice (liability) premiums to be included in the OB cost-based payment, outside of costs included and which have already been accounted for in the PPS medical encounter rate, as follows:

(A) For both an existing and new clinic, OMAP will calculate malpractice premiums that are based on the average costs for the current and next year based on the date the clinic applies for the OB APM delivery encounter rate, as projected by the RHC's malpractice carrier. Costs are the premiums the clinic or individual actually pays, accounting for any reductions or credits.

(B) For existing clinics, OMAP will determine the malpractice premiums reported for physicians and certified nurses performing OB deliveries when the RHC initially enrolled with OMAP and the PPS medical encounter rate was calculated. Premium amounts used in the initial PPS medical encounter rate calculation will be adjusted by the MEI for each subsequent year of enrollment, up to the year of written request for an OB APM delivery encounter rate. The premium(s) adjusted by MEI is an amount included in the current PPS medical encounter rate.

(C) For new clinics, OMAP will determine the actual malpractice premiums for OB physicians and certified nurses performing OB deliveries for the current year.

(D) OMAP will subtract the premiums calculated in either (B) or (C) above, and accounted for in the calculation of the clinic's PPS medical encounter rate, from the average cost of OB malpractice premiums in (A) above, to calculate the projected portion of OB malpractice premiums to be included in calculating the OB payment.

(f) OMAP will calculate the cost of physician on-call time for OB care by multiplying a clinic's adjusted OB on-call hours of coverage by the fixed rate of $20.00 per hour. A clinic's adjusted OB on-call coverage hours will be calculated as follows:

(A) Reducing total clinic coverage hours per year by the clinic's daily office hours; and

(B) Reduced by physician vacation hours; and

(C) Calculated at 60 percent of adjusted on-call time.

(g) The OB payment will be the sum of the difference of averaged malpractice premiums and current actual premiums (e), and the cost of on-call coverage (f), divided by the total number of OB care delivery encounters (d).

(h) The OB APM delivery encounter rate is the sum of the OB payment (g) and the PPS medical encounter rate.

(6) After OMAP has calculated the initial OB APM delivery encounter rate OMAP will inform the RHC.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
Hist.: OMAP 18-2005(Temp), f. 3-15-05, cert. ef. 3-18-05 thru 9-1-05; OMAP 26-2005, f. 4-20-05, cert. ef. 6-1-05; OMAP 48-2005(Temp), f. & cert. ef. 9-15-05 thru 2-15-06

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**Adm. Order No.:** OMAP 49-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 10-1-05 thru 3-15-06
**Notice Publication Date:**
**Rules Amended:** 410-120-1295
**Subject:** The General Rules Program administrative rules govern Office of Medical Assistance Programs' (OMAP) payment for services provided to clients. OMAP temporarily amended OAR 410-120-1295 to reference the reimbursement documents: FCHP Non-Contracted DRG Hospital Reimbursement Rates, effective for services rendered October 1, 2005 through December 31, 2005. This document is necessary to apply the formula established by the reimbursement methodology in ORS 414.743 and is referenced in rule to give correct and appropriate information to hospitals and managed care organizations when applying the formula to claims for reimbursement for services rendered to medical assistance clients. The statute is based upon the budget period that coordinates with the managed care and OMAP contracts. The effective date of the contracts

coincides with the effective date of the reimbursement rate documents, therefore OMAP temporarily amended the rule effective October 1, 2005.

**Rules Coordinator:** Darlene Nelson—(503) 945-6927

**410-120-1295**
**Non-Participating Provider**

(1) For purposes of this rule, a Provider enrolled with the Office of Medical Assistance Programs (OMAP) that does not have a contract with an OMAP-contracted managed care plan is referred to as a Non-Participating Provider.

(2) For covered services that are subject to reimbursement from the managed care plan, a Non-Participating Provider, other than a hospital governed by (3)(b) below, must accept from the OMAP-contracted managed care plan, as payment in full, the amount that the provider would be paid from OMAP if the client was fee-for-service.

(3) The OMAP-contracted Fully Capitated Health Plan (FCHP) that does not have a contract with a Hospital, is required to reimburse, and Hospitals are required to accept as payment in full the following reimbursement:

(a) The FCHP will reimburse a non-participating Type A and Type B Hospital fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the capitation rates paid to the FCHP for the contract period (ORS 414.727).

(b) All other non-participating hospitals, not designated as a rural access or Type A and Type B Hospital, for dates of service on or after October 1, 2003 reimbursement will be based upon the following:

(i) Inpatient service rates are based upon the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(ii) Outpatient service rates are based upon the capitation rates developed for the budget period, at the level of charges, multiplied by the statewide average cost to charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(4) The geographic factor, and the statewide average unit costs for inpatient service rates for subsection (3)(b)(i) and for outpatient service rates for subsection (3)(b)(ii), are calculated by the Department's contracted actuarial firm.

(a) The FCHP Non-Contracted DRG Hospital Reimbursement Rates document, dated October 1, 2003, is effective for dates of service October 1, 2003 through September 30, 2004, and is posted on the Department's Website at www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html;

(b) The FCHP Non-Contracted DRG Hospital Reimbursement Rates document, dated October 1, 2004, is effective for dates of service October 1, 2004 through September 30, 2005, and is posted on the Department's Website at www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html;

(c) The FCHP Non-Contracted DRG Hospital Reimbursement Rates document, dated October 1, 2005, is effective for dates of service October 1, 2005 through December 31, 2005, and is posted on the Department's Website at www.dhs.state.or.us/policy/healthplan/guides/hospital/main.html.

(5) A non-participating hospital must notify the FCHP within 2 business days of an FCHP patient admission when the FCHP is the primary payer. Failure to notify does not, in and of itself, result in denial for payment. The FCHP is required to review the hospital claim for medical appropiateness, compliance with emergency admission or prior authorization policies, member's benefit package, the FCHP contract and Oregon Administrative Rules.

(6) After notification from the non-participating hospital, the FCHP may

(a) Arrange for a transfer to a contracted facility, if the patient is medically stable and the FCHP has secured another facility to accept the patient;

(b) Perform concurrent review; and/or

(c) Perform case management activities.

(7) In the event of a disagreement between the FCHP and Hospital, the provider may appeal the decision as an administrative review as specified in OAR 410-120-1580.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.743
Hist.: OMAP 10-2001, f. 3-30-01, cert. ef. 4-1-01; OMAP 22-2004, f. & cert. ef. 3-22-04; OMAP 23-2004(Temp), f. & cert. ef. 3-23-04 thru 8-15-04; OMAP 33-2004, f. 5-26-04, cert. ef. 6-1-04; OMAP 75-2004(Temp), f. 9-30-04, cert. ef. 10-1-04 thru 3-15-05; OMAP 4-2005(Temp), f. & cert. ef. 2-9-05 thru 7-1-05; OMAP 33-2005, f. 6-21-05, cert. ef. 7-1-05; OMAP 35 2005, f. 7-21-05, cert. ef. 7-22-05; OMAP 49-2005(Temp), f. 9-15-05, cert. ef. 10-1-05 thru 3-15-06

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**Department of Human Services, Self-Sufficiency Programs Chapter 461**

**Adm. Order No.:** SSP 10-2005(Temp)
**Filed with Sec. of State:** 8-29-2005
**Certified to be Effective:** 8-29-05 thru 2-25-06
**Notice Publication Date:**
**Rules Amended:** 461-135-0701, 461-155-0210
**Subject:** Rules 461-135-0701 and 461-155-0210 are being amended to reflect the termination of the General Assistance (GA) program effective October 1, 2005. This program provided cash and medical assistance to individuals with severe physical or mental impairments who were waiting for their Supplemental Security Income (SSI) benefits to be approved by the Social Security Administration (SSA). The General Funds expenditures used to provide a monthly cash payment for indigent individuals with disabling conditions who met the disability and financial requirements for GA were reimbursed to the State when the client became eligible for SSI. These rule changes explain that General Assistance cash benefits will cease after September 30, 2005, that clients will receive OHP Plus medical benefits or OHP Standard benefits as directed by OARs 461-125-0370 and 410-120-1210, and that the GA Payment Standard will be reduced to $0 effective October 1, 2005.
**Rules Coordinator:** Annette Tesch—(503) 945-6067

**461-135-0701**
**Terminate GA and GAM Programs October 1, 2005**

(1) Effective October 1, 2005, the General Assistance (GA) and General Assistance Medical (GAM) programs are not funded. Notwithstanding any other rule of the Department, these programs are closed effective October 1, 2005.

(2) Effective September 30, 2005, all persons eligible for or receiving benefits of the GA or GAM programs become ineligible for these programs. Except as provided in section (4) of this rule, the Department will not authorize or provide any benefit under the GA or GAM programs after September 30, 2005.

(3) Effective October 1, 2005, all GA recipients who receive medical assistance through the OSIPM program will continue to receive OHP Plus benefits through the OSIPM program.

(4) October 1, 2005, all recipients of medical assistance through the GAM program who became ineligible for GAM on September 30 because of the closure of the GAM program may receive OHP benefits as follows:

(a) Clients who have been determined to meet the eligibility requirements of the OSIPM program (*see* OAR 461-125-0370 and the OSIPM eligibility requirements in OAR 461 division 135) will receive the OHP Plus benefits package (*see* OAR 410-120-1210(2)(a)).

(b) Clients may also receive the OHP Plus benefits package for the period that:

(A) The Department has not previously made a determination about whether the client meets the disability requirements for OSIPM under OAR 461-125-0370 and the OSIPM eligibility requirements in OAR 461 division 135; and

(B) A determination is still pending about whether the client meets the disability requirements for OSIPM under OAR 461-125-0370 and the OSIPM eligibility requirements in OAR 461 division 135.

(c) Clients who do not qualify for the OHP Plus benefits may be eligible for the OHP-OPU program under the eligibility requirements set out in OAR 461 division 135, and if eligible, will receive the OHP Standard benefits package (*see* OAR 410-120-1210(2)(b)).

(5) Notwithstanding OAR 461-145-0410, GA payments are excluded from income for purposes of determining OHP eligibility.

Stat. Auth.: ORS 409.050 & 411.060
Stats. Implemented: ORS 411.010, 411.060, 411.710, 411.730 & 411.740
Hist.: AFS 21-2002(Temp), f. & cert. ef. 12-30-02 thru 6-27-03; SSP 12-2003, f. 5-29-03, cert. ef. 6-1-03; SSP 29-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 3-31-04; SSP 6-2004, f. & cert. ef. 4-1-04; SSP 10-2005(Temp), f. & cert. ef. 8-29-05 thru 2-25-06

**461-155-0210**
**Payment Standard; GA, GAM**

(1) Except as provided in section (2) of this rule the payment standard in the GA and GAM programs is as follows:

(a) The payment standard is $314 for a one-person need group and $628 for a two-person need group unless a different rate is specified in section (2) or (3) of this rule.

(b) The payment standard for a GA or GAM client living in a community-based care setting is $297 for room and board, plus $40 personal allowance for clothing and personal incidentals.

(c) For a client in a nursing facility, intermediate care facility for the mentally retarded, psychiatric training center, or an acute hospital for greater than 30 days, the payment standard is $30 for clothing and personal incidentals.

(2) Effective October 1, 2005, the payment standard in the GA and GAM programs is $0.

Stat. Auth.: ORS 409.050 & 411.060
Stats. Implemented: ORS 411.010, 411.060, 411.710, 411.730 & 411.740
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 16-1990, f. 6-29-90, cert. ef. 7-1-90; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 17-1993(Temp), f. & cert. ef. 9-1-93; AFS 29-1993, f. 12-30-93, cert. ef. 1-1-94; AFS 13-1994, f. & cert. ef. 7-1-94; AFS 13-1995, f. 6-29-95, cert. ef. 7-1-95; AFS 16-1995(Temp), f. 7-24-95, cert. ef. 8-1-95; AFS 21-1995, f. 9-20-95, cert. ef. 10-1-95; AFS 1-1996(Temp), f. 1-30-96, cert. ef. 2-1-96; AFS 10-1996, f. 3-27-96, cert. ef. 4-1-96; AFS 11-1997(Temp), f. & cert. ef. 8-1-97; AFS 13-1997, f. 8-28-97, cert. ef. 9-1-97; AFS 4-1998, f. 2-25-98, cert. ef. 3-1-98; AFS 10-1998, f. 6-29-98, cert. ef. 7-1-98; AFS 25-1998, f. 12-28-98, cert. ef. 1-1-99; AFS 10-1999, f. 7-29-99, cert. ef. 8-1-99; AFS 19-2000, f. 7-31-00, cert. ef. 8-1-00; AFS 16-2001(Temp), f. & cert. ef. 8-1-01 thru 9-30-01; AFS 22-2001, f. & cert. ef. 10-1-01; SSP 29-2003(Temp), f. 10-31-03, cert. ef. 11-1-03 thru 3-31-04; SSP 6-2004, f. & cert. ef. 4-1-04; SSP 10-2005(Temp), f. & cert. ef. 8-29-05 thru 2-25-06

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**Adm. Order No.:** SSP 11-2005(Temp)
**Filed with Sec. of State:** 9-1-2005
**Certified to be Effective:** 9-1-05 thru 12-31-05
**Notice Publication Date:**
**Rules Amended:** 461-135-0380, 461-190-0211, 461-190-0241
**Subject:** Rule 461-135-0380 is being amended to close the Employment Initiative (EI) program, effective October 1, 2005.

Rule 461-190-0211 is being amended to eliminate and remove references to TANF “at-risk” payments. At-risk payments are payments necessary to retain a job made to an individual who is at risk of qualifying for the TANF program because the individual is ineligible for TANF solely due to earned income.

Rule 461-190-0241 is being amended to add a provision that limits JOBS support service payments to a total of $1,000 for clients who are in the 12-month transition period after closing TANF. These support service payments cover child care, housing, transportation, and other necessary to retain a job. This amendment is a change to JOBS program policy.

**Rules Coordinator:** Annette Tesch—(503) 945-6067

**461-135-0380**
**Specific Requirements; Employment Initiative Program (EI)**

(1) Effective October 1, 2005, the Employment Initiative (EI) program is not funded. Notwithstanding any other rule of the Department, this program is closed effective October 1, 2005. Effective September 30, 2005, all persons eligible for or receiving benefits of the EI program become ineligible for EI. The Department will not authorize or provide any benefit under this program after September 30, 2005.

(2) The EI program helps clients with disabilities who want to work and who possess the abilities and desire to be gainfully employed. The help may be in the form of services that will assist clients overcome barriers to securing and maintaining employment or payments that will help clients secure or retain employment.

(3) To be eligible for the program, a person must be:

(a) Receiving Medicaid and SSI benefits based on disability;

(b) Receiving Medicaid and Social Security disability benefits;

(c) Enrolled in a vocational rehabilitation program sponsored by the Department under Chapter 344 of the Oregon Revised Statutes; or

(d) Receiving GA or GAM benefits.

(4) The program helps make services and training available to eligible clients to assist them in overcoming barriers to securing and maintaining employment. Services may include:

(a) Life skills training.

(b) Career exploration.

(c) Vocational training.

(d) Development of an acceptable plan for self support.

(e) Job development with local employers.

(f) Employer and community education to such issues as reasonable accommodation.

(g) Referral to state and community partners who will enhance the resources available to assist the client.

(5) Payment for EI expenditures will be authorized within the legislatively approved limitation and will be used to assist individuals with a disability to overcome barriers in securing and maintaining employment. Alternate funding sources must be pursued before payments will be authorized. Payments will be limited to services directly related to the individual’s employment.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060
Hist.: AFS 10-2002, f. & cert. ef. 7-1-02; SSP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**461-190-0211**
**Standards for Support Service Payments**

(1) The Department helps individuals comply with their case plans by providing payments for child care, housing, transportation, and other needs to make participation in required activities successful. These payments are provided for costs directly related to participation in activities, for costs necessary to obtain and retain a job, and for enhancing wages and benefits. In approving JOBS support service payments, the Department must consider lower-cost alternatives. It is not the intent of the Department or of this rule to supplant Department funding with other funding that is available in the community. It is the Department’s expectation that case managers and clients will work collaboratively to seek resources that are reasonably available to the client in order to participate in activities.

(2) Support service payments must be authorized in advance and are subject to the limitations of this rule. The following standards apply to support service payments.

(3) Subject to the limitations of state funding, JOBS payments for support service will be made available to an individual if all of the following are true:

(a) The individual is one of the following:

(A) A TANF applicant or recipient;

(B) A recipient in the Assessment program;

(C) A minor parent who has returned to the minor’s parent’s home in the last 40 days, if the move caused the client to become ineligible for TANF;

(D) A TANF client participating in diagnosis, counseling, or treatment programs for substance abuse or mental health;

(E) A non-citizen who is ineligible for TANF, who is legally able to work in the United States, and who has a child receiving TANF;

(F) A person disqualified from the TANF program for failure to comply with the child-support related requirements of OAR 461-120-0340 and 461-120-0345;

(G) A person eligible for transition benefits and services under OAR 461-190-0241;

(H) A person currently receiving TA-DVS benefits;

(I) A non-custodial parent of a child receiving TANF benefits, if both are residents of Oregon.

(b) The individual has agreed to participate in a JOBS activity as specified in the individual’s case plan.

(4) Denials and Reductions The Department may reduce, close, or deny in whole or in part an individual’s request for a support service payment in the following circumstances:

(a) If the individual is disqualified for failing to comply with a case plan, unless the payment in question is necessary for the client to comply with his or her case plan.

(b) If the purpose for the payment is not related to the individual’s case plan.

(c) If the client disagrees with a support service payment offered or made by the Department as outlined in the client’s *case plan*.

(5) Required Verification:

(a) The Department may require the individual to provide verification of a need for the support service prior to approval and issuance of payment if verification is reasonably available.

(b) The Department may require the individual to provide verification of costs associated with a support service if verification is reasonably available.

(6) Child Care Payments for child care are authorized, as limited by OAR 461-160-0040, if necessary to enable the individual to participate in JOBS program activities. If authorized, payment for child care will be made for:

(a) The lesser of the actual rate charged by the care provider and the rate established in OAR 461-155-0150. The Department rate for children in care less than 158 hours in a month is limited by OAR 461-155-0150,

except that the cost of child care may be paid up to the monthly maximum when children are in care less than 158 hours per month and:

(A) Appropriate care is not accessible to the individual at the hourly rate; or

(B) The individual is a teen parent using on-site care while attending education activities.

(b) The minimum hours necessary, including meal and commute time, for the individual to participate in JOBS activities or to obtain and maintain employment.

(7) Child care payments may be provided when individuals are not participating in activities of the JOBS program if necessary for them to retain their provider. Only the minimum amount necessary to maintain the child care slot with the provider may be covered as established in OAR 461-155-0150. Not more than 30 days between scheduled JOBS activities may be covered.

(8) Housing and Utilities In addition to payments for basic living expenses provided in OAR 461-135-0475, payments may be provided to secure or maintain housing and utilities in the following situations:

(a) To prevent an eviction or utility shut-off, to secure housing in order to find or maintain employment or to participate in activities listed in the individual's case plan. Payment is available when all the following are true:

(A) The individual cannot make a shelter or utility payment due to lack of assets.

(B) The lack of assets did not result from a JOBS or Child Support disqualification, a reduction due to an IPV recovery, overpayment recovery (other than administrative error), or failure by the individual to pay shelter or utility expenses when funds were reasonably available.

(C) The individual's case plan addresses how subsequent shelter or utility payments will be made.

(b) The shelter need results from domestic violence and all the following are true:

(A) The individual is not eligible for TA-DVS.

(B) The individual will be able to pay all subsequent shelter costs, either through the individual's own resources or through other resources available in the community.

(C) The individual's case plan addresses how subsequent shelter costs will be paid.

(c) For clients who are in the Assessment program or are applying for a payment under section (6) of this rule, the Department will make payments if the client meets the eligibility criteria in section (9) of this rule. A client who receives a TANF grant is expected to meet the housing and utility expenses out of the money received each month in the TANF grant. Therefore, for clients who receive a TANF grant, the Department may make payments on a case-by-case basis as appropriate if the client otherwise meets the JOBS support service payment eligibility criteria of this section.

(9) Transportation The Department will provide payments for transportation costs incurred in travel to and from JOBS activities. Payment is made only for the cost of public transportation or the cost of vehicle insurance, repairs, and fuel for a personally owned vehicle. The Department will not authorize payment for repair of a vehicle owned by an individual who is not in the TANF filing group. Payments are subject to the following considerations:

(a) Payments for public transportation are given priority over payments for a privately owned vehicle.

(b) Payment for a privately owned vehicle is provided if the client or driver has a valid license and either of the following is true:

(A) No public transportation is available or the client is unable to use public transportation because of a verifiable medical condition or disability for which no accommodation is available.

(B) Public transportation is available but is more costly than the cost of car repair or fuel.

(10) Other Payments The Department will provide payments for other items that are directly related to participation in JOBS activities. Payments under this section may be authorized for:

(a) Reasonable accommodation of a client's disability.

(b) Costs necessary in obtaining and retaining a job or enhancing wages and benefits, such as:

(A) Clothing and grooming for participation in JOBS activities or job interviews.

(B) Moving expenses necessary to accept employment elsewhere.

(C) Books and supplies for education needs.

(D) Tools, bonding, and licensing required to accept or retain employment.

(11) Students Receiving Financial Aid Authorization for payments for students in vocational training who receive financial aid is subject to the following conditions:

(a) A student whose financial aid consists solely of student loans is not required to use any of that financial aid for support services.

(b) Support service payments are not authorized for services specifically covered by federal or state financial aid other than student loans.

(c) Students whose financial aid consists of a combination of loans and grants may be required to pay for support services from any grant money remaining after payment of tuition, fees solely related to the institution where the individual attends, books, and supplies (applying first the loan and then any grants) if the financial aid award letter specifically permits this use of funds.

Stat. Auth.: ORS 411.060
Stats. Implemented: ORS 411.060 & 418.100
Hist.: AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 30-1990, f. 12-31-90, cert. ef. 1-1-91; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 20-1992, f. 7-31-92, cert. ef. 8-1-92; AFS 12-1993, f. & cert. ef. 7-1-93; AFS 19-1993, f. & cert. ef. 10-1-93; AFS 26-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 36-1996, f. 10-31-96, cert. ef. 11-1-96; AFS 18-1998, f. & cert. ef. 10-2-98; AFS 2-1999, f. 3-26-99, cert. ef. 4-1-99; AFS 3-2000, f. 1-31-00, cert. ef. 2-1-00; SSP 33-2003, f. 12-31-03, cert. ef. 1-4-04; SSP 21-2004, f. & cert. ef. 10-1-04; SSP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

**461-190-0241**
**Transition Services; JOBS**

(1) A client who becomes ineligible for the TANF program or the Assessment program because of an increase in earned income is eligible for transition benefits and services for 12 months upon meeting the criteria in OAR 461-190-0211 for receiving support services in the JOBS program. The total cost of JOBS support service payments may not exceed $1,000 for the duration of the 12-month period. For clients whose eligibility ends for reasons other than income from new employment, the benefits and services are limited to completing any JOBS *activity* in progress at the time program eligibility ends.

(2) The transition period begins on the date determined by the following:

(a) For clients participating in an *OJT activity*, the transition period begins:

(A) When TANF benefits end because of earned income, if there are three or fewer months left in the *OJT* contract.

(B) Three calendar months before the end of the *OJT* contract, if TANF benefits end because of the level of earned income when more than three months remain in the contract.

(b) For clients participating in a *work supplementation activity*, the transition period begins when the wage subsidy (grant diversion) to the employer ends.

(c) For all other clients, the transition period begins when TANF or Assessment program benefits end.

Stat. Auth.: ORS 411.060 & 411.816
Stats. Implemented: ORS 411.060
Hist.: AFS 23-1990, f. 9-28-90, cert. ef. 10-1-90; AFS 9-1991, f. 3-29-91, cert. ef. 4-1-91; AFS 13-1991, f. & cert. ef. 7-1-91; AFS 23-1991(Temp), f. 10-31-91, cert. ef. 11-1-91; AFS 4-1992, f. 2-28-92, cert. ef. 3-1-92; AFS 28-1992, f. & cert. ef. 10-1-92; AFS 27-1996, f. 6-27-96, cert. ef. 7-1-96; AFS 9-1997, f. & cert. ef. 7-1-97; AFS 18-1998, f. & cert. ef. 10-2-98; AFS 25-1998, f. 12-28-95, cert. ef. 1-1-98; SSP 21-2004, f. & cert. ef. 10-1-04; SSP 11-2005(Temp), f. & cert. ef. 9-1-05 thru 12-31-05

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**Department of Justice**
**Chapter 137**

**Adm. Order No.:** DOJ 7-2005
**Filed with Sec. of State:** 8-16-2005
**Certified to be Effective:** 9-2-05
**Notice Publication Date:** 5-1-05
**Rules Adopted:** 137-009-0125, 137-009-0130, 137-009-0135, 137-009-0140, 137-009-0145, 137-009-0150, 137-009-0155, 137-009-0160, 137-009-0165
**Rules Repealed:** 137-009-0000, 137-009-0005, 137-009-0010, 137-009-0045, 137-009-0060, 137-009-0065, 137-009-0100, 137-009-0120
**Subject:** The Department may contract for the services of special legal assistants or private counsel to provide legal services otherwise required by law to be performed by the Attorney General. These rules specify the screening and selection procedures the Department will use to establish personal services contracts with individuals or entities to perform such services. Previous rules substantially identical to the rules being adopted expired by operation of law when the new

Public Procurement Code became effective on March 1, 2005 and are being repealed. The only change in text between the expired/repealed rules and the rules being adopted are corrections to references to rule numbers and the addition of references to the successor to the Department of Administrative Services' VIP System.
**Rules Coordinator:** Carol Riches—(503) 378-6313

**137-009-0125**
**Purpose**

The Department may contract for the services of special legal assistants or private counsel to provide legal services otherwise required by law to be performed by the Attorney General. These rules specify the screening and selection procedures the Department will use to select individuals or entities to perform such services.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0130**
**Definitions**

For purposes of OAR chapter 137, division 009, these terms have the following meanings:

(1) "Attorney General" means the Attorney General of the State of Oregon.

(2) "Contractor" means an individual or entity that is obligated under a contract with the Department to provide legal services required by law to be performed by the Attorney General.

(3) "Department" means the Department of Justice of the State of Oregon.

(4) "Deputy" means the Deputy Attorney General, appointed by the Attorney General to that position pursuant to ORS 180.130.

(5) "Designated Practice Areas" means subject matter areas generally recognized within the legal profession as requiring specialized knowledge of a particular field of law.

(6) "Lowest Overall Cost" means the lowest cost to the state taken as a whole including the prospective Contractor's hourly rates (or other billing methods), available resources, expertise, and ability to accomplish an optimal, timely outcome to a particular matter.

(7) "Master Agreement" means a document that contains contractual provisions that will be included in certain future contracts between the parties. Each future contract will provide detail on scope of services, delivery terms, not-to-exceed amounts and other items necessary to establish a definite contract. A Master Agreement is not a contract, but is a document of understanding between the Department and an individual or entity.

(8) "Solicitation" means a written or oral request for offers, proposals, statements of qualifications, or other information from individuals or entities.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0135**
**Policy**

The policy of the Department is to select Contractors in an expeditious and efficient manner that is consistent with the goal of delivering highly competent legal services at the Lowest Overall Cost to the State of Oregon.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0140**
**Methods for Selecting Contractors**

(1) The Department will use one of the following methods to select a Contractor:

(a) The Department may select a Contractor from a list of individuals or entities established for a Designated Practice Area as set forth in OAR 137-009-0145.

(b) The Department may select a Contractor from a group of respondents to a specific matter Solicitation as set forth in OAR 137-009-0150.

(c) The Department may select a Contractor through direct negotiation as set forth in OAR 137-009-0160.

(2) Nothing in this section shall prevent the Department from entering into an amendment to a contract for legal services according to its terms.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0145**
**Procedure to Develop Lists of Individuals or Entities under Master Agreements**

(1) The Department may use a Solicitation to request proposals or information that describes general or specific legal services to be performed within a defined period of time. The purpose of such a Solicitation is to establish a list of individuals or entities under Master Agreements for a specified period of time to provide legal services within Designated Practice Areas as requested by the Department and agreed to by the individual or entity.

(a) The Department shall provide notice of the Solicitation on the VIP System or its successor operated by the Department of Administrative Services or in any other manner the Department deems appropriate to provide notice to a sufficient number of individuals or entities to develop adequate lists of available individuals or entities.

(b) In accordance with ORS 200.035, the Department will notify the Advocate for Minority, Women and Emerging Small Businesses.

(2) The evaluation criteria in the Solicitation may include, without limitation, consideration of the following factors:

(a) Availability and capability to perform the work;

(b) Fees or costs, including proposed discounts from rates generally charged other clients;

(c) Geographic proximity to the location where the legal services will primarily be performed;

(d) Ethical considerations, such as the existence of conflicts of interest;

(e) Recommendations of subject matter experts, such as client agency representatives with special knowledge or insights into necessary or desirable non-legal knowledge or background;

(f) Any other criteria the Department determines relevant to the provision of legal services.

(3) In weighing the factors set forth above, no single factor shall be determinative. But if one factor strongly suggests the Department should enter into a Master Agreement with a proposer with respect to a Designated Practice Area, it may outweigh one or more other factors that favor other proposers.

(4) The Department may either sign a Master Agreement with qualified individuals or entities in particular Designated Practice Areas or cancel the Solicitation.

(5) For purposes of subsection (1)(b) of this section, if the Department has notified the Advocate for Minority, Women and Emerging Small Businesses of its intent to use the VIP System or its successor as its official vehicle for notifying the Advocate about opportunities to contract to provide legal services, the Department may satisfy the requirement for notice to the Advocate for Minority, Women and Emerging Small Businesses by posting the notice on the VIP System or its successor for at least five calendar days.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5), 200.035 & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0150**
**Solicitation to Engage a Contractor to Provide Legal Services for a Specific Matter**

The Department may use a Solicitation to request proposals to provide legal services on a specific matter:

(1) The Department may provide notice of the Solicitation in any manner the Department deems appropriate to provide notice to a sufficient number of individuals or entities, but in no event shall notice of a Solicitation under this section be provided to fewer than three prospective proposers.

(2) In accordance with ORS 200.035, the Department will notify the Advocate for Minority, Women and Emerging Small Businesses. For purposes of this subsection, if the Department has notified the Advocate for Minority, Women and Emerging Small Businesses of its intent to use the VIP System or its successor as its official vehicle for notifying the Advocate about opportunities to contract to provide legal services, the Department may satisfy the requirement for notice to the Advocate for Minority, Women and Emerging Small Businesses by posting the notice on the VIP System or its successor for at least five calendar days.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5), 200.035 & 279A.025(2)(j)

Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0155**
**Criteria for Selection of Contractor for Specific Matter under OAR 137-009-0145 or 137-009-0150**

(1) If the Department decides to select a Contractor for a specific matter from a list of individuals or entities developed pursuant to OAR 137-009-0145, or from among the proposers to a Solicitation under OAR 137-009-0150, the Department will use the evaluation process described in this section.

(2) The Department will make its selection decision based on an evaluation of factors that the Department determines appropriate in any particular instance, which may include, without limitation:

(a) The experience and level of expertise of Contractor and Contractor's available personnel, as determined by the Department, in the Designated Practice Area and for the type of legal services the Department requires;

(b) Whether the Contractor's available personnel possess any required licenses or certifications required to perform the legal services for the specific matter, such as licenses to practice law in the appropriate jurisdiction, or license to appear in a certain forum;

(c) The legal and business constraints or requirements, if any, imposed by particular characteristics of the matter for which the Department seeks legal services;

(d) The extent and nature of any likely conflicts of interest that exist or could arise if Contractor provided legal services with respect to a particular matter;

(e) The training, expertise, temperament, style and experience of the particular Contractor personnel available to perform work on the specific matter and the training, expertise, temperament, style and experience of the particular State of Oregon agency personnel that will be working on the matter with the Contractor's personnel;

(f) Recommendations of subject matter experts, such as client agency representatives with special knowledge or insights into necessary or desirable non-legal knowledge or background.

(g) Lowest Overall Cost; or

(h) Other factors the Department considers relevant to the selection of a Contractor to provide particular legal services.

(3) In weighing the evaluation factors, no single factor shall be determinative, but Lowest Overall Cost always will be considered.

(4) To reduce the Lowest Overall Cost to the state, the Department should select a Contractor from the list of firms established under OAR 137-009-0145 when the work is within an individual's or entity's Designated Practice Area under a Master Agreement and the Department determines:

(a) The administrative cost of selecting a Contractor under OAR 137-009-0150 outweighs potential cost savings under that process;

(b) The services are likely to be integrally related to other services provided by the Contractor under a Master Agreement, resulting in greater economy and efficiency; or

(c) The Department's need for services is of such urgency that selecting a Contractor under OAR 137-009-0150 would result in unacceptable delay.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0160**
**Direct Negotiation and Contracting**

(1) The Department may directly negotiate and enter into contracts with Contractors to provide legal services without following the procedures set forth in OAR 137-009-0145 through 137-009-0155 in the following circumstances:

(a) The contract's maximum consideration does not exceed $25,000;

(b) The subject matter of the representation is highly confidential, and there is a substantial risk that the interests of the State of Oregon or the Department would be adversely affected by a more public Solicitation;

(c) The subject matter of the representation is highly time sensitive, and there is a substantial risk that the interests of the State of Oregon or the Department would be adversely affected by any delay in obtaining a Contractor;

(d) The cost of the representation will be borne in whole or in part by a nonstate entity and the nonstate entity has a legal right to influence selection of legal counsel; or

(e) Any other situation in which the Attorney General or the Deputy determines that the interests of the Department or the State of Oregon are best served by direct negotiation and contracting with Contractors.

(2) In directly negotiating and entering into a contract with a Contractor, the Department shall consider Lowest Overall Cost.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

**137-009-0165**
**Repealed Rules**

As required by Or Laws 2003, chapter 794, section 334, OAR 137-009-0000, 137-009-0005, 137-009-0010, 137-009-0045, 137-009-0060, 137-009-0065, 137-009-0100 and 137-009-0120 are repealed.

Stat. Auth.: ORS 180.140(5), 183.310(9) & 279A.025(2)(j)
Stats. Implemented: ORS 180.140(5) & 279A.025(2)(j)
Hist.: DOJ 3-2005(Temp), f. & cert. ef. 3-18-05 thru 9-2-05; DOJ 7-2005, f. 8-16-05, cert. ef. 9-2-05

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**Adm. Order No.:** DOJ 8-2005(Temp)
**Filed with Sec. of State:** 9-1-2005
**Certified to be Effective:** 9-1-05 thru 2-17-06
**Notice Publication Date:**
**Rules Adopted:** 137-055-6021
**Rules Amended:** 137-055-1070, 137-055-1120, 137-055-1140, 137-055-1160, 137-055-1180, 137-055-3240, 137-055-3420, 137-055-3430, 137-055-3440, 137-055-3490, 137-055-3500, 137-055-4120, 137-055-4540, 137-055-5020, 137-055-5110, 137-055-5120, 137-055-5240, 137-055-5400, 137-055-5510, 137-055-5520, 137-055-6200
**Rules Suspended:** 137-055-5125
**Subject:** The changes to OARs 137-055-1070; 137-055-1120; 137-055-1140; 137-055-1160; 137-055-1180; 137-055-3240; 137-055-3420; 137-055-3430; 137-055-3440; 137-055-3490; 137-055-3500; 137-055-4120; 137-055-4540; 137-055-5020; 137-055-5110; 137-055-5120; 137-055-5240; 137-055-5400; 137-055-5510; 137-055-5520; 137-055-6200, adoption of OAR 137-055-6021, and suspension of OAR 137-055-5125 are to implement the changes to ORS 107.108 from Senate Bill 1050. The changes to ORS 107.108 are effective September 1, 2005, and these temporary rule changes will suspend, adopt and amend child attending school requirements as outlined in the amended statute.
**Rules Coordinator:** Shawn Brenizer—(503) 986-6240

**137-055-1070**
**Provision of Services**

(1) For the purposes of this rule, the following definitions apply:

(a) "Full services case" means a case in which the full range of support enforcement services required under ORS 25.080(4) are provided;

(b) "Limited services case" means a case in which the provisions of ORS 25.080 do not apply and one or more collection, accounting, distribution or enforcement services are provided pursuant to state or federal law;

(c) "Party" means an obligor, obligee and a child who qualifies as a child attending school under OAR 137-055-5110.

(2) When any Oregon court order for child and/or spousal support is received, the administrator shall:

(a) If the order requires payment of child support or child and spousal support and seeks collection, accounting, distribution and enforcement services:

(A) Create a full services case on the Child Support Enforcement Automated System (CSEAS) if one does not already exist;

(B) Initiate appropriate enforcement action; and

(C) Send the parties the information required in OAR 137-055-1060(4).

(b) If the order requires payment of spousal support only and seeks collection, accounting, distribution and enforcement services:

(A) Create a limited services case on the CSEAS if one does not already exist;

(B) If applicable, add arrears under ORS 25.015 or establish arrears under ORS 25.167; and

(C) Initiate income withholding under ORS 25.372 to 25.427.

(c) If the order is silent, unclear or contradictory on the services to be provided and no application or other written request for support enforcement services has been received:

(A) Create an information only case on the CSEAS for the state case registry if one does not already exist; and

(B) Send the parties a letter explaining that no services will be provided and why. The letter must include a statement that the parties may apply for support enforcement services at any time if the order includes a provision for child support.

(d) If the order seeks only payment through the Department of Justice and no application or other written request for support enforcement services has been received:

(A) Create an information only case on the CSEAS for the state case registry, if one does not already exist, to receive and distribute payments in accordance with OAR 137-055-6020; and

(B) Send the parties a letter explaining that the program will only provide distribution of support payments and why. The letter must include a statement that the obligor or obligee may apply for support enforcement services at any time if the order includes a provision for child support.

(e) If the provisions of subsection (c) or (d) apply and a party subsequently completes an application or other written request for support enforcement services, the administrator shall process the application or request in accordance with OAR 137-055-1060.

(3) When a person applies for services under OAR 137-055-1060 for establishment or enforcement of a child support order, the case is a full services case.

(a) The administrator will perform all mandated services under state and federal law; and

(b) The administrator will determine which non-mandated services will be provided, but may consider input from the applicant in making that determination.

(4)(a) When a person applies for services under OAR 137-055-1060 and there is more than one parent who may be obligated to pay support, the applicant may apply for services:

(A) To establish and collect support from only one parent; or

(B) To establish and collect support from more than one parent.

(b) A separate application under OAR 137-055-1060 is required for each parent the applicant wishes to pursue.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 25.020, 25.080, 25.140, 25.164 & 107.108
Hist.: AFS 20-2002, f. 12-20-02 cert. ef. 1-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-1070; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-1070; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-1120**
**Case Closure**

(1) The administrator may close a child support case, whenever the case meets at least one of the following criteria for case closure:

(a) There is no longer a current support order, and arrears are under $500 and there are no reasonable expectations for collection or the arrears are uncollectible under state law;

(b) The non-custodial parent or putative father is deceased and no further action, including a levy against the estate, can be taken;

(c) Paternity cannot be established because:

(A) A parentage test, or a court or administrative process, has excluded the putative father and no other putative father can be identified;

(B) In a case involving incest or forcible rape, or where legal proceedings for adoption are pending, the Department of Human Services (DHS) or the administrator has determined that it would not be in the best interests of the child to establish paternity; or

(C) The identity of the biological father is unknown and cannot be identified after diligent efforts, including at least one interview by the administrator with the recipient of services;

(D) Action to establish paternity has not been initiated and the child is at least 18 years old.

(d) The location of the non-custodial parent is unknown, and the state parent locator service has made regular attempts using multiple sources, all of which have been unsuccessful, to locate the non-custodial parent:

(A) Over a three-year period when there is sufficient information to initiate an automated locate effort; or

(B) Over a one-year period when there is not sufficient information to initiate an automated locate effort.

(e) When paternity is not at issue and the non-custodial parent cannot pay support for the duration of the child's minority because the parent is both:

(A) Institutionalized in a psychiatric facility, is incarcerated with no chance for parole, or has a medically verified total and permanent disability with no evidence of support potential; and

(B) Without available income or assets which could be levied or attached for support.

(f) The non-custodial parent:

(A) Is a citizen of, and lives in, a foreign country;

(B) Does not work for the Federal government or for a company or state with headquarters in or offices in the United States;

(C) Has no reachable income or assets in the United States; and

(D) Oregon has been unable to establish reciprocity with the country.

(g) The state parent locator service has provided location-only services based upon a request under 45 CFR 302.35(c)(3);

(h) The custodial parent or recipient of services requests closure, and:

(A) There is no assignment to the state of medical support; and

(B) There is no assignment of arrears that have accrued on the case.

(i) The custodial parent or recipient of services is deceased and no trustee or personal representative has requested services to collect arrears;

(j) DHS or the administrator pursuant to OAR 137-055-1100(2), has made a finding of good cause or other exceptions to cooperation and has determined that support enforcement may not proceed without risk or harm to the child or caretaker;

(k) In a non-TANF case (excluding a Medicaid case), the administrator is unable to contact the custodial parent, or recipient of services, within 60 calendar days, despite an attempt of at least one letter sent by first class mail to the last known address;

(l) In a non-TANF case, the administrator documents the circumstances of non-cooperation by the custodial parent, or recipient of services, and an action by the custodial parent, or applicant for services, is essential for the next step in providing enforcement services; or

(m) The administrator documents failure by the initiating state to take an action which is essential for the next step in providing services.

(2)(a)(A) Except as otherwise provided in this section, if the administrator elects to close a case pursuant to subsection (1)(a), (1)(e), (1)(f), (1)(h), (1)(i) or (1)(k) through (1)(m) of this rule, the administrator will notify all parties to the case, which may include a child who qualifies as a child attending school under OAR 137-055-5110, in writing at least 60 calendar days prior to closure of the case of the intent to close the case.

(B) If the administrator elects to close a case pursuant to subsection (1)(b) through (1)(d) of this rule, the administrator:

(i) Will notify the obligee, and any child attending school, in writing at least 60 days prior to closure of the case of the intent to close the case;

(ii) Is not required to notify the obligor of the intent to close the case; and

(iii) If the provisions of paragraph (1)(c)(D) apply, is not required to notify any other party.

(C) If the administrator elects to close a case pursuant to subsection (1)(g) of this rule, the administrator is not required to notify either obligee or obligor of the intent to close the case.

(D) If the administrator elects to close a case pursuant to subsection (1)(h) of this rule, the administrator will notify all parties to the case in writing at least 60 calendar days prior to closure of the case of the intent to close the case, except:

(i) When the case is a Child Welfare or Oregon Youth Authority case in which the child has left state care, an order under OAR 137-055-3290 is not appropriate, and a notice and finding has not been initiated, the case will be closed immediately; and

(ii) No closure notice will be sent to the parties unless a party had contact with the Child Support Program, Child Welfare or the Oregon Youth Authority regarding the child support case.

(E) If the administrator elects to close a case pursuant to subsection (1)(j) of this rule, the administrator will:

(i) notify the obligee, and any child attending school, in writing at least 60 days prior to closure of the case of the intent to close the case; and

(ii) not notify the obligor of the intent to close the case.

(b) The 60-day time frame in paragraph (2)(a)(A) is independent of the 60-day calendar time frame in subsection (1)(k).

(c) The administrator will document the notice of case closure by entering a narrative line, or lines, on the child support computer system and will include the date of the notice.

(d) The content of the notice in paragraph (2)(a)(A) must include, but is not limited to, the specific reason for closure, actions a party can take to prevent closure, and a statement that an individual may reapply for services at any time.

(3) Notwithstanding paragraph (2)(a)(A) of this rule, a case may be closed immediately if:

(a) All parties agree to waive the notice of intent to close and the 60-day objection period when the notice of intent to close has not yet been sent; or

(b) All parties agree to waive the remainder of the 60-day objection period when the notice of intent to close has already been sent.

(4) The administrator will keep a case open if, in response to the notice sent pursuant to paragraph (2)(a)(A) of this rule:

(a) The applicant or recipient of services:

(A) Supplies information which could lead to the establishment of paternity or of a support order, or enforcement of an order; or

(B) Reestablishes contact with the administrator, in cases where the administrator proposed to close the case under subsection (1)(k) of this rule; or

(b) The party who is not the applicant or recipient of services completes an application for services.

(5) A party may request at a later date that the case be reopened if there is a change in circumstances that could lead to the establishment of paternity or a support order, or enforcement of an order, by completing a new application for services.

(6) The administrator will document the justification for case closure by entering a narrative line or lines on the child support computer system in sufficient detail to communicate the basis for the case closure.

Stat. Auth.: ORS 25.080 & 180.345
Stats. Implemented: ORS 25.020 & 25.080
Hist.: AFS 35-1986(Temp), f. & ef. 4-14-86; AFS 66-1986, f. & ef. 9-19-86; AFS 27-1988, f. & cert. ef. 4-5-88; AFS 66-1989, f. 11-28-89, cert. ef. 12-1-89, Renumbered from 461-035-0055; AFS 15-1993, f. 8-13-93, cert. ef. 8-15-93; AFS 13-1999, f. 10-29-99, cert. ef. 11-1-99; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0050; AFS 2-2001, f. 1-31-01, cert. ef. 2-1-01; AFS 28-2001, f. 12-28-01, cert. ef. 1-1-02; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-1120; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-1120; DOJ 4-2005, f. & cert. ef. 4-1-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-1140**
**Confidentiality of Records in the Child Support Program**

(1)(a) As used in this rule, “employee” means a person employed by the Department of Justice (DOJ) or a district attorney office that provides Child Support Program (CSP) services;

(b) “Party” means any party to a support or paternity case, which may include a child who qualifies as a child attending school under OAR 137-055-5110, or a party’s attorney.

(2) For purposes of this rule, and subject to the limitations set forth in section (3) of this rule, the contents of a case record include, but are not limited to:

(a) The names of the obligor, beneficiary and obligee or other payee;

(b) The addresses of the obligor, beneficiary and obligee or other payee;

(c) The address of record and address of service of the obligee, beneficiary or obligor;

(d) The name and address of the obligor’s employer;

(e) The social security numbers of the obligor, the obligee and beneficiaries;

(f) The record of all legal and collection actions taken on the case;

(g) The record of all accrual and billings, payments and distribution of payments;

(h) The narrative record; and

(i) The contents of any paper file maintained for purposes of establishment and/or enforcement of a child support order or for accounting purposes.

(3) Any data listed in section (2) of this rule or any other data that resides on the Child Support Enforcement Automated System (CSEAS) that is extracted from computer interfaces with other agencies’ computer systems is not considered to be child support information until or unless the data is used for child support purposes. Until such data is used for child support purposes it is not subject to any exceptions to confidentiality and it may not be released to any other person or agency in any circumstance, except as provided in ORS 25.260(5) and as may be provided in other agency rule.

(4) Child support case related records, files, papers and communications are confidential and may not be disclosed or used for purposes other than those directly connected to the administration of the CSP except:

(a) Information may be shared as provided in ORS 25.260(5), OAR 137-055-1320 and 137-055-1360 and as may be provided in other agency rule;

(b) Information may be shared for purposes of any investigation, prosecution or criminal or civil proceeding conducted in connection with the administration of:

(A) Title IV-D of the Social Security Act, child support programs in Oregon and other states;

(B) Title IV-A of the Social Security Act, Temporary Assistance to Needy Families; or

(C) Title XIX of the Social Security Act, Medicaid programs.

(c) Information may be shared as required by state or federal statute or rule;

(d)(A) Elected federal and state legislators and the Governor are considered to be within the chain of oversight of the CSP. Information about a child support case may be shared with these elected officials and their staff in response to issues brought by constituents who are parties to the case;

(B) County commissioners exercise a constituent representative function in county government for county administered programs. District attorney offices that operate child support programs may respond to constituent issues brought by county commissioners of the same county if the constituent is a party in a case administered by that office. District attorneys are DOJ sub-recipients. CSP Administration may also respond to constituent issues brought by county commissioners on district attorney administered child support cases where the constituent is a party;

(C) Information disclosed under paragraphs (A) and (B) of this subsection is subject to the restrictions in section (6) of this rule;

(e) When a party requires the use of an interpreter in communicating with the administrator, information given to such an interpreter is not a violation of any provision of this rule; and

(f) A person who is the executor of the estate or personal representative of a deceased party is entitled to receive any information that the deceased party would have been entitled to receive.

(5)(a) The CSP may release information to a private industry council as provided in 42 USC 654a(f)(5).

(b) The information released under subsection (a) of this section may be provided to a private industry council only for the purpose of identifying and contacting noncustodial parents regarding participation of the noncustodial parents in welfare-to-work grants under 42 USC 603(a)(5).

(c) For the purposes of this section, “private industry council” means, with respect to a service delivery area, the private industry council or local workforce investment board established for the service delivery area pursuant to Title I of the Workforce Investment Act (29 USC 2801, et seq.). “Private industry council” includes workforce centers and one-stop career centers.

(6)(a) Information from a case record may be disclosed to a party in that case outside a legal proceeding, except for the following personal information about the other party:

(A) The residence or mailing address of the other party if that other party is not the state;

(B) The social security number of the other party;

(C) The name, address and telephone number of the other party’s employers;

(D) The telephone number of the other party;

(E) Income and asset information of the other party;

(F) Financial institution account information of the other party;

(G) The driver’s license number of the other party; and

(H) Any other information which may identify the location of the minor child or other party, such as day care provider’s name and address.

(b) Except for personal information described in subsection (a) of this section, information from a case record may be provided to a party via the CSP web page if appropriate personal identifiers, such as social security number, case number or date of birth are required to be provided in order to access such information.

(7) Notwithstanding the provisions of subsection (6)(a), an employee may disclose personal information described in paragraphs (6)(a)(A) through (6)(a)(H) to a party, if disclosure of the information is otherwise required by rule or statute.

(8) Any information from the case record, including any information derived from another agency, that was used for any calculations or determinations relevant to the legal action may be disclosed to a party. Where there is a finding of risk and order for nondisclosure of information pursuant to OAR 137-055-1160, all nondisclosable information must be redacted before documents are released.

(9) Requestors may be required to pay for the actual costs of staff time and materials to produce copies of case records before documents are released.

(10)(a) Information from case records may be disclosed to persons not a party to the child support case who are making contact with the CSP on behalf of a party, if the following conditions are met:

(A) The person who is not a party to the case provides the social security number of the party for whom they are making the inquiry or the child support case number;

(B) The person who is not a party to the case making the contact on behalf of the party is the current spouse or domestic partner of the party and residing with the party or a parent or legal guardian of the party; and

(C) The CSP determines that the person is making case inquiries on behalf of the party and disclosure of such information would normally be made to the party in reply to such an inquiry.

(b) Disclosure of information is limited to the specific inquiries made on behalf of the party and is subject to the restrictions in subsections (6)(a) and (b) of this rule.

(11) Except as provided in subsections (10)(a) and (b) of this rule, information from a case record may not be disclosed to a person who is not a party to the case unless:

(a) The party has granted written consent to release the information to the person; or

(b) The person has power of attorney for the party, the duration and scope of which authorizes release of information from a case record at the time that the person requests such information. The power of attorney remains in effect until a written request to withdraw the power of attorney is submitted by the party or by the person, unless otherwise noted on the power of attorney.

(12) A child support case account balance is derived from the child support judgment, which is public information, and from the record of payments, which is not. Therefore, the case balance is not public information, is confidential and may not be released to persons not a party except as otherwise provided in this rule.

(13) Information obtained from the Internal Revenue Service and/or the Oregon Department of Revenue is subject to confidentiality rules imposed by those agencies even if those rules are more restrictive than the standards set in this rule, and may not be released for purposes other than those specified by those agencies.

(14) Criminal record information obtained from the Law Enforcement Data System or any other law enforcement source may be used for child support purposes only and may not be disclosed to parties or any other person or agency outside of the CSP. Information about the prosecution of child support related crimes initiated by the administrator may be released to parties in the child support case.

(15) Employees with access to computer records or records of any other nature available to them as employees may not access such records that pertain to their own child support case or the child support case of any relative or other person with whom the employee has a personal friendship or business association. No employee may perform casework on their own child support case or the case of any relative or other person with whom the employee has a personal friendship or business association.

(16) When an employee receives information that gives reasonable cause to believe that a child has suffered abuse as defined in ORS 419B.005(1)(a) the employee must make a report to the Department of Human Services as the agency that provides child welfare services and, if appropriate, to a law enforcement agency if abuse is discovered while providing program services.

(17) Employees who are subject to the Disciplinary Rules of the Oregon Code of Professional Responsibility must comply with those rules regarding mandatory reporting of child abuse. To the extent that those rules mandate a stricter standard than required by this rule, the Disciplinary Rules also apply.

(18) If an employee discloses or uses the contents of any child support records, files, papers or communications in violation of this rule, the employee is subject to progressive discipline, up to and including dismissal from employment.

(19) To ensure knowledge of the requirements of this rule, employees with access to computer records, or records of any other nature available to them as employees, are required annually to:

(a) Review this rule and the CSP Director's automated tutorial on confidentiality;

(b) Complete with 100 percent success the CSP Director's automated examination on confidentiality; and

(c) Sign a certificate acknowledging confidentiality requirements. The certificate must be in the form prescribed by the CSP Director.

(20)(a) For DOJ employees, each signed certificate must be forwarded to DOJ Human Resources, with a copy kept in the employee's local office drop file;

(b) For district attorney employees, each signed certificate must be kept in accordance with county personnel practices.

(21) Notwithstanding any other provision of this rule, an employee may release a party's name and address to a local law enforcement agency when necessary to prevent a criminal act that is likely to result in death or substantial bodily harm.

Stat. Auth.: ORS 25.260 & 180.345
Stats. Implemented: ORS 25.260, 127.005 & 411.320
Hist.: AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 19-1998, f. 10-5-98, cert. ef. 10-7-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0291; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-1160; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-1160; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 12-2004, f. & cert. ef. 10-1-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-1160**
**Confidentiality — Finding of Risk and Order for Nondisclosure of Information**

(1) For the purposes of this rule the following definitions apply:

(a) A claim of risk for nondisclosure of information means a claim by a party to a paternity or support case made to the administrator, an administrative law judge or the court that there is reason to not contain or disclose the information specified in ORS 25.020(8)(a) or OAR 137-055-1140(6)(a) because the health, safety or liberty of a party or child would unreasonably be put at risk by disclosure of such information;

(b) A finding of risk and order for nondisclosure of information means a finding by the administrator, an administrative law judge or the court, which may be made ex parte, that there is reason to not contain or disclose the information specified in ORS 25.020(8)(a) or OAR 137-055-1140(6)(a) because the health, safety or liberty of a party or child would unreasonably be put at risk by disclosure of such information.

(2) A claim of risk for nondisclosure of information may be made to the administrator by a party, which may include a child who qualifies as a child attending school under OAR 137-055-5110, at any time that a child support case is open. Forms for making a claim of risk for nondisclosure of information will be available from all child support offices and be made available to other community resources. At the initiation of any legal process that would result in a judgment or administrative order establishing paternity or including a provision concerning support, the administrator will provide parties an opportunity to make a claim of risk for nondisclosure of information.

(3) The administrator will make a finding of risk and order for nondisclosure of information when a party makes a written and signed claim of risk for nondisclosure of information pursuant to section (2) of this rule unless the party does not provide an address of record pursuant to section (5) of this rule.

(4) An administrative law judge will make a finding of risk and order for nondisclosure of information when a party makes a claim of risk for nondisclosure of information in a hearing unless the party does not provide an address of record pursuant to section (5) of this rule.

(5) A party who makes a claim of risk for nondisclosure of information must provide an address of record that is releasable to the other party(ies) in legal proceedings. The claim of risk for nondisclosure of information form provided to the party by the administrator must have a place in which to list an address of record. If a requesting party does not provide an address of record, a finding of risk and order for nondisclosure of information will not be made.

(6) When a finding of risk and order for nondisclosure of information has been made, the administrator must ensure that all pleadings, returns of service, orders or any other documents that would be sent to the parties or would be available as public information in a court file does not contain or must have deleted any of the identifying information specified in ORS 25.020(8)(a) or OAR 137-055-1140(6)(a). Any document sent to the court that contains any of the information specified in ORS 25.020(8)(a) or OAR 137-055-1140(6)(a) must be in a sealed envelope with a cover sheet informing the court of the confidential nature of the contents.

(7) A finding of risk and order for nondisclosure of information will be documented on the child support case file and will remain in force until such time as a party who requested a claim of risk retracts the claim in writing.

(8) A party who requested a claim of risk may retract the claim on a form provided by the administrator. When a signed retraction form is received by the administrator, the administrator will enter, or will ask the

court to enter, a finding and order terminating the order for nondisclosure of information.

(9) Any information previously protected under an order for nondisclosure of information will be subject to disclosure when the order for nondisclosure of information is terminated. The retraction form provided by the administrator will advise the requestor that previously protected information may be released to the other party(ies).

(10) In cases where the administrator is not involved in the preparation of the support order or order establishing paternity, or when child support services under ORS 25.080 are not being provided, any claim of risk for nondisclosure of information pursuant to ORS 25.020 must be made to the court.

(11) Notwithstanding section (5) of this rule, where the court has made a finding of risk and order for nondisclosure of information and the case is receiving or subsequently receives child support services pursuant to ORS 25.080, the administrator will implement the court's finding pursuant to this rule. In such a case, if the party fails to provide an address of record within 30 days of a written request from the administrator, the administrator will use, in order of preference, the party's mailing, contact or residence address as the address of record. The written request from the administrator must advise the party that if no address of record is provided within 30 days, the administrator will use the party's mailing, contact or resident address as the address of record, and the new address of record may be released to the other party(ies).

Stat. Auth.: ORS 25.020 & 180.345
Stats. Implemented: ORS 25.020
Hist.: AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 19-1998, f. 10-5-98, cert. ef. 10-7-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0291; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-1160; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-1160; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 12-2004, f. & cert. ef. 10-1-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-1180**
**Confidentiality — Address of Record**

(1) "Address of record" means an address provided by a party in a child support or paternity case to the administrator that may be an address other than the party's home address but is an address where the party can receive legal papers. The address of record may be released in writing to the other party during the pendency of a child support or paternity legal proceeding. The address of record will be used on all legal documents.

(2) A party, which may include a child who qualifies as a child attending school under OAR 137-055-5110, may provide or amend an address of record to the administrator at any time the child support case is open.

(3) The Child Support Program will provide annual notice to parties that they may provide an address of record to the administrator at any time.

(4) The administrator will provide notice to parties of the opportunity to provide an address of record at the initiation of any legal action that requires the service of legal documents on a party or would cause the following to be shared with the other party as part of the legal action:

(a) Home, mailing or contact address;

(b) Social security number;

(c) Telephone number;

(d) Driver license number;

(e) Employer's name, address and telephone number.

(5) The administrator will maintain the address of record on the case record.

(6) If a party has provided an address of record and the address is more than six months old, the administrator will provide the party with notice and opportunity to update the address of record prior to initiating any legal action.

(7) An address of record may be any place that a party can receive mail but must be located within the same state as the party's home.

(8) An address of record shall be documented on the case record and will remain in force until such time as a party may retract the address of record in writing.

(9) When a party provides an address of record during a hearing, a final order issued under OAR 137-003-0665 must include a notation of the address of record.

(10) Notwithstanding the provisions of section (8), when documents sent to a party's address of record are returned because the address of record is not valid, the administrator shall use, in order of preference, the party's mailing, contact or residence address as the address of record. The administrator shall notify the party that such address may be released to the other party(ies), and inform the party that a new address of record may be submitted.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 25.011, 25.020, 25.080 & 25.085
Hist.: AFS 23-1998, f. & cert. ef. 11-2-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0292; AFS 5-2001, f. 3-30-01, cert. ef. 4-1-01; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-1180; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-1180; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 5-2005, f. & cert. ef. 7-15-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-3240**
**Establishment of Arrears on Oregon Order Support Cases**

(1) The administrator will establish arrears on support cases when the following conditions have been met:

(a) There has been an application for support enforcement services from either party in the case or there has been a mandatory referral for support enforcement services by an order of the court or because TANF cash assistance, Medicaid, foster care or Oregon Youth Authority services have been provided to the family;

(b) There is an Oregon support order or the order from another state has been registered in Oregon;

(c) The administrator has determined that there is a need to establish the arrears balance on the case because:

(A) The administrator has no record or an incomplete accounting case record;

(B) An establishment of income withholding has been requested by an obligor or obligee pursuant to ORS 25.381; or

(C) There is a reason which necessitates that the arrears on the case record be reestablished; and

(D) There has been a request for arrears establishment by a party.

(2) A party requesting establishment or reestablishment of arrears must furnish an accounting that shows the payment history in as much detail as is necessary to demonstrate the periods and amounts of any arrears.

(3) Where arrears had earlier been established, through a process which afforded notice and an opportunity to contest to the parties, the arrears from that period will not be reestablished except that if interest had not been included in the establishment, interest may be added for that period.

(4) The enforcing agency may establish or reestablish arrears by either:

(a) Use of the judicial process authorized under ORS 25.167; or

(b) Use of the administrative process authorized under ORS 416.429.

(5) Notwithstanding section (4) of this rule, if the arrears to be established are for spousal support arrears or for both child and spousal support arrears, the administrator will use the process in ORS 25.167.

(6) Upon completion of the arrears establishment process in subsection (4)(a) or subsection (4)(b) of this rule, the case record will be adjusted to reflect the new arrears amount.

(7) Notwithstanding any other provision of this rule, arrears may be established when:

(a) There is an Oregon court order and less than 180 days have elapsed since the date the order was entered; and

(b) Notice has been sent to the parties, which may include a child who qualifies as a child attending school under OAR 137-055-5110, that the Child Support Program will enter arrears established in the order and arrears for the period from the effective date of the order to the date of the notice if neither party requests within the 60-day period following the date of the notice that the arrears be established under the process found in ORS 25.167 and 416.429.

(8) If neither party under section (7) of this rule responds within 60 days of the notice to request arrears be established under the process found in ORS 25.167 and 416.429, the amount of the arrears under section (7) of this rule will be the amount of arrears added to the case record.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 25.015
Hist.: AFS 5-1996, f. 2-21-96, cert. ef. 3-1-96; AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0047; AFS 2-2001, f. 1-31-01, cert. ef. 2-1-01; AFS 15-2002, f. 10-30-02, ef. 11-1-02; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-3240; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-3240; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-3420**
**Periodic Review and Modification of Child Support Order Amounts**

(1) For the purposes of this rule, the following definitions apply:

(a) "Determination" means an order resulting from a periodic review which finds that the current order of support is in "substantial compliance" with the Oregon guidelines.

(b) "Guidelines" means the guidelines, the formula, and related provisions in OAR 137-050-0320 through 137-050-0490.

(c) "Periodic Review" means proceedings initiated under ORS 25.287.

(d) "Review" means an objective evaluation by the administrator of the information necessary for application of the guidelines to determine:

(A) The presumptively correct child support amount; and

(B) The need to provide in the order for the child's health care needs through health care coverage or other means, not to include Medicaid, regardless of whether an adjustment in the amount of child support is necessary.

(e) "Substantial compliance" means that the current support order is within at least 15 percent or $50, whichever is less, of the presumptively correct child support amount as calculated using the guidelines. When making this determination, the 15 percent or $50 formula will be applied to the currently ordered support amount.

(2) For all child support cases receiving support enforcement services under ORS 25.080, the Child Support Program will notify annually the obligor and obligee of their right to request a periodic review of the amount of support ordered.

(3) The purpose of a periodic review is to determine, based on information from the parties and other sources as appropriate, whether the current child support order should be modified to assure substantial compliance with Oregon's child support guidelines, or to order health care coverage for the child(ren).

(4) The administrator may initiate a periodic review if a written request for periodic review is received from any party, which may include a child who qualifies as a child attending school under OAR 137-055-5110, and 24 months have passed since the date the most recent support order took effect, or the date of a determination that the most recent support order should not be adjusted.

(5) The administrator must complete the determination that the order is in substantial compliance with the guidelines or complete the modification of the existing order within 180 days of receiving a written request for a periodic review, or locating the non-requesting parent, if necessary, whichever occurs later.

(6) The administrator is responsible for conducting a periodic review in this state or for requesting that another state conduct a review pursuant to OAR 137-055-7190. As provided in ORS 110.429 and 110.432, the law of the state reviewing the order applies in determining if a basis for modification exists.

(7) Upon receipt of a written request for a periodic review, the administrator will notify the non-requesting party(ies) of the review in writing and provide a copy of the notice to the requesting party. The notice must advise the parties:

(a) Of the opportunity to provide information, with regard to themselves and the other party if known, which might affect the administrator's calculation of the presumed correct support amount under the child support guidelines, and that each party has 30 days from the date of the notice to provide such information in writing to the administrator;

(b) That the administrator will consider written information received from any party prior to calculating the presumed correct amount of support;

(c) That the administrator will not conduct a review or calculate a presumed correct child support amount until 30 days has passed since the date of the notice unless documentation or written information is received from the parties before the 30 days have passed; and

(d) That a modification to the support amount will affect only support owing on or after the date of service on the last non-requesting party.

(8) The administrator will notify the parties in writing of the presumed correct support amount under the child support guidelines. This notification:

(a) May be by service of a proposed determination that the existing order is in substantial compliance with the guidelines; or

(b) May be by service of a motion or petition to modify the current support order, pursuant to applicable statutes and administrative rules;

(c) Must advise the parties that each party has 30 days from the date of service of the notice to object to the determination or proposed modification in writing if they so choose, and that the order will not be final until at least the 30 day period has passed; and

(d) Must include the request for hearing form for each of the parties if the administrator uses an administrative determination or motion form.

(e) Must be sent to an adult child who has requested notification of any modification proceeding under OAR 137-055-5110.

(9) If a party wishes to object to the proposed determination or modification, the party must file a written request for hearing with the administrator or court before the 30 day period has passed.

(10) Upon receipt of a written request for hearing opposing the proposed determination or modification, the administrator will:

(a) Review the case to determine whether the support should be recalculated and, if so, notify the parties of the new presumed amount;

(b) Seek a consent order; or

(c) Ensure that the matter is set for hearing if no other resolution is achieved.

(d) If a party is objecting to a proposed determination, send a copy of the proposed determination and hearing request to an adult child who has requested notification of any modification proceeding under OAR 137-055-5110.

(11) If no request for hearing is filed within the 30 day period, the administrator will submit the determination or modification of the support order to the circuit court for entry in the court register.

(12) If a hearing is held on a determination and the administrative law judge makes a finding that the order is not in substantial compliance with the guidelines, the administrative law judge must enter a modified order with the support amount that complies with the guidelines.

(13) An appeal under this rule will be as provided in ORS 25.287.

(14) No provision of this rule precludes the parties from obtaining the services of private legal counsel at any time to pursue modification of the support order pursuant to all applicable laws.

Stat. Auth.: ORS 416.455 & 180.345
Stats. Implemented: ORS 25.080, 25.287, 107.135 & 416.425
Hist.: AFS 65-1989, f. 10-31-89, cert. ef. 11-1-89; AFS 11-1992(Temp), f. & cert. ef. 4-30-92; AFS 26-1992, f. & cert. ef. 9-30-92; AFS 20-1993, f. 10-11-93, cert. ef. 10-13-93; AFS 21-1994, f. 9-13-94, cert. ef. 12-1-94; AFS 17-1997(Temp), f. & cert. ef. 9-16-97; AFS 17-1997(Temp) Repealed by AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 75-1998, f. 9-11-98, cert. ef. 9-15-98; AFS 13-1999, f. 10-29-99, cert. ef. 11-1-99; AFS 9-2000, f. 3-13-00, cert. ef. 4-1-00; AFS 21-2000, f. & cert. ef. 8-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0072; AFS 23-2001, f. 10-2-01, cert. ef. 10-6-01; AFS 28-2001, f. 12-28-01, cert. ef. 1-1-02; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-3420; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-3420; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 4-2005, f. & cert. ef. 4-1-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-3430**
**Substantial Change in Circumstance Review and Modification of Child Support Order Amounts**

(1) For purposes of this rule the definitions provided in OAR 137-055-3420 apply.

(2) Notwithstanding OAR 137-055-3420, proceedings may be initiated at any time to review and modify a support obligation based upon a substantial change in circumstances.

(3) The administrator will conduct a review based upon a request for a change of circumstances modification only when:

(a) Oregon has jurisdiction to modify; and

(b) The administrator receives a written request for modification based upon a change of circumstances and at least 60 days have passed from the date the existing support order was entered, except for those cases where a review is requested pursuant to paragraphs (3)(c)(H) or (I); and

(c) At least one of the following criteria are met:

(A) A change in the written parenting time agreement or order has taken place;

(B) The financial or household circumstances of one or more of the parties are different now than they were at the time the order was entered;

(C) Social Security benefits received on behalf of a child due to a parent's disability or retirement were not previously considered in the order or they were considered in an action initiated before October 23, 1999;

(D) Veterans' benefits received on behalf of a child due to a parent's disability or retirement were not previously considered in the order or they were considered in an action initiated before October 23, 1999;

(E) Survivors' and Dependents' Education Assistance benefits received by the child or on behalf of the child were not previously considered in the order;

(F) Since the date of the last order, the obligor has been incarcerated, as defined in OAR 137-055-3300;

(G) The needs of the child(ren) have changed;

(H) There is a need to provide health care coverage for the child(ren);

(I) A change in the physical custody of the child(ren) has taken place; or

(J) An order is being modified to include a subsequent child of the parties.

(d) And the requesting party (if other than the administrator), which may be a child who qualifies as a child attending school under OAR 137-055-5110:

(A) Completes a written request for modification based upon a substantial change of circumstances;

(B) Pursuant to ORS 416.425(6), provides appropriate documentation for the criteria in subsection (c) of this section showing that a substantial change of circumstances has occurred; and

(C) Completes a Uniform Income Statement or Uniform Support Affidavit.

(4) Upon receipt of a written request for a review and modification, or upon the administrator's own initiative, the administrator will notify the non-requesting party(ies) of the review in writing and provide a copy of the notice to the requesting party (if any). The notice will inform the parties:

(a) Of the opportunity to provide information, with regard to themselves and the other party if known, which might affect the administrator's calculation of the presumed correct support amount under the child support guidelines, and that each party has 30 days from the date of the notice to provide such information in writing to the administrator;

(b) That the administrator will consider written information received from any party prior to calculating the presumed correct amount of support;

(c) That the administrator will not conduct a review or calculate a presumed correct child support amount until 30 days have passed since the date of the notice unless documentation or written information is received from all parties before the 30 days have passed; and

(d) That a modification to the support amount will affect only support owing on or after the date of service on the last non-requesting party.

(5) A request for review will be granted unless:

(a) The conditions in section (3) have not been met; or

(b) The review was requested due to one of the criteria in paragraphs (3)(c)(A) through (3)(c)(G), and the order is in substantial compliance with the guidelines. The determination of substantial compliance will be made as outlined in OAR 137-055-3420(1)(e).

(6) If the request for review is granted, the administrator will:

(a) Initiate a motion or petition to modify the current support order, pursuant to applicable statutes and administrative rules;

(b) Advise the parties in writing of the presumed correct support amount under the child support guidelines. This notification:

(A) Must be by service of a motion or petition to modify the current support order, pursuant to applicable statutes and administrative rules;

(B) Must advise the parties that each party has 30 days from the date of service of the notice to object to the proposed modification in writing if they so choose, and that the order will not be final until at least the 30 day period has elapsed; and

(C) Must include the request for hearing form for each of the parties as provided in OAR 137-055-2160, if the administrator uses an administrative motion form.

(c) Send a copy to the adult child who has requested notification of any modification proceeding under OAR 137-055-5110.

(7) If a party wishes to object to the proposed modification, the party must file a written request for hearing with the administrator or court before the 30 day period has passed.

(8) Upon receipt of a written request for hearing opposing the proposed modification, the administrator will:

(a) Review the case to determine whether the support should be recalculated and, if so, notify the parties of the new presumed amount;

(b) Seek a consent order; or

(c) Ensure that the matter is set for hearing if no other resolution is achieved.

(9) If a party submits, in writing, newly acquired information after a proposed modification has been served, the administrator will review the case pursuant to subsection (8)(a).

(10) If no request for hearing is filed within the 30 day period, the administrator will submit the modification of the support order to the circuit court for entry in the court register.

(11) If the request for review is denied, the administrator will notify the requesting party of the denial in writing within 30 days and inform the party of their right to file a motion for modification as provided in ORS 416.425. The administrator will advise the party on how to obtain the Oregon Judicial Department packet which has been prescribed for this purpose.

(12) An appeal under this rule will be as provided in ORS 416.427.

(13) No provision of this rule precludes the parties from obtaining the services of private legal counsel at any time to pursue modification of the support order pursuant to all applicable laws.

(14) If a request for review and modification is received because a change in the physical custody of the child(ren) has taken place, a party may also request a credit back to the date the change in physical custody took place in accordance with OAR 137-055-5510.

Stat. Auth.: ORS 416.455 & 180.345
Stats. Implemented: ORS 25.080, 25.287, 107.135 & 416.425
Hist.: DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 16-2004, f. 12-30-04, cert. ef. 1-3-05; DOJ 4-2005, f. & cert. ef. 4-1-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-3440**
**Effective Date of Modification Under ORS 416.425**

(1) In any proceeding to modify a support order under ORS 416.425, the modification may be effective on or at any time after the last nonrequesting party is served with a motion to set aside, alter or modify the judgment.

(2) If a motion to set aside, alter or modify a judgment is served on more than one nonrequesting party, the modification may be effective on or at any time after the last nonrequesting party is served.

(3)(a) For purposes of this rule a nonrequesting party is an individual obligee, a child who qualifies as a child attending school under OAR 137-055-5110, or an obligor under the child support order.

(b) An adult child, as defined in OAR 137-055-5110, who has sent a written request to the administrator to be a party to the modification is not a nonrequesting party for purposes of determining the effective date of a modification.

(4) If an amended motion is initiated and served on the parties, the effective date may be the date the original motion was served on the last nonrequesting party.

(5) This rule applies to any modification finalized after January 5, 2004.

Stat. Auth.: ORS 107.135, 180.345 & 416.455
Stats. Implemented: ORS 416.425
Hist.: AFS 7-1998, f. 3-30-98, cert. ef. 4-1-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-1080; AFS 15-2002, f. 10-30-02, ef. 11-1-02; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-3440; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-3440; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 12-2004, f. & cert. ef. 10-1-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-3490**
**Suspension of Enforcement**

(1) For purposes of this rule, "credit balance" means that payments received on a support account exceed all amounts owed by the obligor for ongoing and past-due support.

(2) When a motion has been filed to terminate, vacate, or set aside a support order or when a motion has been filed to modify a support order because of a change in physical custody of the child, the administrator may suspend enforcement of the support order if:

(a) Collection of support would result in the support account accruing a credit balance if the motion were granted; and

(b) The obligee, and the child who qualifies as a child attending school under OAR 137-055-5110, does not object to suspending enforcement of the support order.

(3) When enforcement is to be suspended under this section, the administrator shall send written notice of the proposed suspension to the obligee, and the child attending school, and shall send a copy of the notice to the obligor;

(4) The notice shall advise the obligee, and the child attending school, that the obligee, and the child attending school, have 14 days from the date the notice is sent to object in writing to the proposed suspension of enforcement and to give the reason(s) for the objection.

(a) If the suspension is due to a motion to terminate, vacate or set aside a support order, the obligee, and the child attending school, may object only on the basis that a credit balance would not result if the motion were granted.

(b) If the suspension is due to a motion to modify the support order because of a change in physical custody, the obligee, or child attending school, may object only on the basis that:

(A) The child(ren) is/are not in the physical custody of the obligor;

(B) The child(ren) is/are in the custody of the obligor without the consent of the obligee or without a court order for legal custody; or

(C) A credit balance would not result if the motion were granted.

(D) When an obligee, or the child attending school, files a written objection under this subsection, the administrator shall not suspend enforcement. However, if the obligee or the child attending school's written objection results in the obligor accruing a credit balance, the provisions of OAR 137-055-6260 shall apply. In addition, the obligee, or the child attending school, may incur an overpayment under OAR 137-055-6220.

Stat. Auth.: ORS 25.125 & 180.345
Stats. Implemented: ORS 25.125
Hist.: AFS 26-1997, f. 12-31-97, cert. ef. 1-1-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0069; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-3490; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-3490; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-3500**
**Joinder of a New Party to a Child Support Proceeding**

(1) In any proceeding under ORS 416.400 to 416.470 to establish or modify a child support obligation, any party may join any other person who has physical custody of a child in the proceeding.

(2) Before a person may be joined as a party, the administrator will determine who has physical custody of the child. The determination of who has physical custody of a child is not affected by who may have legal custody of the child. A person has physical custody when that person is responsible for the care, control and supervision of the child. The administrator will make this determination upon reliable objective information including one or more of, but not limited to, the following:

(a) Written agreement of all parties to the proceeding and of the person having physical custody of the child;

(b) Current school or day care records of the child, indicating the child's name, address and primary caretaker;

(c) Notarized statements by persons who are knowledgeable about the child's primary place of residence and primary physical custodian;

(d) Letters of guardianship or other court records;

(e) Current state or federal agency records.

(3) The administrator will send written notification of the determination of physical custody and joinder to all parties and the person proposed to be joined as a party. The notice will inform the parties and the person proposed to be joined that:

(a) A determination of physical custody will result in joining the person with physical custody as a party to the action;

(b) A person who is joined as a party has the rights of a party, including the right to receive current child support;

(c) An objection to the determination of who has physical custody must be made to the administrator in writing within 30 days of the date that the determination was mailed.

(4) The notice described in section (3) may be served on the parties, which may include a child who qualifies as a child attending school under OAR 137-055-5110, and the person proposed to be a party as part of an action to modify or establish a support order in the same manner that service is required for that action in ORS 416.400 to 416.470. If an action to establish or modify has already been served, the notice of determination of physical custody and joinder will be sent to the parties and the person proposed to be a party by regular mail at the last known address. If no objection is received within the time allotted in section (3) the person determined to have physical custody of the child, will be joined as a party to the action.

(5) If a written objection is filed pursuant to section (3) of this rule, the matter will proceed as follows:

(a) The administrator will attempt to resolve the dispute with the persons involved and, if the dispute is resolved, issue an order reflecting how the matter is resolved;

(b) If the dispute cannot be resolved, the written objection will be considered a request for a hearing and the issues of physical custody and joinder will then be heard and determined by a administrative law judge, pursuant to procedures established under ORS 416.400 to 416.470. The issues of physical custody and joinder may be determined at the hearing to establish or modify a support obligation. The administrative law judge's determination of physical custody and joinder will be included in the order to modify or establish support and may be appealed pursuant to ORS 416.427;

(c) If the issues of physical custody and joinder are raised for the first time during a hearing to modify or establish support, the administrative law judge has authority to postpone the hearing and to order the administrator to serve a person alleged or claiming to have physical custody of the child. After service is accomplished, the administrative law judge may proceed with the hearing and has authority to make a determination of physical custody in accordance with section (2) of this rule. The administrative law judge's determination of physical custody and joinder will be included in the order to modify or establish support and may be appealed pursuant to ORS 416.427.

(6) Any person who has been previously joined as a party, pursuant to this rule, will be removed as a party after the administrator has determined that the child is no longer in the custody of that person. In making this determination, the administrator may use the criteria specified in subsections (2)(a) through (2)(e) of this rule.

Stat. Auth.: ORS 180.345 & 416.455
Stats. Implemented: ORS 416.407
Hist.: AFS 13-1999, f. 10-29-99, cert. ef. 11-1-99; AFS 2-2000, f. 1-28-00, cert. ef. 2-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-1065; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-3500; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-3500; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-4120**
**Alternative Payment Method**

(1)(a) If an exception to income withholding has been granted when support is accruing because the child(ren) is in the custody of DHS or OYA as provided in ORS 416.417, an alternative payment method may be any method of paying support allowable pursuant to OAR 137-055-5020, except:

(b) If the child(ren) is in the custody of DHS, electronic payment withdrawal (EPW) is not an allowable option.

(2) Except as provided in subsections (1)(a) and (b), for all cases receiving support enforcement services under ORS 25.080, the only alternative method of paying support to income withholding is through electronic payment withdrawal from the obligor's bank account as described in OAR 137-055-5020.

(3) The administrator may allow payment by EPW if:

(a) The obligor qualifies for an exception to income withholding as provided in OAR 137-055-4080 or 137-055-4110;

(b) The obligor submits a completed application for EPW;

(c) The obligee consents to payment by EPW; or

(d) The child who qualifies as a child attending school under OAR 137-055-5110 is the only payee consents to payment by EPW; and

(e) The obligor continues to pay the amount due for current support each month until DCS activates the EPW payment method on the case.

(4) The administrator will not continue to forward a request for consent to the obligee, or the child attending school, if the obligee, or the child attending school has failed to consent at any time within the previous six months.

(5) An alternative payment method will remain in effect:

(a) Regardless of any subsequent modifications to the child support order, provided the obligor pays off any arrears resulting from the modification within 30 days of when the administrator codes the modification onto the case record, unless a court orders otherwise.

(b) Until the case qualifies for initiated income withholding as provided in OAR 137-055-4100, including cases where the arrears result because the obligor's financial institution refuses to honor an EPW payment, when presented for payment by DCS, due to insufficient funds in the obligor's account.

Stat. Auth.: ORS 25.396, 25.427 & 180.345
Stats. Implemented: ORS 25.396
Hist.: AFS 24-1991, f. 11-26-91, cert. ef. 12-1-91; AFS 29-1992, f. 10-8-92, cert. ef. 11-1-92; AFS 7-1994, f. & cert. ef. 4-1-94; AFS 30-1994, f. 12-29-95, cert. ef. 1-1-95; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0178; AFS 14-2001, f. 6-29-01, cert. ef. 7-1-01; AFS 28-2001, f. 12-28-01, cert. ef. 1-1-02; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-4120; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-4120; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 12-2004, f. & cert. ef. 10-1-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-4540**
**Restriction of Passports**

(1) When the Division of Child Support submits delinquent child support accounts for IRS tax refund offset pursuant to OAR 137-055-4340, the federal Department of Health and Human Services (DHHS) will select cases in which the delinquency is $5,000 or more for passport restriction.

(2) Passport restriction means the United States Secretary of State will refuse to issue a passport or may revoke, restrict or limit a passport which was previously issued.

(3) The obligor and the obligee will receive notice of passport restriction with the notice of tax refund offset specified in OAR 137-055-4340. The notice will advise the obligor and the obligee of the right to an administrative review regarding this action:

(a) The obligor or obligee may request an administrative review as specified in the notice;

(b) The only issues that may be considered in the review are:

(A) Whether the obligor is the person who owes the support balance as indicated by the case record; or

(B) Whether the support balance indicated by the official case record is correct.

(4) Upon receipt of the request for review, the administrator will schedule the review and notify the obligor, obligee, and the child who qualifies as a child attending school under OAR 137-055-5110 of the date, time and place of the review. The decision made in the review and the basis for this decision will be recorded in writing and mailed to the parties.

(5) Passport restriction may continue when the delinquency is reduced to less than $5,000.

(6) Where a passport has been restricted and the obligor has either paid the delinquency in full or entered into and shown compliance with an agreement pursuant to this rule, the CSP will give notice to the State

Department to release the passport restriction. Notice will be by the process specified by DHHS.

(7) An agreement is either payments made by income withholding, an agreement pursuant to section (8), or an agreement for a hardship exception pursuant to section (10) of this rule.

(8) Any agreement under this section must:

(a) Be in writing and signed by the obligor;

(b) Specify the due date for payments. The administrator may negotiate a due date other than the due date on the case record;

(c) Assume Oregon minimum wage for the obligor in determining income level if the obligor claims income in an amount less than minimum wage and no evidence is found that the obligor has income in an amount greater than Oregon minimum wage;

(d) State the amount of the payment. When feasible, there must be a lump sum payment to pay the delinquency in full or an initial lump sum payment to significantly reduce the delinquency. The amount of any ongoing payments must be the amount that could be obtained from an income withholding order pursuant to ORS 25.414;

(e) State that the agreement may be amended if there is a change in the amount of current child support;

(f) State that the agreement may be amended if there is a change in income which would change the agreement amount per the calculations in subsection (8)(d) of this rule;

(g) State that the agreement is terminated if the obligor fails to comply with the terms of the agreement;

(h) State that failure to comply with terms of the agreement will result in notification to the State Department to restrict the passport;

(i) State that the agreement does not preclude other enforcement actions to collect current child support and arrears, including, but not limited, to income withholding, and state and federal income tax offset;

(j) Include a statement that the obligor is required to notify the administrator within 10 days when there is a change in employment;

(k) State that information voluntarily provided may be used in other enforcement actions, including contempt actions.

(9) Any agreement made pursuant to this rule may be voided by the administrator if either subsections (9)(a) or (b) of this rule apply.

(a) The income of the holder of the passport/obligor changes; or

(b) The holder of the passport/obligor has under reported income in establishment of the agreement.

(10) When ongoing monthly support is owed, under the following circumstances, an exception to the requirements in subsection (8)(d) of this rule may be made if the obligor claims a hardship. If an obligor claims a hardship and all of the conditions are met for this exception, the enforcement entity will make an exception and limit the maximum amount of the payment agreement to 100 percent of the current support amount for the case. If the obligor has multiple child support cases, the administrator may limit the amount of the payment agreement to the lesser of 100% of the current support amount or the case's pro rata share of 50 percent of disposable earnings based on amounts of monthly support obligations per case. The conditions and time frames for exceptions are:

(a) The obligor requests a periodic review and modification or a substantial change in circumstance modification under the provisions of OAR 137-055-3420 or requests such a review and modification and is referred to the appropriate enforcement entity office to make the request. This exception will terminate after the administrator finishes the review and modification process. If the exception is granted pending the obligor's request for a periodic or substantial change in circumstances review and modification and the obligor has not made such a request to the appropriate administrator within ten days, the exception may be terminated. If the obligor must ask another state for a review and modification, the obligor must furnish verification to the administrator within 30 days that such a request was made to the other state. If such verification is not provided, this exception may be terminated.

(b) All other hardship periods will terminate after a three-month period. These hardships may be granted for temporary conditions that limit an obligor's ability to make support payments.

(11) The administrator will provide notice to the obligee, and the child attending school of any agreement entered into by sending the obligee, and the child attending school a copy of the agreement.

Stat. Auth.: ORS 25.625 & 180.345
Stats. Implemented: ORS 25.625
Hist.: AFS 23-1997, f. 12-29-97, cert. ef. 1-1-9; AFS 15-2000, f. 5-31-00, cert. ef. 6-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0234; AFS 2-2001, f. 1-31-01, cert. ef. 2-1-01; AFS 15-2001, f. 7-31-01, cert. ef. 8-1-01; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-4540; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-4540; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5020**
**Payment of Support Obligations**

(1) Regardless of the provisions of a support order, the obligor must make all support payments to the Division of Child Support (DCS) while the obligee receives assistance in the form of TANF cash assistance, foster care or Oregon Youth Authority services.

(2) The obligor must continue to pay support to DCS after assistance ends, for as long as arrears are assigned to the state or support enforcement services are provided.

(3) When a case with a support order is activated on the Child Support Enforcement Automated System, DCS will send notice to the obligor and obligee of the requirement to pay through DCS. Except as provided in OAR 137-055-5060, DCS will begin billing in the first full calendar month following 30 days from receipt of the referral or from the date the TANF benefits are issued. DCS shall determine the arrears on a newly activated case pursuant to OAR 137-055-3240.

(4) An obligor may pay DCS by money order, personal check, certified check, cashier or traveler's check, earnings allotment, cash or by authorizing electronic payment withdrawal from the obligor's account at a financial institution.

(5) Payment by electronic payment withdrawal may be established by completing an application furnished by and delivered to DCS, subject to the following conditions:

(a) The obligor's financial institution must be a participant in the Oregon Automated Clearinghouse Association;

(b) The obligor must be subject to a support order requiring payment to DCS or support enforcement services are being provided under ORS 25.080;

(c) The application must be complete and signed by all signatories to the obligor's account at the financial institution;

(d) The application must establish a monthly withdrawal date, no later than the monthly support due date, and the amount to be paid to DCS on each monthly withdrawal date from the obligor's account at the financial institution;

(e) DCS will notify the applying obligor, the obligee, and the child who qualifies as a child attending school under OAR 137-055-5110, by mail if they qualify for the electronic payment withdrawal process and of the initial withdrawal date;

(f) The obligor may revoke the electronic payment withdrawal authorization by notifying DCS at least 10 days before the monthly withdrawal date;

(g) DCS may revoke the authorization when there are insufficient funds in the obligor's account to make the authorized payment and no advance notice of that has been received. DCS will mail a notice of revocation to the parties;

(h) DCS may refuse an obligor's application if it is not fully completed, or if the obligor has made any support payment to DCS with insufficient funds in the 12-month period preceding the obligor's application.

Stat. Auth.: ORS 25.080, 25.427 & 180.345
Stats. Implemented: ORS 25.020 & 25.396
Hist.: AFS 80-1989, f. 12-21-89, cert. ef. 2-1-90; AFS 14-1990, f. & cert. ef. 6-7-90; AFS 4-1991, f. 1-28-91, cert. ef. 2-1-91; AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0020; AFS 14-2001, f. 6-29-01, cert. ef. 7-1-01; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5020; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5020; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 16-2004, f. 12-30-04, cert. ef. 1-3-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5110**
**Child Attending School**

The purpose of this rule is to provide additional information as to how the Child Support Program (CSP) will apply the provisions of ORS 107.108 when the order or modification provides for support until the child is age 21, so long as the child is a child attending school in accordance with ORS 107.108.

(1) In addition to the definitions found in ORS 107.108, as used in OAR chapter 137, division 055, the following terms have the meanings outlined below:

(a) "Active member of the military" means:

(A) A member of the Army, Navy, Air Force, Marine Corps, or Coast Guard (collectively known as the "armed forces"), who is serving on active duty; or

(B) A member of the National Guard who is serving full-time National Guard state or federal active duty; or

(C) A cadet at a federal service academy.

(b) "Adult child" means a child over the age of 18 and under the age of 21, who is not married or otherwise emancipated, and is not currently a child attending school.

(c) "Child attending school" has the meaning given in ORS 107.108, except a child attending school does not include an active member of the military.

(d) "Legal proceeding" means any action related to the support order which requires the service of documents on a party and that provides all parties with an opportunity to object. For a child attending school, a legal proceeding also includes service of:

(A) An income withholding order; and

(B) A National Medical Support Notice (NMSN).

(e) "Satisfactory academic progress" means:

(A) For a child attending high school who is over age 18 but under age 21, enrollment in school and meeting attendance requirements or as defined by the school; or

(B) For a child attending post high school classes, as defined by the higher educational institution.

(2) If the obligor has not provided the child attending school with an address to send the documents required by ORS 107.108 to, the administrator may release the address of record of the obligor to the child attending school. If the obligor does not provide an address to the CSP or to the child, the obligor's failure to receive required documents is not a basis for objecting that a child does not qualify as a child attending school.

(3) If there has been a finding and order of nondisclosure on behalf of the child attending school pursuant to ORS 25.020:

(a) The child may send the obligor's copy of the initial notice of intent to attend or continue to attend school to the administrator for the administrator to forward to the obligor. The child must submit a copy of the documents to the administrator within the time periods set out in ORS 107.108. The administrator will redact the following information prior to sending a copy of the documents to the obligor:

(A) Residence, mailing or contact address including the school name and address;

(B) Social security number;

(C) Telephone number including the school telephone number;

(D) Driver's license number;

(E) Employer's name, address and telephone number; and

(F) Name of registrar or school official.

(b)(A) The written consent form required under ORS 107.108 must authorize the administrator to contact the school.

(B) The administrator will contact the school once each academic year and will provide information to the obligor sufficient to confirm the child's status as a child attending school.

(4) DCS will distribute support directly to the child attending school, unless good cause is found to distribute support in some other manner. For purposes of this section "good cause" may include:

(a) The child is in the care of the Oregon Youth Authority (OYA);

(b) The child provides written notarized authorization for distribution to the obligee;

(c) The court, administrative law judge or administrator orders otherwise; or

(d) The administrator is enforcing the Oregon order at the request of another state and that state has indicated they are unable to distribute support directly to the child.

(5) If a child attending school is in the care of OYA, any and all reporting duties of the child attending school will be the duty of OYA.

(6) When the administrator has suspended or reinstated a support obligation pursuant to ORS 107.108, a party may request an administrative review of the action within 30 days after the date of the notice of suspension or reinstatement.

(a) The only issues which may be considered in the review are whether:

(A) The child meets the requirements of a child attending school;

(B) The written notice of the child's intent to attend or continue to attend school was received in a timely manner;

(C) The written consent or proof of written consent was received.

(b) The burden of proof for the administrative review is on the requesting party to provide documentation supporting the allegation(s).

(c) An administrative review under ORS 107.108 and this rule can only be requested once per semester or term as defined by the school, or three months from the date of a previous request for review if the school does not have semester or term, unless new supporting documentation can be provided.

(7) If the obligee claims good cause under OAR 137-055-1090, the child attending school may apply for services to enforce the existing support obligation on behalf of the child attending school only. If the child attending school applies for services all arrears for that child will accrue to the child attending school as provided for in OAR 137-055-6021, until the child's 21st birthday and then will be file credited off the case.

(8) If a court orders payment from a higher education savings plan in lieu of support under ORS 107.108:

(a) The department will cease collection and billing actions on behalf of that child at age 18. If the support order is for a single or last remaining child the department will close the case unless there are arrears on the case.

(b) If payments are ordered from a higher education savings plan and the court has not provided for a modification of the support amount for any remaining children of the order, this is a substantial change of circumstances for purposes of modifying the support order.

(c) If payment from a higher education savings plan has been ordered, the administrator will not take action to subsequently modify the support order to include child attending school support provisions for that child.

(9) The administrator will follow ORCP 7 when computing time frames for service of documents required by ORS 107.108.

(10) Except for support orders originally issued by a state other than Oregon and being enforced under the provisions of ORS 110.303 to 110.452, if the most recent order or modification for support cites ORS 107.108 or otherwise provides for support of a "child attending school," the administrator will follow the provisions of ORS 107.108 and this rule, regardless of other child attending school provisions that may be in the support order.

Stat. Auth.: ORS 25.020, 107.108 & 180.345
Stats. Implemented: ORS 25.020, 25.080, 107.108 & 416.407
Hist.: AFS 23-2001, f. 10-2-01, cert. ef. 10-6-01; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5110; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5110; DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 5-2005, f. & cert. ef. 7-15-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5120**
**Child Attending School — Arrears**

(1) Unless otherwise provided by a support judgment, a child attending school is not a judgment creditor to the support order.

(2)(a) Notwithstanding section (1), support for a child attending school that is not paid when due will accrue to a child attending school account and any arrears payment received prior to the child turning age 21 will be distributed to the child attending school as outlined in OAR 137-055-6021.

(b) When the child attending school turns age 21, any arrears in the child attending school account, will be transferred to the obligee as the judgment creditor.

(3) Notwithstanding the provisions in OAR's 137-055-3240, 137-055-6021 and 137-055-6200, unless the child attending school is named as a judgment creditor in the order, the administrator will not establish arrears at the request of a child attending school.

(4) For purposes of arrears proceedings, a child attending school will be included as a limited party who will receive notice and may provide information regarding:

(a) The accuracy of the amount of the arrears; and

(b) Any payments received directly by the child attending school from the obligor.

(5)(a) When an obligee requests establishment of arrears for any time period during which a child was a child attending school, the arrears will be established to the obligee's account.

(b) If the child attending school is the only, or last remaining, child on the case, the administrator will not establish arrears for any time period when services were not being provided and support is only being paid for the child attending school. Arrears may only accrue to the child attending school account from the date the administrator begins providing child support services.

(6) A child attending school may not satisfy arrears but may agree to a credit for direct payment, pursuant to OAR 137-055-5240, against arrears which have accrued to the child attending school account only.

Stat. Auth.: ORS 25.020 & 180.345
Stats. Implemented: ORS 107.108
Hist.: AFS 21-1991, f. 10-23-91, cert. ef. 11-1-91; AFS 26-1991, f. 12-31-91, cert. ef. 1-1-92; AFS 9-1992, f. & cert. ef. 4-1-92; AFS 31-1992, f. 10-29-92, cert. ef. 11-1-92; AFS 18-1997(Temp), f. 9-23-97, cert. ef. 10-4-97; AFS 18-1997(Temp) Repealed by AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 23-1997, f. 12-29-97, cert. ef. 1-1-98; AFS 2-2000, f. 1-28-00, cert. ef. 2-1-00; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0136; AFS 23-2001, f. 10-2-01, cert. ef. 10-6-01; AFS 17-2002(Temp), f. 10-30-02, cert. ef. 11-1-02 thru 4-29-03; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5120; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5120; DOJ 12-2004, f. & cert. ef. 10-1-04; DOJ 4-2005, f. & cert. ef. 4-1-05; DOJ 5-2005, f. & cert. ef. 7-15-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5125**
**Support for Child Attending School — Oregon Orders Entered Prior to October 4, 1997**

(1) The purpose of this rule is to define how the Child Support Program (CSP) will apply the provisions of ORS 107.108 regarding support or maintenance for a child attending school, in performing its official billing, accrual, distribution, and record-keeping functions for ongoing support when:

(a) The last order or modification for support was entered prior to October 4, 1997; and

(b) The order or modification provides for support until the child is age 21 so long as the child is a child attending school in accordance with ORS 107.108.

(2) The terms used in this rule shall have the meanings set out in OAR 137-055-5110.

(3) The Division of Child Support (DCS) shall perform its official billing, accrual, distribution, and record-keeping functions for each child on a support obligation who qualifies as a "child attending school" after attaining age 18, unless the obligee or the child has failed to provide written notification as provided in sections (5) and (11) of this rule.

(4) When a child is attending school and a "normal break" occurs between academic terms at the school, the obligor will continue to owe ongoing support and DCS shall continue official accounting functions throughout such break if the case records show that the child intends to resume classes at the start of the first regular academic term following the break.

(5) At least 30 days prior to the child's 18th birthday, the CSP shall send written notification to the obligee, the child, and, if appropriate, the Oregon Youth Authority (OYA) that unless the obligee or the child sends written notification to the CSP prior to the child's 18th birthday that the child will continue to attend school, DCS will terminate official accounting functions effective the date the child attains age 18.

(6) Upon receipt of the written notification from the obligee or the child that the child will continue to attend school, the CSP will send the Child Attending School Compliance Requirements to the parties and the child. Such notice shall:

(a) List all of the compliance requirements to continue to receive support as a child attending school;

(b) Include objection information;

(c) Advise the parties of their right to a change in circumstance modification in accordance with OAR 137-055-3420; and

(d) Include information for the child to make a claim of risk for nondisclosure of information pursuant to ORS 25.020 and OAR 137-055-1160.

(7) Support shall be distributed to the child only upon order of the court or written permission of the obligee.

(8) The obligor, obligee and a child who has attained age 18 and is a child attending school may enter into a written agreement to apply the provisions which are applicable to support orders and modifications entered on or after October 4, 1997, as outlined in OAR 137-055-5120.

(9) DCS shall terminate official accounting functions on the case when one of the following conditions occurs:

(a) The obligee or child fails to provide written notification as required under section (5) of this rule;

(b) The obligor has submitted a written objection under section (11) of this rule and the obligee or child has failed to provide compliance documents as required by that section;

(c) The obligee or child sends written notice that the child no longer qualifies as a child attending school; or

(d) The obligee or child fails to provide a valid compliance form within 30 calendar days from the date of a written notice from the CSP advising that an authorized representative of the school sent a written notice to the CSP that the child no longer qualifies as a child attending school.

(e) The child or the obligee fails to provide a valid compliance form within 30 calendar days from the date of a written notice from the CSP advising that OYA has notified the CSP that the child is no longer in the care of the OYA.

(10) When the CSP receives written notification from the obligee, child or authorized representative of the school that the child is no longer enrolled in school at least half time or notification from OYA that the child is no longer in the care of OYA, DCS shall terminate official accounting functions on the case for any such child effective the date the notice is received by the CSP.

(11) If an obligor submits a written objection asserting that the child no longer is attending school, the administrator shall send written notification to the obligee and child that a completed CSP Child Attending School Compliance Form must be received within 30 calendar days from the date of the administrator's written notification.

(a) If a valid compliance form is received within 30 days, the administrator will send a copy to the obligor. If there has been a finding and order of nondisclosure on behalf of the child pursuant to ORS 25.020, the administrator shall redact the following information prior to sending a copy to the obligor:

(A) Residence, mailing or contact address including the school name and address;

(B) Social security number;

(C) Telephone number including the school telephone number;

(D) Driver's license number;

(E) Employer's name, address and telephone number; and

(F) Name of registrar or school official.

(b) If the compliance form is not received within 30 days or does not show that child is in compliance, DCS shall terminate official accounting functions on the case for any such child effective the date the CSP receives the obligor's written objection, and shall notify all parties of this termination.

(12) The CSP shall resume official accounting functions for the child anytime prior to the child attaining the age of 21, if the obligee or child submits a valid CSP Child Attending School Compliance Form showing that the child is currently enrolled in school at least half time.

(a) Official accounting functions shall resume effective the date the CSP receives the completed form.

(b) The administrator shall establish arrears in accordance with OAR 137-055-3240, only upon the request of the obligee.

(13) Notwithstanding the CSP Child Attending School Compliance Form requirement of sections (11) and (12) of this rule, as of the Fall term or semester of 2002, the child may submit this Compliance Form with only the portion "TO BE COMPLETED BY STUDENT/CHILD ATTENDING SCHOOL" completed; but the child must attach an enrollment verification certificate from the school's contracted clearinghouse to the Compliance Form.

(14) In any case, up until the child attains the age of 21, DCS shall resume official accounting functions upon receipt of a written statement from the obligor that the obligor wishes to continue paying ongoing support for such child. If such verification occurs, the CSP shall inform all parties and resume official accounting functions effective the payment due date following receipt of such verification. If the obligor later decides to stop paying ongoing support for such child, the obligor shall provide a written statement to the CSP. The CSP shall treat such statement as an objection received under section (11) of this rule.

(15) In any case, the CSP shall honor the provisions of a court or administrative order to reinstate or terminate the duty of support to a "child attending school" under ORS 107.108

(16) If the most recent order or modification for support cites ORS 107.108 or otherwise provides for support of a "child attending school," the CSP shall follow the provisions of ORS 107.108 and this rule, regardless of other child attending school provisions that may be in the support order.

Stat. Auth.: ORS 25.020 & Sec. 2, Ch. 73 OL 2003
Stats. Implemented: ORS 25.020 & 107.108
Hist.: AFS 23-2001, f. 10-2-01, cert. ef. 10-6-01; AFS 17-2002(Temp), f. 10-30-02, cert. ef. 11-1-02 thru 4-29-03; SSP 4-2003, f. 2-25-03, cert. ef. 3-1-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5125; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5125; Suspended by DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5240**
**Credit for Support Payments not made to the Division of Child Support**

(1) In accordance with ORS 25.020, on any support case where the obligor is required to pay support through the Division of Child Support (DCS), DCS will not credit the obligor's support account for any payment not made through DCS, except as provided in ORS 25.020 and this rule.

(2) The other provisions of this rule notwithstanding, on any case where an order of another state is registered in Oregon under ORS Chapter 110 for enforcement only, and either the issuing state, as defined in ORS 110.303(9), or the obligee's state of residence has an active child support accounting case open, DCS does not have authority to give credit for payments not paid through Oregon DCS. In any such case, the obligor seeking credit must request credit from the issuing state or the obligee's state of residence, whichever has the active child support accounting case. DCS will adjust its records to reflect credit for such payments only upon receiving notification from the issuing state or the obligee's state of residence, in

writing, by electronic transmission, by telephone, or by court order, that specified payments will be credited.

(3) DCS will give credit for payments not made to DCS when:

(a) Payments are not assigned to the State of Oregon or to another state; and

(A) The obligor and obligee agree in writing that specific payments were made and should be credited; or

(B) The obligor, and the child who qualifies as a child attending school under OAR 137-055-5110, agree in writing that specific payments were made and should be credited for amounts that accrued during the time the child was a child attending school.

(b) Payments are assigned to the State of Oregon, and all of the following additional conditions are true:

(A) The obligor, obligee, and/or the child attending school, make sworn written statements that specific payments were made;

(B) The obligor, or obligee, or the child attending school, present canceled checks, or other substantial evidence, to corroborate that the payments were made; and

(C) The administrator has given written notice to the obligee, prior to the obligee making a sworn written statement under subsection (a), of any potential criminal or civil liability that may attach to an admission of receiving the assigned support. Potential criminal or civil liability may include, but is not limited to:

(i) Prosecution for unlawfully receiving public assistance benefits.

(ii) Liability for repayment of any public assistance overpayments for which the obligee may be liable.

(iii) Temporary or permanent disqualification from receiving public assistance, food stamp, or medical assistance benefits due to an intentional program violation being established against the obligee for failure to report, to the administrator, having received payments directly from the obligor.

(c) The administrator is enforcing the case at the request of another state, regardless of whether or not support is assigned to that other state, and that state verifies that payments not paid to DCS were received by the other state or by the obligee directly. Such verification may be in writing, by electronic transmission, by telephone, or by court order.

(d) An order of an administrative law judge, or an order from a court of appropriate jurisdiction, so specifies.

(4) To receive credit for payments not made to DCS, the obligor may apply directly to the administrator for credit, by providing the documents and evidence specified in section (3) of this rule.

(5) Except as provided in section (2) of this rule if the obligee or the child attending school, or other state does not agree that payments were made, pursuant to subsection (3)(a) or (3)(c) of this rule, or does not make a sworn written statement under subsection (3)(b), the obligor may make a written request to the administrator for a hearing.

(a) An administrative law judge may order, by written final order following a hearing, that DCS must credit the obligor's support account for a specified dollar amount of payments not made through DCS, or for all payments owed through a specified date.

(b) DCS will credit the obligor's account to the extent specified by written order of an administrative law judge.

(c) Prior notice of the hearing and of the right to object will be served upon the obligee in accordance with ORS 25.085, and the child attending school.

(d) Prior notice of the hearing and of the right to object may be served upon the obligor by regular mail to the address provided by the obligor when applying for credit.

(e) Any such hearing conducted under ORS 25.020 and this rule is a contested case hearing in accordance with ORS 183.413 through 183.470. Any party may also seek a hearing de novo in the Oregon circuit court.

(f) The other provisions of this section notwithstanding, an administrative law judge does not have jurisdiction under this section in cases where the administrator is enforcing another state's order.

(6) When an obligor wishes to request a contested case hearing, or when an obligor or obligee wishes to request a hearing de novo in the Oregon circuit court or to appeal a court order or a hearing order, responsibility for doing so rests solely with that obligor or obligee. Such responsibility includes preparation and filing of all forms and documents required by the court or administrative law judge, and payment of all fees required by the court. The administrator will not have any such responsibility on behalf of the obligor or obligee, except as specifically required by law or administrative rule.

(7) Nothing in this rule precludes DCS from giving credit for payments not made through DCS when a judicial determination has been made giving credit or satisfaction, or when the person to whom the support is owed has completed and signed a "satisfaction of support judgment" form adopted by DCS in accordance with OAR 137-055-5220.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 25.020 & 25.085
Hist.: AFS 42-1995, f. 1-28-95, cert. ef. 1-1-96; AFS 8-1996, f. 2-23-96, cert. ef. 3-1-96; AFS 7-1998, f. 3-30-98, cert. ef. 4-1-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0157; AFS 15-2002, f. 10-30-02, ef. 11-1-02; SSP 15-2003, f. 6-25-03, cert. ef. 6-30-03; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5240; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5240; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5400**
**Obligor Receiving Cash Assistance, Presumed Unable to Pay Child Support**

(1) Cases for obligors receiving cash assistance as specified in ORS 25.245(1) from Oregon will be identified and processed as set forth in ORS 25.245. Obligors receiving cash assistance as specified in ORS 25.241(1) from another state or tribe must provide to the administrator written proof of receipt of such case assistance. The written proof must:

(a) Be provided by the obligor to the administrator to initiate suspension and every three months thereafter;

(b) Include the date the cash assistance payment was first made, the amount of the cash assistance for each and every month in which cash assistance was received, and the ending date, if known, of the cash assistance;

(c) Be official documentation, recognized by the issuing agency, that covers each and every month that cash assistance was received, including but not limited to a benefits award letter, deposit record or receipt.

(2)(a) When an obligor has provided written proof of receipt of cash assistance pursuant to section (1) of this rule, the administrator will, subject to section (3) of this rule, credit the case for arrears accrued from the date the obligor submitted written proof of receipt of cash assistance back to the date the cash assistance was first made, but not earlier than October 6, 2001;

(b) When an obligor notifies the administrator that the obligor is no longer receiving cash assistance, the administrator will begin accrual and billing pursuant to the support order currently in effect with the next support payment due following the end of the last month that the obligor received public assistance;

(c) If the obligor fails to provide written proof of receipt of cash assistance pursuant to section (1) of this rule, the administrator will begin accrual and billing pursuant to the support order currently in effect with the next support payment due for the month following the month for which the obligor last provided written proof;

(d) If the obligor provides written proof of receipt of cash assistance pursuant to section (1) of this rule after failing to provide timely written proof of receipt of cash assistance within three months, thereby causing the administrator to begin billing and accrual pursuant to subsection (c) of this section, support accrual may be suspended and arrears may be credited pursuant to subsection (a) of this section.

(3)(a) Within 30 days of receipt of information that the obligor is receiving cash assistance as specified in ORS 25.245(1), the administrator must send a notice to all parties to the support order, which may include a child who qualifies as a child attending school under OAR 137-055-5110. The notice will contain a statement of the presumption that support accrual ceases and include the following:

(A) A statement of the month in which cash assistance was first made;

(B) A statement that unless the party objects, that child support payments have ceased accruing beginning with the support payment due on or after the date the obligor began receiving cash assistance, but not earlier than:

(i) January 1, 1994, if the obligor received Oregon Title IV-A cash assistance, Oregon general cash assistance, Oregon Supplemental Income Program cash assistance or Supplemental Security Income Program payments by the Social Security Administration; or

(ii) October 6, 2001, if the obligor received Title IV-A cash assistance or general cash assistance from another state or Tribe.

(C) A statement that the administrator will continue providing enforcement services, including medical support enforcement, if applicable, and services to collect any arrears;

(D) A statement that if the obligor ceases to receive cash assistance as specified in ORS 25.245(1), accrual and billing will begin with the next support payment due following the end of the last month that the obligor receives cash assistance or for which the obligor provided written proof;

(E) A statement that any party may object to the presumption that the obligor is unable to pay support by sending to the administrator a written objection within 20 days of the date of service;

(F) A statement that the objections must include a written description of the resource or other evidence that might rebut the presumption of inability to pay; and

(G) A statement that the entity responsible for providing enforcement services represents the state and that low cost legal counsel may be available.

(b) Included with each notice under this section will be a separate form for the party to use if they choose to file an objection to the presumption that the obligor is unable to pay support.

(4) The notice under section (3) of this rule will be served on the obligee, and the child attending school, by personal service or by certified mail. The notice will be served upon the obligor by regular mail. The administrator will document the service of all parties to the support order on the case record, and include the date of service.

(5) Except as provided in subsections (a) and (b) of this section, an administrative law judge, or the court, may grant credit or satisfaction against arrears that accrue for the month or months the obligor receives cash assistance as specified in ORS 25.245(1), if the administrator has not suspended the accrual or credited the child support case. Credit or satisfaction may not be granted for months:

(a) Prior to January 1, 1994, if the obligor received Oregon Title IV-A cash assistance, Oregon general cash assistance, Oregon Supplemental Income Program cash assistance or Supplemental Security Income Program payments by the Social Security Administration; or

(b) Prior to October 6, 2001, if the obligor received Title IV-A cash assistance or general cash assistance from another state or Tribe.

Stat. Auth.: ORS 25.245 & 180.345
Stats. Implemented: ORS 25.245
Hist.: AFS 4-1994, f. & cert. ef. 3-4-94; AFS 20-1998, f. & cert. ef. 10-5-98; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0120; AFS 23-2001, f. 10-2-01, cert. ef. 10-6-01; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5400; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5400; DOJ 5-2005, f. & cert. ef. 7-15-05; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5510**
**Request for Credit Against Child Support Arrears for Physical Custody of Child**

(1) In accordance with ORS 416.425, the administrator may allow a credit against child support arrearages for periods of time during which the obligor has physical custody of the child(ren) when:

(a) Physical custody was pursuant to a court ordered parenting time schedule and the court order specifically states that the obligor is allowed a credit for parenting time that is not already factored into the monthly child support amount;

(b) Physical custody was with the knowledge and consent of the obligee; or

(c) The obligor has custody of the child(ren) pursuant to court order.

(2) A request for credit against child support arrears under this rule must be made in writing either:

(a) If the credit is requested for a time period immediately prior to the effective date of the modification; or

(b) Independently of a request for modification, for any time period within two years prior to the date of the request.

(3)(a) Credit for physical custody may only be given if the child(ren) is/are with the obligor for 30 consecutive days or the entire month for which credit is sought. When the obligor is seeking a credit for less than all of the children under a child support order, a credit may only be given if the order is not a class order as defined in OAR 137-055-1020.

(b) Credit may not be given against any arrears which have accrued to a child who qualifies as a child attending school under OAR 137-055-5110.

(4) Notwithstanding section (3), the credit may only be allowed to the extent it will not result in a credit balance, as defined in OAR 137-055-3490(1).

(5) The administrator will send to the parties, which may include a child attending school, by regular mail or by service as part of the modification action, notice and proposed order of the intended action, including the amount to be credited. Such notice will inform the parties that:

(a) Within 30 days from the date of this notice, a party may request an administrative hearing;

(b) The request for hearing must be in writing;

(c) The only basis upon which a party may object is that:

(A) The obligor did not have physical custody of all the child(ren) under the support order for the time periods requested;

(B) The obligor had physical custody of the child(ren), but the custody was not with the knowledge and consent of the obligee and the obligor does not have legal custody of the child(ren);

(C) The obligor had physical custody of the child(ren) pursuant to a court order for parenting time and the order does not allow the obligor a credit for periods of parenting time.

(6) Any appeal of the decision made by an administrative law judge must be to the circuit court for a hearing de novo.

(7) If a credit is allowed pursuant to this rule, the credit will be applied as follows:

(a) If none of the arrears are assigned to the state, the credit will be applied to the family's unassigned arrears;

(b) If there are arrears assigned to the state and the child was receiving assistance during any time period for which the obligor had physical custody of the child(ren), the credit will be applied in the following sequence:

(A) State's permanently assigned arrears, not to exceed the amount of unreimbursed assistance;

(B) State's temporarily assigned arrears, not to exceed the amount of unreimbursed assistance;

(C) Family's unassigned arrears;

(D) Family's conditionally assigned arrears.

(c) If there are arrears assigned to the state and the child was not receiving assistance during any time period for which the obligor had physical custody of the child(ren), the credit will be applied in the following sequence:

(A) Family's unassigned arrears;

(B) Family's conditionally assigned arrears;

(C) State's permanently assigned arrears, not to exceed the amount of unreimbursed assistance;

(D) State's temporarily assigned arrears, not to exceed the amount of unreimbursed assistance.

(d) The terms used in this section are as defined in OAR 137-055-6020.

Stat. Auth.: ORS 180.345 & 416.455
Stats. Implemented: ORS 416.425
Hist.: DOJ 2-2004, f. 1-2-04 cert. ef. 1-5-04; DOJ 10-2004, f. & cert. ef. 7-1-04; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-5520**
**Request for Credit Against Child Support Arrears for Social Security or Veterans' Benefits Paid Retroactively on Behalf of a Child**

(1) In accordance with ORS 107.135, the purpose of this rule is to define the process for allowing a credit against child support arrears for Social Security or Veterans' benefits paid retroactively to the child, or to a representative payee administering the funds for the child's use and benefit.

(2) As used in this rule, Social Security benefits are as defined in OAR 137-050-0320.

(3) As used in this rule, Veterans' benefits include both apportioned Veterans' benefits and Survivors and Dependents Educational Assistance, as defined in OAR 137-050-0320.

(4) The request for credit against arrears will be considered if submitted within 180 days of the date of the determination letter from the Social Security Administration (SSA) or the Department of Veterans' Affairs (DVA) regarding a retroactive payment on behalf of the child.

(5) A request for credit against a child support arrears for Social Security or Veterans' benefits paid retroactively on behalf of the child must be made either:

(a) With a request for a periodic review and modification or a substantial change in circumstance modification if there is a current support obligation for that child. The modification must have an effective date on or after October 23, 1999; or

(b) Independently of a request for a modification if there is no longer a current support obligation for that child.

(6) A request for credit against arrears made within the time frames set out in section (4) will be treated as a request for a change of circumstances modification. The party may otherwise qualify for a modification pursuant to OAR 137-055-3420.

(7) Documentation of the SSA or DVA retroactive payment paid on behalf of the child must be provided by either the obligor, the obligee, or the child who qualifies as a child attending school under OAR 137-055-5110.

(8)(a) The credit for Survivors and Dependents Educational Assistance will be a dollar for dollar credit against the child support arrears; and

(b) The credit for Social Security and apportioned Veterans' benefits may be a dollar for dollar credit against the child support arrears.

(9) Notwithstanding subsections (8)(a) and (b), the maximum credit allowed will be limited to the amount of the child support arrears. In no circumstances will the credit exceed the amount of the retroactive SSA or DVA payment made on behalf of the child.

(10) The administrator will send to the parties by regular mail notice and proposed order of the intended action, including the amount to be credited and how the amount was calculated. Such notice will advise the parties of the right to an administrative hearing regarding this action:

(a) The obligor, obligee, or the child attending school, within 30 days from the date of this notice, may request an administrative hearing as specified in the notice;

(b) The request for hearing must be in writing;

(c) The only basis upon which the obligor or obligee may object is that:

(A) The lump sum payment was not received; or

(B) The lump sum payment amount used in the calculation is not correct.

(d) Any appeal of the decision made by an administrative law judge will be to the circuit court for a hearing de novo.

(11) If no timely written request for hearing is received, the order will be filed in circuit court.

(12) If the credit determined in subsections (8)(a) and (b), is less than the amount of arrears owed per section (9), the file credit will be applied as follows:

(a) If none of the arrears are assigned to the state, the credit will be applied to the family's unassigned arrears;

(b) If there are arrears assigned to the state and the child was receiving assistance during any time period covered by the retroactive payment per the SSA or DVA determination letter, the credit will be applied in the following sequence:

(A) State's permanently assigned arrears, not to exceed the amount of unreimbursed assistance;

(B) State's temporarily assigned arrears, not to exceed the amount of unreimbursed assistance;

(C) Family's unassigned arrears;

(D) Family's conditionally assigned arrears.

(c) If there are arrears assigned to the state and the child was not receiving assistance during any time period covered by of the retroactive payment per the SSA or DVA determination letter, the credit will be applied in the following sequence:

(A) Family's unassigned arrears;

(B) Family's conditionally assigned arrears;

(C) State's permanently assigned arrears, not to exceed the amount of unreimbursed assistance;

(D) State's temporarily assigned arrears, not to exceed the amount of unreimbursed assistance.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 25.020 & 107.135
Hist.: AFS 13-1999, f. 10-29-99, cert. ef. 11-1-99; AFS 32-2000, f. 11-29-00, cert. ef. 12-1-00, Renumbered from 461-195-0159; DOJ 6-2003(Temp), f. 6-25-03, cert. ef. 7-1-03 thru 12-28-03, Renumbered from 461-200-5520; DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03, Renumbered from 461-200-5520; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-6021**
**Distribution: General Provisions**

(1) DOJ will distribute support payments within two business days after receipt if sufficient information identifying the payee is provided, except:

(a) Support payments received as a result of tax refund intercepts will be distributed within thirty calendar days of receipt or, if applicable, within fifteen calendar days of an administrative review or hearing. If the state is notified by the Secretary of the U.S. Treasury (the Secretary) or the Oregon Department of Revenue (DOR) that an offset on a non-assistance case is from a refund based on a joint return, distribution may be delayed, up to a maximum of six months, until notified by the Secretary or DOR that the obligor's spouse has been paid their share of the refund;

(b) Support payments received from a garnishment, issued pursuant to ORS Chapter 18, will be held for 40 days if the garnishee is making a payment of other than wages or 120 days if the garnishee is making a payment of wages unless the obligor waives the right to make a challenge to a garnishment as set out in OAR 137-055-4520 or, if the obligor or any person who has an interest in the garnished property makes a challenge to garnishment, the support payment will be held pending the court decision;

(c) Support payments for future support will be distributed as provided in section (11) of this rule;

(d) Support payments for less than five dollars:

(A) May be delayed until a future payment is received which increases the payment amount due the family to at least five dollars; or

(B) May be retained by DOJ if case circumstances are such that there is no possibility of a future payment, unless the obligee requests issuance of a check.

(e) When a check has been dishonored, support payments made by check from the same payor may be held in accordance with OAR 137-055-6240; or

(f) When an obligor contests an order to withhold, funds will be disbursed pursuant to OAR 137-055-4160(5).

(2) DOJ will distribute support payments received on behalf of a family who has never received assistance to the family, first toward current support, then toward support arrears, not to exceed the amount of arrears.

(3) DOJ may send support payments designated for the obligee to another person or entity caring for the child(ren); however, prior to doing so, DOJ will require a notarized statement of authorization from the obligee or a court order requiring such distribution. DOJ will change the payee to a private collection agent that the obligee has retained for support enforcement services only in accordance with OAR 137-055-6025.

(4) Child support and spousal support have equal priority in the distribution of payments.

(5)(a) For Oregon support orders or modifications, a prorated share (unless otherwise ordered) of current support payments received within the month due will be distributed directly to the child who qualifies as a child attending school under OAR 137-055-5110.

(b) Any arrears resulting from unpaid current support to the child attending school will accrue to the child until the child reaches the age of 21, at which time arrears will revert to, and be owed to, the obligee.

(c) Any payment received on arrears, except for a federal tax offset, will be distributed on a prorated share to the obligee and the child attending school until the child reaches the age of 21.

(6) If the obligor has a current support obligation for multiple children on a single case, those children have different assistance status and the order does not indicate a specified amount per child, current support payments will be prorated based upon the number of children and their assistance status. Support payments in excess of current support for these cases will be distributed as provided in OAR 137-055-6022.

(7) DOJ will retain the fee charged by the Secretary for cases referred for Full Collection Services per OAR 137-055-4360 from any amount subsequently collected by the Secretary under this program. DOJ will credit the obligor's case for the full amount of collection and distribute the balance as provided in OAR 137-055-6022.

(8) Within each arrears type in the sequence of payment distribution in OAR 137-055-6022, 137-055-6023 or 137-055-6024, DOJ will apply the support payment to the oldest debt in each arrears type.

(9) Any excess funds remaining after arrears are paid in full will be processed as provided in OAR 137-055-6260 unless the obligor has elected in writing to apply the credit balance toward future support as provided in section (11) of this rule.

(10) DOJ will distribute support payments representing future support on a monthly basis when each such payment actually becomes due in the future. No amounts may be applied to future months unless current support and all arrears have been paid in full.

Stat. Auth.: ORS 25.020, 25.610 & 180.345
Stats. Implemented: ORS 18.645, 25.020 & 25.610
Hist.: DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

**137-055-6200**
**Adjusting Case Arrears When an Error is Identified**

The purpose of this rule is to set out what the administrator will do when an error is identified which requires adjusting the arrears of a case.

(1) "Complete payment record" means that the Division of Child Support (DCS) has kept the payment record for the support judgment from the date of the first support payment required under the judgment, or the obligee or the administrator established arrears for the time period when DCS did not keep the payment record on the case.

(2) A notice will only be sent as provided for in this rule when the amount of arrears to be adjusted is at least $5.

(3) If the error occurred within the current billing cycle, the administrator will adjust the arrears on the case record.

(4) If DCS has a complete payment record for the support payment judgment and the error occurred prior to the current billing cycle, the administrator will adjust the arrears on the case record and send a notice to the parties, which may include a child who qualifies as a child attending

school under OAR 137-055-5110, advising of the change in the case arrears.

(5) If DCS does not have a complete payment record for the support payment judgment and the error occurred prior to the current billing cycle, but within the previous 180 days, the administrator will:

(a) Send a notice to the parties that the administrator will adjust the arrears on the case record as indicated in the notice if none of the parties object within a 30-day period following the date of the notice;

(b) If none of the parties object within 30 days of the notice, the administrator will adjust the arrears on the case record as indicated in the notice;

(c) If any party objects within 30 days of the notice, the administrator will establish the arrears under the process found in ORS 25.167 or 416.429.

(6) If DCS does not have a complete payment record for the support payment judgment and the error occurred over 180 days ago, the administrator will establish the arrears under the process found in ORS 25.167 or 416.429.

(7) Notwithstanding any other provision of this rule, if under a contingency order the error is due to a failure to accurately reflect on the case record the periods of residence of the child in state care, the administrator will adjust the arrears on the case record and notify the obligor unless the Department of Human Services or Oregon Youth Authority directs otherwise.

(8) On a closed case:

(a) If all the arrears to be added to case are assigned to the state, the administrator will not open the case if it is for a period of less than four months of accrual or less than $500;

(b) If all the arrears to be added to case are assigned to the state and the arrears are for a period of a least four months or $500, the administrator will open the case and establish the arrears under the process found in ORS 25.167 or 416.429;

(c) If any of the arrears to be added to the case are owed to the obligee, the administrator will send a notice to the obligee and, if the arrears are for at least $25, ask if the obligee wants enforcement of the arrears. If the obligee requests enforcement, the administrator will open the case and establish the arrears under the process found in ORS 25.167 or 416.429;

(d) Except as otherwise provided in OAR 137-055-6110, if the error was due to an accounting error of the administrator and the adjustment to arrears will cause a credit balance, the administrator will return the excess amount to the obligor if the amount is at least $5 and pursue an overpayment as appropriate; or

(e) If the error was not due to an accounting error of the administrator and the adjustment to arrears will cause a credit balance, the administrator will send an informational notice to the parties.

(9) Notwithstanding section (5) or section (8), on any case in which the applicant for services has requested non-enforcement and the error only affects the amount of arrears owed to the obligee, the administrator will update the case record appropriately.

Stat. Auth.: ORS 180.345
Stats. Implemented: ORS 25.020
Hist.: DOJ 10-2003, f. 9-29-03, cert. ef. 10-1-03; DOJ 8-2005(Temp), f. & cert. ef. 9-1-05 thru 2-17-06

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## Department of Oregon State Police
## Chapter 257

**Adm. Order No.:** OSP 3-2005
**Filed with Sec. of State:** 9-12-2005
**Certified to be Effective:** 9-12-05
**Notice Publication Date:** 8-1-05
**Rules Amended:** 257-010-0025, 257-010-0035
**Subject:** Adopt OAR 257-010-0025(13) establishing fee of $52.00 for conducting criminal records checks under ORS 181.533. These checks were originally provided under OAR 257-010-0025(12) for the fee of $12.00. OAR 257-010-0025(12) will now be dedicated to the fee for conducting non-retained applicant and regulatory fingerprint based criminal records checks.

Adopt OAR 257-010-0025(14) pertaining to customer responsibility for covering the prevailing user fee charged by the FBI for fingerprint based record checks. This new section relocates language previously found in OAR 257-010-0025(1)(B).

Amend OAR 257-010-0025(1)(B) by changing fee from $2.00 to $4.00; OAR 257-010-0025(1)(C)(d) by changing fee from $15.00 to $10.00; OAR 257-010-0025(11) by changing fee from $15.00 to $27.00; OAR 257-010-0025(12) by changing fee from $12.00 to $28.00 and eliminating language no longer applicable to this section; OAR 257-010-0035(6) by changing fee from $12.00 to $33.00; and, OAR 257-010-0035(7) by changing fee from $5.00 to $20.00.
**Rules Coordinator:** Cort Dokken—(503) 378-3725, ext. 4105

**257-010-0025**
**Access to and Use of Criminal Offender Information**

(1) Access to OSP criminal offender information by any means shall be limited to:

(a) Criminal Justice Agencies, where the information is to be used for the administration of criminal justice, Criminal Justice Agency employment, or the information is required to implement a federal or state statute, local ordinance, Executive Order, or administrative rule that expressly refers to criminal conduct and contains requirements or exclusions expressly based on such conduct, or other demonstrated and legitimate needs;

(b) Designated Agencies upon Executive Order of the Governor, where the information is required to implement a federal or state statute, Executive Order, or administrative rule that expressly refers to criminal conduct and contains requirements or exclusions expressly based on such conduct or for agency employment purposes, or licensing purposes, or other demonstrated and legitimate needs:

(A) When a Designated Agency requests criminal offender information about an individual from OSP under ORS 181.555(1) for agency employment, licensing or other permissible purposes, the agency shall provide documentation that the individual:

(i) Gave prior written consent for the agency to make a criminal offender record check through the OSP; or

(ii) Has received written notice from the agency that a criminal offender record check may be made through the OSP. Notice shall be provided prior to the time the request is made and shall include: Notice of the manner in which the individual may be informed of the procedures adopted under ORS 181.555(3) for challenging inaccurate criminal offender information; and notice of the manner in which the individual may become informed of rights, if any, under Title VII of the Civil Rights Act of 1964; and notice that discrimination by an employer on the basis of arrest records alone may violate federal civil rights law and that the individual may obtain further information by contacting the Bureau of Labor and Industries.

(B) When an authorized agency or organization requests, in written form, criminal offender information about an individual from OSP under ORS 181.555(1), that agency will be charged a fee of $4 for each individual checked (fee does not apply when check is made by agency using their LEDS terminal).

(c) Qualified entities upon successful determination as being a qualified entity by the OSP Identification Services Section. Qualified entities may request from OSP Identification Services Section a criminal records check for purposes of evaluating the fitness of a subject individual as an employee, contractor or volunteer. The OSP Identification Services Section may access state and federal criminal records only through use of the subject individual's fingerprints.

(A) Before the OSP Identification Services Section conducts a criminal records check based on the subject individual's fingerprints:

(i) The OSP Identification Services Section shall determine whether the entity requesting the criminal records check is a qualified entity as defined in 257-010-0015(14) and has executed a user agreement making that determination;

(ii) The qualified entity must establish criteria to be used by the OSP Identification Services Section in reviewing the criminal offender information for a final record check determination;

(iii) The qualified entity must provide the criteria established under paragraph (ii) of this subsection to the OSP Identification Services Section; and

(iv) The qualified entity must have informed the subject individual that the qualified entity might request a fingerprint-based criminal records check and that the subject individual may obtain a copy of the record check report from, or challenge the accuracy or completeness of the record check report through, the OSP Identification Services Section or the Federal Bureau of Investigation.

(B) Upon receipt of a subject individual's criminal offender information, the OSP Identification Services Section shall make a final record check determination by comparing the criminal offender information with the criteria provided to the OSP Identification Services Section by the qualified entity under subsection (A)(ii) of this section. In making the final record check determination, the OSP Identification Services Section may

only consider information that the Department of State Police may disclose under ORS 181.560. The OSP Identification Services Section may only consider records of any conviction, or of any arrest less than one year old on which there has been no acquittal or dismissal.

(C) The OSP Identification Services Section shall only respond to a qualified entity's inquiry concerning a subject individual in the following manner and shall not provide specific criminal offender information:

(i) Yes. (No disqualifying criteria established by the qualified entity and ORS 181.560 was found.)

(ii) No. (One or more disqualifying criteria established by the qualified entity and ORS 181.560 was found.)

(d) A person or agency not defined as a Criminal Justice, Designated Agency, or Qualified Entity has access only through the OSP Identification Services Section pursuant to ORS 181.555 and 181.560. The request must be submitted in writing and may be hand carried or mailed to the OSP Identification Services Section. A fee of $10 will be charged for each check. A fee of $5 will be charged for each request for copy certification by a notary public in addition to any other applicable fee. Checks are to be made payable to the Oregon State Police. Inquiries are to be addressed to Oregon State Police, Identification Services Section, 3772 Portland Road N.E., Salem, OR 97303. Inquiries may also be made through the OSP webpage at www.osp.state.or.us, when a customer account is established for billing purposes.

(e) The requesting party must furnish OSP with sufficient information to assist identifying and notifying the individual of interest. If the information is sought for employment purposes the requester must state on the written request that the individual has been so advised and the manner in which the individual was so advised;

(f) These individuals will be advised by letter the name of the requestor, and that they are allowed to review their criminal history for inaccurate or incomplete information. They will also be advised that they may become informed of certain rights under Title VII of the Civil Rights Act of 1964 by contacting the Bureau of Labor and Industries;

(g) If a challenge is received prior to the end of the statutory 14 day waiting period, response to the requester will be held in abeyance until the challenge is resolved;

(h) OSP will respond to all requests and furnish Oregon conviction information and any arrest information less than one year old on which there has been no acquittal or dismissal. If the compiled information does not meet the above criteria or there is no record of the subject, OSP will reply to the requester that there is no criminal record.

(2) Access to Oregon CCH information by means of computer terminals shall be limited to Criminal Justice and Designated Agencies using their agency identification number (ORI) as authorized by OSP in an "Agency Agreement."

(3) Oregon criminal offender information may be shared between authorized Criminal Justice and Designated Agencies. All other secondary dissemination of criminal offender information by authorized agencies or personnel is prohibited unless expressly permitted by Oregon Revised Statute. Dissemination of Oregon criminal offender information by the Department of Human Services or the Employment Department to public or private agencies authorized by ORS 181.537(1)(d) shall be limited to persons with a demonstrated and legitimate need to know the information. Such need must be demonstrated to the satisfaction of the Department of Human Services or the Employment Department responsible for the dissemination of the information. Title 28, United States Code, Section 534 and Title 28, Code of Federal Regulations, Section 20.33(b), prohibits dissemination of FBI criminal offender information to public or private agencies by Criminal Justice or Designated Agencies. Inquiries for nonofficial purposes or the checking of records for unathorized persons or agencies is prohibited. A person wishing to review their criminal history record maintained by the FBI should write to: Federal Bureau of Investigation, CJIS Division, Attn: SCU, Module D2, 1000 Custer Hollow Road, Clarksburg, West Virginia, 26306. The FBI will inform the person how to obtain a copy of their record and, if necessary, how to challenge the accuracy or completeness of that record.

(4) Criminal offender information may be furnished to authorized Criminal Justice and Designated Agency employees and no person who has been convicted of a crime which could have resulted in a sentence to a federal or state penitentiary will be allowed to operate a computer terminal accessing CCH information or have access to Criminal offender information. All authorized agency employees as described above must be fingerprinted and the fingerprint card submitted to OSP. The fingerprint cards will be searched against the state and federal criminal record files. The "Reason Fingerprinted" may be for criminal justice employment such as "Police Officer," "Corrections Officer" or "Access to CCH." These fingerprint cards will be retained by OSP and entered into the CCH File. Exceptions to this rule may be made in extraordinary circumstances upon written application to the Superintendent of the Oregon State Police setting forth such circumstances. The Superintendent of OSP will maintain a central file where such exception authorization shall be filed.

(5) Screening of Criminal Justice and Designated Agency employees who have access to CCH or criminal offender information records is the responsibility of the employing agency.

(6) Any Criminal Justice or Designated Agency obtaining Oregon or FBI criminal offender information, either directly through that agency's computer terminal, through the computer terminal of another agency, or directly from OSP, must have executed a written "Agency Agreement" with the OSP prior to such access. Any public or private agency receiving Oregon criminal offender information from the Department of Human Services or the Employment Department pursuant to ORS 181.537(1)(c) or (d) must have executed a written "Agency Agreement" with the Department of Human Services or the Employment Department prior to receiving the information. Dissemination of Oregon criminal offender information received under authority of ORS 181.537(1)(d) by a public or private agency is strictly prohibited.

(7) Security of computer terminals. Any computer terminal with CCH accessing capability must be physically secure and placed in a location not available to unauthorized persons. Computer terminals must be so placed that unauthorized persons may not observe the content of messages transmitted or received on such computer terminal.

(8) Security of criminal offender information records. Any Criminal Justice or Designated Agency or private entity obtaining or receiving criminal offender information shall maintain those records in secure files, available only to authorized agency employees, until they are destroyed by burning, shredding or secure and confidential recycling and shall treat those records in such a manner that the record does not become public information in any later proceeding, except through court order or as otherwise provided by law.

(9) Radio Transmission. Any radio transmission of criminal offender information records shall be limited to essential details only, with information identifying individuals and offenses concealed insofar as possible. Plain text transmission of an entire (summary or full CCH) record is prohibited.

(10) Fee for relief from the bar of purchasing/possessing a firearm. When a person barred from possessing a firearm under ORS 166.250(1)(c)(A), (B), (D) or (E) or barred from purchasing a firearm under ORS 166.470 and is granted relief from the bar by a court under ORS 166.274, a fee of $12 will be charged to enter and maintain this information in the CCH File as authorized under ORS 166.274(4)(c).

(11) Fee for conducting applicant and regulatory fingerprint based criminal record background check when fingerprint card is retained in the CCH File. A fee of $27 will be charged to conduct a fingerprint based criminal record background check when the fingerprint card and related information is entered and maintained in the CCH File.

(12) Fee for conducting applicant and regulatory fingerprint based criminal record background check when fingerprint card is not retained in the CCH File. A fee of $28 will be charged to conduct a fingerprint based criminal record background check when the fingerprint card and related information is returned to the contributor or destroyed by the ISS. This fee will be waived as provided in ORS 181.556(1) & (2).

(13) Fee for conducting applicant and regulatory fingerprint based criminal record background check for qualified entity based on criteria established by the qualified entity. A fee of $52 will be charged to conduct a fingerprint based criminal record background check and fitness determination. The fingerprint card and results of the fitness determination will be returned to the contributor. This fee will be waived as provided in ORS 181.556(1) & (2).

(14) Agencies authorized by Oregon Revised Statute or federal law to submit fingerprint record checks to the FBI, Identification Division via OSP, are responsible to pay the prevailing user fee charged by the FBI for those fingerprint record checks in addition to the OSP user fee, except as otherwise provided by state or federal law.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 166.291, 166.412, 181.537, 181.555, 181.560(4), 183.310 - 183.550, 192.440 & 194.164

Stats. Implemented: ORS 166.291, 166.412 & 181.880

Hist.: DSP 2, f. 6-14-74, ef. 7-11-74; DSP 4, f. 4-22-76, ef. 4-30-76; DSP 1-1981, f. & ef. 5-1-81; DSP 3-1981, f. 10-30-81, ef. 11-1-81; DSP 1-1982, f. 3-12-82, ef. 3-15-82; OSP 1-1990, f. & cert. ef. 6-4-90; OSP 1-1991, f. 5-17-91, cert. ef. 7-1-91; OSP 1-1992, f. 3-17-92, cert. ef. 3-18-92; OSP 4-1993, f. & cert. ef. 12-20-93; OSP 4-1994, f. & cert. ef. 8-2-94; OSP 3-1996, f. 5-24-96, cert. ef. 7-1-96; OSP 1-2002, f. & cert. ef. 3-8-02; OSP 1-2005(Temp), f. & cert. ef. 3-1-05 thru 8-27-05; OSP 3-2005, f. & cert. ef. 9-12-05

**257-010-0035**
**Access by Individuals for Purpose of Review and/or Challenge**

(1) All individuals desiring to review information concerning them maintained in the OSP Criminal Offender Information System or Firearm Instant Check System, or who believes that the information as maintained is inaccurate, incomplete, or maintained in violation of any state or federal statute or act, shall be entitled to review such information and obtain a copy thereof for the purpose of review, challenge or correction.

(2) Verification of such individual's identity may only be effected through submission, in writing, of name, date of birth, and a set of rolled ink fingerprints to the Oregon State Police, Identification Services Section, 3772 Portland Road N.E., Salem, OR 97303. The request for review may be made at the Oregon State Police, Identification Services Section, 3772 Portland Road N.E., Salem, OR 97303, or through mail or postal service. The OSP may prescribe reasonable hours and places of inspection. If the request is made by mail or postal service, after positive identification by the OSP of the fingerprints submitted, copy of the record, along with the fingerprints submitted for that purpose, will be returned to the individual making the request to the address provided in the request.

(3) All data included in the Criminal Offender Information System is obtained from contributing Criminal Justice and Designated Agencies. All data included in the Firearm Instant Check System is obtained from contributing Oregon Gun Dealers as defined in 18 U.S.C. §921. If after review of the information concerning them as maintained in such record, the individual believes that it is incomplete or incorrect in any respect and wishes changes, corrections, or updating of the alleged deficiency, they must make application directly to the contributor of the questioned information, requesting the appropriate agency or Gun Dealer to correct it in accordance with its respective administrative rules and procedures. Upon receipt of an official communication directly from the agency or Gun Dealer which contributed the original information, the OSP will make any changes necessary in accordance with the information supplied by the agency or Gun Dealer.

(4) Any individual whose record is not removed, modified, or corrected as they may request, following refusal by the agency originally contributing such information, may proceed under the provisions of Rules 30.00 to 30.80 of the Attorney General's Model Rules of Practice and Procedures under the Administrative Procedure Act, relating to contested cases and judicial review. After conclusion of such procedure or review, any information found to be inaccurate, incomplete, or improperly maintained, shall be removed from the individual's record and the originating agency so notified with copy of the record as corrected being furnished to the challenging individual.

(5) Any Criminal Justice or Designated Agency receiving a record after such notice of contested case has been filed and prior to final determination, shall be notified by the OSP that the record is being challenged.

(6) All individuals desiring to obtain a police clearance or documentation of no record maintained in the OSP Criminal Offender Information System for purposes other than review, challenge or correction specified in (1) will be charged a fee of $33 for each request. Verification of the requesting individual's identity shall only be effected through submission and positive identification of the person's fingerprints.

(7) All individuals desiring to obtain a set of their inked fingerprints for purposes other than review, challenge or correction specified in section (1) of this rule will be charged a fee of $20 for each fingerprint card provided, except as provided in ORS 181.556(1) & (2).

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 166.291, 166.412, 181.537, 181.555, 181.560(4), 183.310 - 183.550, 192.440 & 194.164
Stats. Implemented: ORS 166.291, 166.412 & 181.880
Hist.: DSP 2, f. 6-14-74, ef. 7-11-74; DSP 4, f. 4-22-76, ef. 4-30-76; OSP 1-1990, f. & cert. ef. 6-4-90; OSP 1-1991, f. 5-17-91, cert. ef. 7-1-91; OSP 1-1992, f. 3-17-92, cert. ef. 3-18-92; OSP 4-1993, f. & cert. ef. 12-20-93; OSP 4-1994, f. & cert. ef. 8-2-94; OSP 3-1996, f. 5-24-96, cert. ef. 7-1-96; OSP 1-2002, f. & cert. ef. 3-8-02; OSP 1-2005(Temp), f. & cert. ef. 3-1-05 thru 8-27-05; OSP 3-2005, f. & cert. ef. 9-12-05

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**Department of Oregon State Police, Office of State Fire Marshal**
**Chapter 837**

**Adm. Order No.:** OSFM 13-2005(Temp)
**Filed with Sec. of State:** 8-16-2005
**Certified to be Effective:** 8-16-05 thru 2-11-06
**Notice Publication Date:**
**Rules Amended:** 837-012-0625, 837-012-0750, 837-012-1230
**Subject:** These rule changes are needed to rescind explosives and fireworks fees that were not ratified by the 2005 legislature.
**Rules Coordinator:** Pat Carroll—(503) 373-1540, ext. 276

**837-012-0625**
**Retail Permit Fees**

(1) Permit fees shall be paid at, or mailed to, the Office of State Fire Marshal and shall accompany the Permit Application.

(2) Payment shall be made by personal check, business check, cashier's check or money order made payable to the Office of State Fire Marshal. If the fee is paid by either personal or business check, the Office of State Fire Marshal shall not take any action on the Permit Application until the check has cleared the bank.

(3) The permit fee for each Permit Application shall be $50.

(4) Permit fees are non-refundable and non-transferable.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.110 - 480.165
Hist.: FM 1-1990(Temp), f. & cert. ef. 1-12-90; FM 4-1990, f. & cert. ef. 7-10-90; OSFM 14-2000, f. & cert. ef. 12-4-00; OSFM 11-2001, f. & cert. ef. 12-14-01; OSFM 3-2005, f. & cert. ef. 2-15-05; OSFM 13-2005(Temp), f. & cert. ef. 8-16-05 thru 2-11-06

**837-012-0750**
**Display Permit Application Fees**

(1) Display Permit Application fees shall be paid at, or mailed to, the Office of State Fire Marshal and shall accompany the Display Permit Application.

(2) Payment shall be made by personal check, business check, cashier's check or money order made payable to the Office of State Fire Marshal. If the fee is paid by either personal or business check, the Office of State Fire Marshal shall not take any action on the Display Permit Application until the check has cleared the bank.

(3) The Display Permit Application fee for a Display Permit is $50.

(4) Display Permit Application fees are non-refundable and non-transferable.

Stat. Auth.: ORS 480.150
Stats. Implemented: ORS 480.110 - 480.165
Hist.: FM 2-1992, f. & cert. ef. 3-10-92; OSFM 4-2002(Temp), f. & cert. ef. 2-25-02 thru 8-19-02; OSFM 7-2002, f. & cert. ef. 6-20-02; OSFM 2-2005, f. & cert. ef. 2-15-05; OSFM 13-2005(Temp), f. & cert. ef. 8-16-05 thru 2-11-06

**837-012-1230**
**Fees**

(1) Fees Shall be payable to the Office of State Fire Marshal.

(2) Fees Shall be paid at, or mailed to, the Office of State Fire Marshal and Shall accompany the appropriate application.

(3) Payment Shall be made by personal check, business check, cashier's check or money order made payable to the Office of State Fire Marshal. If the fee is paid by either personal or business check, the Office of State Fire Marshal Shall not take any action on the application until the check has cleared the bank.

(4) Fees are:

(a) $50 — Certificate of Possession.

(b) $30 — Examination.

(c) $125 — Magazine Registration with Office of State Fire Marshal inspection.

(d) $50 — Magazine Registration with acceptance of BATFE inspection.

(5) Fees are non-refundable and non-transferable.

Stat. Auth.: ORS 476 & 480
Stats. Implemented: ORS 480.200 - 480.290 & 480.990(6)
Hist.: OSFM 5-2000(Temp), f. & cert. ef. 4-12-00 thru 10-9-00; OSFM 12-2000, f. & cert. ef. 10-6-00; OSFM 1-2004, f. & cert. ef. 1-14-04; OSFM 5-2004, f. & cert. ef. 11-10-04; OSFM 4-2005, f. & cert. ef. 2-17-05; OSFM 13-2005(Temp), f. & cert. ef. 8-16-05 thru 2-11-06

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**Department of Transportation**
**Chapter 731**

**Adm. Order No.:** DOT 5-2005
**Filed with Sec. of State:** 8-23-2005
**Certified to be Effective:** 8-23-05
**Notice Publication Date:** 7-1-05
**Rules Adopted:** 731-146-0010, 731-146-0012, 731-146-0015, 731-146-0020, 731-146-0025, 731-146-0030, 731-146-0040, 731-146-0050, 731-146-0060, 731-146-0070, 731-146-0080, 731-146-0090, 731-146-0100, 731-146-0110, 731-146-0120, 731-146-0130, 731-146-0140, 731-147-0010, 731-147-0020, 731-147-0030, 731-147-0035, 731-147-0040, 731-147-0050, 731-147-0055, 731-147-0060, 731-148-0010, 731-148-0020, 731-149-0010
**Rules Repealed:** 731-010-0030, 731-146-0010(T), 731-146-0015(T), 731-146-0020(T), 731-146-0025(T), 731-146-0030(T), 731-146-0040(T), 731-146-0050(T), 731-146-0060(T), 731-146-

0070(T), 731-146-0080(T), 731-146-0090(T), 731-146-0100(T), 731-146-0110(T), 731-146-0120(T), 731-146-0130(T), 731-146-0140(T), 731-147-0010(T), 731-147-0020(T), 731-147-0030(T), 731-147-0035(T), 731-147-0040(T), 731-147-0050(T), 731-147-0060(T), 731-148-0010(T), 731-148-0020(T), 731-149-0010(T)

**Subject:** Chapter 794, Oregon Laws 2003 (HB 2341) replaced ORS Chapter 279, the Public Contracting Code, with Chapters 279A, 279B and 279C effective March 1, 2005. The law specifies that all rules adopted pursuant to ORS Chapter 279 expire March 1, 2005. Therefore, ODOT is adopting OAR Chapters 146, 147, 148 and 149 to adopt the Department of Justice new model public contracting rules, which replace the existing model contract rules and additional provisions that apply to ODOT contracts. These rules cover general provisions related to public contracting; the selection process for architectural, engineering and land surveying and related services; procurement of goods and services; and public contracts for construction services. These permanent rules replace temporary rules adopted effective March 1, 2005.

**Rules Coordinator:** Brenda Trump—(503) 945-5278

**731-146-0010**
**Application**

(1) The Oregon Department of Transportation (ODOT) adopts OAR 137-046-0100 through 137-046-0480 (effective March 1, 2005), the Department of Justice Model Rules, General Provisions Related to Public Contracting including the additional provisions provided in these rules.

(2) Unless the context of a specifically applicable definition in the Code or Model Rules requires otherwise, capitalized terms used in ODOT's public contracting rules (ODOT's Rules) will have the meaning set forth in the division of ODOT's Rules in which they appear, and if not defined there, the meaning set forth in Code or Model Rules.

Stat. Auth.: ORS 279A.065
Stats. Implemented: ORS 279A.030 & 279A.065
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0012**
**Delegation of Authority**

(1)(a) "Designated Procurement Officer" (DPO) means the individual designated and authorized by the Director of the Oregon Department of Transportation (ODOT) to perform certain Procurement functions described in these rules.

(b) "Chief Procurement Officer" (CPO) of the Department of Administrative Services (DAS) means the individual designated and authorized by the Director of DAS to perform certain Procurement functions described in Oregon Administrative Rules Chapter 125, Divisions 246, 247, 248, and 249.

(2) Pursuant to ORS 279A.050, ODOT has authority to procure or supervise the procurement of all goods, services, public improvements and personal services relating to the operation, maintenance or construction of highways, bridges and other transportation facilities that are subject to the authority of ODOT. ODOT recognizes the benefit of statewide consistency and expertise when certain procurements under ODOT authority are instead procured for ODOT by the Department of Administrative Services. Therefore:

(a) ODOT delegates authority to the Chief Procurement Officer to procure goods and services for ODOT under Statewide Price Agreements, including, but not limited to: 5 and 10 Yard Dump Trucks, Snowplows, Street Sweepers, Glass Beads, Aluminum Sign Blanks, and Sheeting. This delegation also includes the authority to conduct associated Contract Administration. Procurements under this delegation shall be processed in accordance with Oregon Administrative Rules Chapter 125, Divisions 246, 247, 248, and 249.

(b) The ODOT Designated Procurement Officer may act on behalf of ODOT and, by written agreement between ODOT DPO and DAS CPO, delegate to DAS on a case-by-case basis other Procurements which are under ODOT's authority. If such delegation is accepted, DAS shall process these procurements under Oregon Administrative Rules Chapter 125, Divisions 246, 247, 248, and 249.

(c) For Procurements where there is a question of whether procurement authority is held by ODOT or DAS, ODOT DPO and DAS CPO will make final determination pursuant to procedures set forth in DAS policy. These Procurements include but are not limited to: Information Technology with the exclusion of Intelligent Transportation Systems (supporting and maintaining traffic flow on State Highways, which is under ODOT procurement authority), License Plates, Driver and Motor Vehicle Services, Motor Carrier Transportation Procurements, and Non-Highway related training.

Stat. Auth.: ORS 279A.065(5)(a), 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070, 279A.140
Hist.: DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0015**
**Special Approvals for Public Contracts When Required**

(1) When Attorney General legal sufficiency review and approval is required under ORS 291.047, the Oregon Department of Transportation must seek legal approval.

(2) When ODOT contracts for services normally provided by another Contracting Agency or for services for which another Contracting Agency has statutory responsibilities, ODOT is required to seek the other Contracting Agency's approvals. Examples of these special approvals include, but are not limited to:

(a) Oregon Department of Administrative Services (DAS), Risk Management Division for providing tort liability coverage.

(b) DAS, Information Resource Management Division (IRMD), Publishing and Distribution for printing services.

(c) DAS, State Controller's Division for accounting services.

(d) Office of the Treasurer, Debt Management Division for financial and bond counsel services (bond counsel services also require the approval of the Attorney General).

(e) DAS, Information Resources Management Division (IRMD) for information-system related and telecommunications services. ODOT is also encouraged to use the DAS IRMD's Enterprise Planning and Policy Section as a resource in carrying out information system-related projects. This may include:

(A) Assistance to ODOT in developing Statements of Work related to information system projects;

(B) Reviews to assure consistency with State standards and direction; and

(C) A listing of vendors that provide information system-related services.

(f) Attorney or Financial Auditing Services.

(3) The Attorney General has sole authority to contract for attorney services. Exceptions may be granted in Writing on a case-by-case basis only by the Attorney General.

(4) The Secretary of State Audits Division has sole authority to contract for financial auditing services. Exceptions may be granted in Writing on a case-by-case basis only by the Secretary of State Audits Division.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.140(2)
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0020**
**Reporting Requirements for Personal Services Contracts**

(1) Application. For the purposes of Division 146 only, "Personal Services" includes Architectural, Engineering and Land Surveying Services and Related Services.

(2) The Department of Administrative Services (DAS) State Procurement Office maintains an electronic reporting system called the Oregon Procurement Information Network (ORPIN) that maintains a report form for reporting Personal Services Contracts. ODOT must submit this report form to the DAS State Procurement Office for each Contract and subsequent Contract Amendment. The report form must include ODOT's name, not-to-exceed amount of the Contract, the name of the Contractor, the duration of the Contract, and its basic purpose. Whenever ODOT pays in a calendar year under a Personal Services Contract for services historically performed by its employees more than ODOT would have paid to its employees performing the same Work, ODOT must so report to DAS and include in the report a statement of justification for the greater costs, pursuant to ORS 279A.140(2)(h)(A)(i).

(3) ODOT must keep in the Procurement File all Personal Services Contracts, justification statements, when applicable, documentation of the selection process for each Contract, and report forms the later of six years following the Contract's expiration or termination, or the period as may be required by applicable law, or until the conclusion of any audit, controversy, or litigation arising out of or related to the particular Contract in the Procurement File. A Procurement File may be destroyed following the conclusion of the applicable retention period.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.140(h)(A)
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0025**
**Independent Contractor Status For Personal Services Contracts**

(1) ODOT must develop a Statement of Work for services that will not result in an employee relationship with the potential Contractor.

(2) An independent contractor certification by Contractors must be included as a contract provision in each contract.

(3) If the nature of the services or project is such that an employee/employer relationship will exist, ODOT must hire the individual through normal personnel procedures.

(4) The Contract must include the Contractor's legal name, address, and Social Security or federal tax identification number.

(5) The Contract must provide that the Contractor is responsible for federal Social Security, except those categories excluded by law, and for any federal or state taxes applicable to the contract payment.

Stat. Auth.: ORS 279A.140(2)(h)(A)(i)
Stats. Implemented: ORS 279A.140 & 279A.070
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0030**
**Procurement Files**

(1) This Rule applies only to Procurements exceeding the Intermediate Procurement Threshold for Goods or Services; Procurements exceeding the Informal Selection Threshold for Architectural, Engineering, and Land Surveying Services; and Procurements exceeding the Intermediate Procurement Threshold for Public Improvements pursuant to OAR 137-047-0270, 137-048-0210, and 137-049-0160, respectively.

(2) Each Procurement File must contain:

(a) An executed Contract, if awarded;

(b) The record of the actions used to develop the Contract;

(c) A copy of the Solicitation, if any;

(d) Any required findings or statement of justification for the selection of the Contractor and sourcing method pursuant to ORS 279A.200 through 279A.220 (Cooperative Procurement); 279B.055 through 279B.085 (seven methods for Goods or Services); 279C.100 through 279C.125 (Architectural, Engineering and Land Surveying and Related Services); or 279C.300 through 279C.450 (Public Improvements); and

(e) Documentation of Contract Administration pursuant to this rule.

(3) Each Procurement File may also contain, if required by ORS or Division 146 rules:

(a) A list of prospective Contractors notified of any Solicitation.

(b) The method used to advertise or notify prospective Contractors.

(c) A copy of each Offer that resulted in the Award of a Contract.

(d) The method of evaluating Offers, the results of the evaluation, and basis of selection.

(e) The record of any Negotiation of the Statement of Work and results.

(f) A record of all material Communications regarding the Solicitation by interested Contractors.

(g) All information describing how the Contractor was selected, including the basis for awarding the Contract.

(h) A copy of the Request for Special Procurement, if any.

(4) ODOT must maintain Procurement Files, including all documentation, for a period not less than six (6) years, except for ten (10) years beyond each Contract's expiration date for Architectural, Engineering and Land Surveying Services and Related Services or for another period in accordance with another provision of law.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0040**
**Contract Administration; General Definitions**

(1) "Contract Administration" means all functions related to a given Contract between ODOT and a Contractor from the time the Contract is awarded until the Work is completed, accepted, and all payment has been made, or until the Contract is terminated, payment has been made, and disputes have been resolved.

(2) "Contract terms and conditions" means the entire Contract document including but not limited to:

(a) The Contract;

(b) A Solicitation Document incorporated by reference in the Contract; and

(c) All attachments, exhibits or other requirements specifically referenced in the Contract.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0050**
**Contract Administration; General Provisions**

(1) Authority. ODOT must conduct all Procurements, including Contract Administration, for Goods or Services, including Architectural, Engineering and Land Surveying Services and Related Services, and Public Improvements, pursuant to ORS 279A.050 and ORS 279A.075.

(2) Contract Administrator. ODOT must appoint, in Writing, a Contract Administrator as an ODOT representative for each Contract. The Contract Administrator may delegate in Writing a portion of the Contract Administrator's responsibilities to a technical representative for specific day-to-day administrative activities for each Contract.

(3) Documentation of Contract Administration. This section applies only to the following Procurements pursuant to OAR 125-047-0270, 125-048-0210, and 125-049-0160, respectively:

(a) Procurements exceeding the Intermediate Procurement Threshold for Goods or Services.

(b) Informal Selection Threshold for Architectural, Engineering, and Land Surveying Services and Related Services.

(c) Procurements exceeding the Intermediate Procurement Threshold for Public Improvements.

(4) Requirements. Documentation of Contract Administration is a part of the Procurement File in accordance with OAR 731-046-0030, and this documentation must include:

(a) An executed Contract;

(b) The record of the actions used to administer the Contract;

(c) The name and contact information for the Contract Administrator and any technical representative delegates, together with a description of duties delegated to any technical representative;

(d) All executed Amendments;

(e) Claims related to the Contract;

(f) Release of claims documents;

(g) Contract close-out documents; and

(h) Other documents related to Contract Administration.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0060**
**Payment Authorization of Cost Overruns for Goods or Services including Architectural, Engineering and Land Surveying Services and Related Services Contracts**

(1) Payments on Contracts that exceed the maximum contract consideration require approval from ODOT's Designated Procurement Officer and may require approval from the Department of Justice pursuant to OAR 137-045-0010 et seq. Approval may be provided if there is compliance with all of the following:

(a) The Original Contract was duly executed and, if required, approved by the Attorney General.

(b) The Original Contract has not expired or been terminated as of the date Written approval to increase the Contract amount is granted.

(c) The cost overrun is not associated with any change in the Statement of Work set out in the Original Contract.

(d) The cost overrun arose out of extraordinary circumstances or conditions encountered in the course of contract performance that were reasonably not anticipated at the time the Original Contract, or the most recent Amendment, if any, was signed. Such circumstances include, but are not limited to cost overruns that:

(A) Address emergencies arising in the course of the Contract that require prompt action to protect the Work already completed.

(B) Comply with official or judicial commands or directives issued during contract performance.

(C) Ensure that the purpose of the Contract will be realized.

(e) The cost overrun was incurred in good faith, results from the good faith performance by the Contractor, and is no greater than the prescribed hourly rate or the reasonable value of the additional Work or performance rendered.

(f) Except for the cost overrun, the Contract and its objective are within the statutory authority of ODOT and ODOT currently has funds available for payment under the Contract.

(g) An officer or employee of ODOT has presented a Written report to ODOT's Designated Procurement Officer within 60 days of the discovery of the overrun that states the reasons for the cost overrun and demonstrates to the satisfaction of ODOT's Designated Procurement Officer that

the Original Contract and the circumstances of the overrun satisfy the conditions stated above.

(h) ODOT's Designated Procurement Officer approves in Writing the payment of the overrun, or such portion of the overrun amount as ODOT's Designated Procurement Officer determines may be paid consistent with the conditions of this Rule. If ODOT's Designated Procurement Officer has signed the Contract, or has immediate supervisory responsibility over performance of the Contract, that Person must designate an alternate delegate to grant or deny Written approval of payment.

(2) ODOT must obtain an Attorney General's approval of the Contract Amendment, if such approval is required by ORS 291.047, before making any overrun payment.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0070**
**Ethics in Public Contracting — Policy**

Oregon Public Contracting is a public trust. ODOT and Contractors involved in Public Contracting must safeguard this public trust.

Stat. Auth.: ORS 244.010 - 244.400, 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 244.010 - 244.400, 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0080**
**Ethics in Selection and Award of Public Contracts**

ODOT officers, employees or agents involved in the process of the selection and award of Public Contracts must carefully review and comply with the provisions of ORS 244.010 through 244.400.

Stat. Auth.: ORS 244.010 - 244.400, 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 244.010 - 244.400, 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0090**
**Ethics in Appointments to Advisory Committees**

ODOT's Designated Procurement Officer or a delegate may appoint procurement advisory committees to assist with Specifications, procurement decisions, and structural change that can take full advantage of evolving procurement methods as they emerge within various industries, while preserving competition pursuant to ORS 279A.015.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0100**
**Non-retaliation**

Retaliation against anyone who complies with the Public Contracting Code and Rules in Division 146 related to ethics is prohibited. Any officer, employee or agent of ODOT or Contractor who engages in retaliation action will be subject to penalties pursuant to ORS 279A.990 and related rules. Also, any Contractor who engages in a retaliation action may be debarred.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0110**
**Ethics in Specification Development**

(1) ODOT and Contractors must not develop Specifications that primarily benefit a Contractor, directly or indirectly, to the detriment of ODOT or the best interest of the State.

(2) ODOT must not develop Specifications that inhibit or tend to discourage Public Contracting with Qualified Rehabilitation Facilities (QRF) under ORS 279.835 through 279.855 and OAR 125-055-0005 through 125-055-0045 where those Specifications inhibit or tend to discourage the acquisition of QRF-produced Goods or Services without reasonably promoting the satisfaction of bona fide, practical procurement needs of ODOT.

(3) ODOT and Contractors must not develop Specifications that inhibit or tend to discourage Public Contracting under other public procurement laws or policies of the Department.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0120**
**Ethics in Sole Source**

ODOT may not select a Sole-Source Procurement pursuant to ORS 279B.075 and avoid a competitive Procurement if the purpose of the selection is to primarily benefit the Contractor, directly or indirectly, to the detriment of ODOT or the best interest of the State.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070, 279B.075 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0130**
**Fragmentation**

A Procurement may not be artificially divided or fragmented so as to constitute a Small Procurement, pursuant to ORS 279B.065, or an Intermediate Procurement, pursuant to ORS 279B.070.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070 & 279B.065
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-146-0140**
**Ethics in ODOT and Contractor Communications**

(1) Research Phase. ODOT is encouraged to conduct research with potential Contractors who can meet the State's needs. This research includes but is not limited to:

(a) Meetings with potential Contractors;

(b) Industry presentations; and

(c) Demonstrations by Contractors that, in ODOT's discretion, demonstrate Goods or Services that may be able to meet ODOT's needs.

(2) ODOT must document all items discussed during the research phase of Solicitation development. The research phase ends the day of a Solicitation release or request for a Quote pursuant to an Intermediate Procurement, unless the Solicitation or Intermediate Procurement provides for a different process that permits on-going research.

(3) Solicitation and Contracting Phase. Any communication between ODOT and Contractors regarding a Solicitation, that occurs after the Solicitation release or request for a Quote and before the Award of a Contract, must only be made within the context of the Solicitation Document or Intermediate Procurement requirements.

(4) Communication may allow for discussions, negotiations, Addenda, Contractor questions, and ODOT's answers to Contractor questions about terms and conditions, specifications, Amendments, or related matters. During this phase, telephone conversations and meetings must be documented in the Procurement File. Written inquiries regarding the Solicitation should be responded to by ODOT in Writing.

(5) A record of all communications regarding the Solicitation by interested Contractors must be made a part of the Procurement File pursuant to OAR 731-146-0030.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.065(5)(a), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0010**
**Application**

The Oregon Department of Transportation adopts OAR 137-047-0000 through 137-047-0800 (effective March 1, 2005) with the exception of 137-047-0270(4) and 137-047-0275, the Department of Justice Model Rules, Public Procurements for Goods or Services General Provisions including the additional provisions provided in these rules.

Stat. Auth.: ORS 279A.065
Stats. Implemented: ORS 279B.015
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0020**
**Life Cycle Costing**

(1) Policy. Life Cycle Costing provides an acquisition method that is consistent with the concept of sustainability and also drives the concept of lowest cost of ownership and best value of the equipment purchased. When planning the award method of an Invitation to Bid (ITB) or Request for Proposal (RFP) for products or equipment, ODOT may consider using Life Cycle Costing whenever the costs of system operation, support, and disposal, and other quantifiable costs are significant in comparison with the cost of acquisition.

(2) For the purpose of chapter 731, division 147 rules, the following definitions apply:

(a) "Life-Cycle Cost" means the total cost to ODOT of acquiring, operating, supporting and (if applicable) disposing of the Goods being acquired.

(b) "Life Cycle Costing" means the various quantifiable cost factors, in addition to the acquisition cost of Goods or Services (Goods or Services are also referred to in Division 147 as "product, equipment, and service, separately or in any combination thereof").

(3) Concept. The concept of Life Cycle Costing will be limited to begin with the acquisition of the product or service, will include all the associated cost(s) of ownership, such as purchase price, shipping, maintenance and repair, longevity, and include disposition cost(s) at the end of life of the products or services. The initial acquisition price is adjusted with additional cost streams expected to occur over the anticipated life of the product or equipment. These additional cost streams must be clearly thought out costs or adjustments, and must be based upon reasonable assumptions. Cost streams are discrete elements of costs that relate to the particular purchase considered for Life Cycle Costing. In some cases cost streams may include negative costs or savings that are expected to result in a particular cost stream:

(a) Acquisition costs are all costs associated with acquiring a product or service for ODOT's use. For complex items, several Contracts may be required and costs may involve research and development as well as production, delivery, and installation of the item.

(b) Typical cost streams may include:

(A) Switching costs which are costs associated with changing from current equipment or products to another model or brand of equipment or products. Typically such costs may include: removal, shipping, training, and replacement of supporting supplies. Switching costs may also include increased project management or additional transition time.

(B) Operating and support costs which are all costs, including third party contract costs, associated with equipment, supplies, utilities, fuel, and services needed to operate and maintain an operational system.

(C) Disposal costs which are costs, including third party contract costs, associated with removing equipment from service and disposing of it. Evaluations that consider Life-Cycle Cost should also consider any significant salvage or resale value at the time of disposal. The DAS Oregon Property Services may help with estimating values, and with adherence to current rules regarding disposition of State property.

(4) Solicitation Requirements. Life Cycle Cost methodology is permitted under this rule for use in either an ITB or an RFP. When conducting a Life Cycle Costing-based award, the Solicitation must:

(a) Advise prospective Offerors how Life Cycle Costing will be considered in an award decision by using one of the following options:

(A) Awards may be made based on lowest evaluated cost resulting from Life Cycle Costing. Under this approach, the evaluation includes Life Cycle Costs in the Solicitation issued by ODOT;

(B) Awards of Invitations to Bid to the lowest Bidder include the total Life Cycle Costs as a part of the bid evaluation methodology and award. The lowest total Life Cycle Cost is considered the low Bid; or

(C) Awards of RFPs may include a Life Cycle Costing award factor in two ways:

(i) The RFP may include Life Cycle Costs as a part of the total points awarded for costs. In this method, all Life Cycle Costs are calculated and the lowest total Life Cycle Cost is awarded the maximum points allocated for cost in the RFP; or

(ii) The RFP may include a separate Life Cycle Cost factor that is assessed as weight or points and is considered in addition to other factors in the proposal evaluation methodology. As a separate evaluation factor, it may be used in addition to costs, when the cost factor does not consider Life Cycle Costing elements.

(b) Provide for adjustments to the cost stream when Life Cycle Costs continue over a period of years, for one or more of the following:

(A) Time value of money;

(B) Cost uncertainty; or

(C) Inflation factors.

(5) Factors in the Solicitation. To the extent ODOT considers practical, the Solicitation must provide relevant information (e.g., projected item usage, operating environment, the operating period, and other information that will be considered in the evaluation of the offer). ODOT may include projections and estimates of life and cycle times from independent third party sources. The Solicitation must describe how Life Cycle Cost will be applied in the award process. Factors not described in the Solicitation may not be used in the evaluation.

(6) Elements that may be used in Awards. Solicitations must describe what relevant costs, along with appropriate information to support Life Cycle Costs, the Offer must provide. Typical elements used in Life Cycle Costing Awards may include:

(a) Average unit price, including (when appropriate) recurring and nonrecurring production costs;

(b) Delivery, shipping and transportation costs;

(c) Switching costs prepared by ODOT that include a reasonable estimate of what it will cost to switch from a current product or brand to another;

(d) Unit operating and support costs (e.g., manpower, energy, parts requirements, scheduled maintenance, and training);

(e) Unit disposal costs (e.g., the cost of removing equipment from the Contracting Agency facility);

(f) Unit salvage or residual value; and

(g) Related information as requested to support costs such as testing and operational data.

(7) Award Decision. Award of an Invitation to Bid using Life Cycle Cost methods must be made to the responsible firm whose responsive offer provides the lowest overall cost of ownership in accordance with the Life Cycle Cost evaluation factors listed in the solicitation document. In the case of a Life Cycle Cost Request for Proposal, award must be made to the responsible firm whose responsive offer, after consideration of Life Cycle Cost factors as a part of price evaluation, and other factors listed in the Solicitation Document are determined to be the most Advantageous or best Proposal for ODOT.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.025, 279B.270 & 279B.280
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0030**
**Emergency Procurements Process**

(1) ODOT may award a Public Contract as an Emergency Procurement pursuant to the requirements of OAR 137-047-0280 and 137-049-0150, whichever may apply. When an Emergency Procurement is authorized, the Procurement must be made with competition that is practicable under the circumstances.

(2) Pursuant to the requirements of this rule, ODOT may, in its discretion, enter into a Public Contract without competitive Solicitation if an emergency exists. Emergency means circumstances that could not have been reasonably foreseen that create a substantial risk of loss, damage, interruption of services or threat to public health or safety that requires prompt execution of a Contract to remedy the condition.

(3) Regardless of the dollar value of the Contract, when entering into an Emergency Contract, ODOT must:

(a) Make a Written declaration of Emergency, including findings describing the Emergency that requires the prompt execution of the Contract , stating the anticipated harm from failure to establish the Contract on an expedited basis;

(b) Encourage competition that is practicable under the circumstances; and

(c) Record the measures taken under subsection (b) of this section to encourage competition; the amounts of the Bids, Quotes or Proposals obtained, if any; and the reason for selecting the Contractor.

(4) Pursuant to ORS 279B.080, the head of the Contracting Agency, or person designated under ORS 279A.075, must declare the existence of the Emergency, as required by subsection (3)(a) of this rule, which must authorize ODOT to enter into an Emergency Contract.

(5) Any Contract awarded under this rule must be awarded within 60 days following the declaration of the Emergency unless an extension has been granted by the head of ODOT, or Person designated.

(6) For Contracts greater than $5,000, ODOT must report a summary of the Contract on the Oregon Procurement Information Network (ORPIN) maintained by the DAS State Procurement Office and provide the Department of Justice, Attorney General with a copy of the Written documentation required in section (3) of this rule within a reasonable period of time or thirty (30) Days, whichever is less, following the declaration of an Emergency. ODOT must maintain a copy of the report in its Emergency Procurement File.

(7) Emergency Public Contracts may be exempted from Department of Justice legal sufficiency review requirement pursuant to OAR 137-045-0070.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.080
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0035**
**Sole Source Delegation by Type**

The Chief Procurement Officer of the DAS State Procurement Office has granted approval and authority including Contract Administration to ODOT's Designated Procurement Officer to conduct Sole Source Procurements outside of ODOT's authority under ORS 279A.050 up to the $150,000.00 threshold. ODOT must seek written approval from the DAS State Procurement Office for Sole Source Procurements outside of ODOT's authority under ORS 279A.050 that exceed $150,000.00.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.075
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0040**
**Special Delegated Procurements**

(1) Terms used in Division 147 rules have the same meaning as defined in ORS 279B.085.

(2) Authorization. The Chief Procurement Officer of the DAS State Procurement Office has granted approval and authority per OAR 125-246-0140, and 125-247-0288 to the ODOT Designated Procurement Officer for the following Special Procurements:

(a) Brand Names or Products, "or Equal," Single Seller and Sole Source;

(b) Equipment Repair and Overhead;

(c) Purchases of Used Personal Property; and

(d) Reverse Auctions.

(3) The following apply to Brand Names or Products, "or Equal," Single Seller and Sole Source procurements:

(a) "Procurement of Brand Name 'or Equal' Products" means the Procurement of a product after specifying the registered Brand name of the product or requiring the same Specifications of the Brand Name product.

(b) Specifications. Solicitation Specifications for Public Contracts must not expressly or implicitly require any product of any particular manufacturer or seller except:

(A) "Or Equal" Specification. ODOT may specify a particular brand name, make or product suffixed by "or equal," "or approved equal," "or equivalent," "or approved equivalent," or similar language if there is no other practical method of Specification; and

(B) Specifying a particular make or product. ODOT may specify a Brand Name, make, or product without an "or equal" or equivalent suffix if there is no other practical method of Specification, after documenting the Procurement File with the following:

(i) A brief description of the Solicitation(s) to be covered including volume of contemplated future purchases;

(ii) The Brand Name, mark, or product to be specified; and

(iii) The reason ODOT is seeking this procurement method, which must include at least one of the following findings in the Procurement File:

(I) It is unlikely that Specification of the Brand Name, mark or product will encourage favoritism in the award of the Public Contracts or substantially diminish competition;

(II) Specification of the Brand Name, mark or product would result in substantial cost savings to ODOT; or

(III) Efficient utilization of existing equipment or supplies requires the acquisition of compatible equipment or supplies.

(c) Public Notice. ODOT must make a reasonable effort to notify all known suppliers of the specified product and invite such suppliers to submit competitive bids or proposals; or must document the Procurement File with findings of current market research to support the determination that the product is available from only one seller. Posting a notice on ORPIN for a reasonable time period satisfies this requirement.

(d) Purchasing From Sole Source, Single Seller. ODOT may purchase a particular product or service (also known as Goods or Services) available from only one source if ODOT meets the requirements of paragraphs (b)(A) and (B) of this section and a Sole-Source Procurement pursuant to ORS 279B.075. ODOT, prior to purchase, must document the Procurement File with ODOT's findings of current market research to support the determination that the product or service is available from only one seller or source. ODOT's findings must also include:

(A) A brief description of the Contract or Contracts to be covered including volume of contemplated future purchases;

(B) Description of the Goods or Services to be purchased; and

(C) The reason ODOT is seeking this procurement method, that could include the following reasons:

(i) Efficient utilization of existing Goods or Services requires the acquisition of compatible Goods or Services;

(ii) The required product is data processing equipment which will be used for research where there are requirements for exchange of software and data with other research establishments; or

(iii) The particular product is for use in a pilot or an experimental project.

(e) Single Manufacturer, Multiple Sellers. ODOT may specify Goods or Services available from only one manufacturer, but available through multiple sellers, if ODOT meets the requirements of paragraphs (b)(A) and (B) of this section and the following:

(A) If the total purchase is $5,000 or more but does not exceed $150,000 and a comparable product or service is not available under an existing Mandatory Use Contract, competitive quotes must be obtained and retained in the Procurement File for Intermediate Procurements; or

(B) If the purchase exceeds $150,000, and the comparable Good or Services is not available under an existing Mandatory Use Contract, ODOT must follow the Solicitation process for Competitive Sealed Bids or Competitive Sealed Proposals.

(f) Single Manufacturer, Multiple Purchases. If ODOT intends to make several purchases of the product of a particular manufacturer or seller for a period not to exceed five (5) years, ODOT must so state in the Procurement file, the Solicitation Document, if any, and the public notice described in paragraph (b)(B) of this section. Such documentation and public notice constitute sufficient notice as to subsequent purchases. If the total purchase amount is estimated to exceed $150,000, this must be stated in the advertisement for Bids or Proposals.

(g) If ODOT competitively solicits, it must comply with the rules for that method of Solicitation pursuant to ORS 279B.055 through 279B.075 and 137-047-0255 through 137-047-0263.

(h) Nothing in this rule exempts ODOT from obtaining the approval of the Attorney General for legal sufficiency review requirement pursuant to ORS 291.047.

(i) ODOT must comply with ORS 200.035, notwithstanding this rule.

(4) The following apply to Equipment Repair and Overhaul procurements:

(a) Conditions. ODOT may enter into a Public Contract for equipment repair or overhaul without competitive bidding, subject to the following conditions:

(A) Service or parts required are unknown and the cost cannot be determined without extensive preliminary dismantling or testing; or

(B) Service or parts required are for sophisticated equipment for which specially trained personnel are required and such personnel are available from only one source; and

(b) Process and Criteria. ODOT must use competitive methods wherever possible to achieve best value and must document in the Procurement File the reasons why a competitive process was deemed impractical. If the anticipated purchase exceeds $5,000, ODOT must post notice on ORPIN. The resulting Contract must be in Writing and ODOT's Procurement File must document the use of this Special Procurement rule by number to identify the sourcing method. Nothing in this rule waives the Department of Justice legal sufficiency review requirement if applicable under ORS 291.047.

(5) The following apply to Purchase of Used Personal Property procurements:

(a) Authorization. Subject to the provisions of this rule, ODOT may purchase used property or equipment without competitive bidding and without obtaining competitive quotes, if, at the time of purchase, ODOT has determined and documented that the purchase will:

(A) Be unlikely to encourage favoritism or diminish competition; and

(B) Result in substantial cost savings or promote the public interest.

(b) "Used personal property or equipment" means the property or equipment which has been placed in its intended use by a previous owner or user for a period of time recognized in the relevant trade or industry as qualifying the personal property or equipment as "used," at the time of ODOT's purchase. "Used personal property or equipment" generally does not include property or equipment if ODOT was the previous user, whether under a lease, as part of a demonstration, trial or pilot project, or similar arrangement.

(c) Process and Criteria:

(A) For purchases of used personal property or equipment with a cost not exceeding $150,000, ODOT must, where feasible, obtain three competitive Quotes, unless ODOT has determined and documented that a purchase without obtaining competitive Quotes will result in cost savings and will not diminish competition or encourage favoritism.

(B) For purchases of used personal property or equipment exceeding $150,000, ODOT must use competitive methods wherever possible to

achieve best value and must document in the Procurement File the reasons why a competitive process was deemed impractical. If the anticipated purchase amount exceeds $5,000, ODOT must post notice on ORPIN. The resulting Contract must be in Writing and ODOT's Procurement File must document the use of this Special Procurement rule by number to identify the sourcing method. Nothing in this rule waives the Department of Justice legal sufficiency review requirement if applicable under ORS 291.047.

(6) The following apply to Reverse Auction procurements:

(a) Process. A Reverse Auction means a process for the purchase of Goods or Services by a buyer from the lowest Bidder. ODOT, as the buyer, must conduct Reverse Auctions by first publishing a Solicitation that describes its requirements, and the Contract terms and conditions. Then, ODOT must solicit online Bids from all interested Bidders through an Internet-based program. The Solicitation must set forth a start and end time for Bids and specify any combination of the following type of information to be disclosed to Bidders during the Reverse Auction:

(A) The prices of the other Bidders or the price of the most competitive Bidder;

(B) The rank of each Bidder (e.g., (i) "winning" or "not winning" or (ii) "1st, 2nd, or higher");

(C) The scores of the Bidders if ODOT chooses to use a scoring model that weighs non-price factors in addition to price; or

(D) Any combination of paragraphs (A), (B) and (C) of this subsection.

(b) Before the Reverse Auction commences, Bidders must be required by ODOT to assent to the Contract terms and conditions, either in Writing or by an Internet "click" agreement. The Bidders then compete for the award of a Contract by offering successively lower prices, informed by the price(s), ranks, and scores, separately or in any combination thereof, disclosed by ODOT. The identity of the Bidders must not be revealed during this process. Only the successively lower price(s), ranks, scores and related details, separately or in any combination thereof, will be revealed to the participants. ODOT may cancel this Solicitation if it determines that it is in ODOT's or the State's best interest. At the end of the Bidding process, and if the solicitation has not been cancelled, ODOT must award any potential Contract to the lowest Responsible Bidder or in the case of multiple awards, lowest Responsible Bidders pursuant to ORS 279A.055(10)(b). This process allows ODOT to test and determine the suitability of the Goods or Services before making the Award. ODOT must comply with the following public notice procedures for this type of Solicitation:

(A) ODOT must disclose the Reverse Auction process in the Solicitation Documents.

(B) ODOT must provide initial notice of this Solicitation through ORPIN.

(C) ODOT must give subsequent notices of the price(s) offered, rank(s), score(s) and related details to the initial Bidders, as described in the Solicitation Document.

(D) ODOT must issue a Notice of Intent to award at least seven (7) calendar days prior to making the Award.

(c) Prequalification. For each Solicitation, under ORS279B.085, on a case-by-case basis, ODOT may determine whether prequalification of suppliers is needed. If prequalification is used, ODOT must pre-qualify suppliers and provide an appeal process in accordance with ORS 279B.120 and related rules.

(7) The following process applies to Advertising Contracts: ODOT must use competitive methods wherever possible to achieve best value and must document in the Procurement File the reasons why a competitive process was deemed to be impractical. If the anticipated purchase exceeds $5,000, ODOT must post notice on ORPIN. The resulting Contract must be in Writing and the Procurement File must document the use of this Special Procurement Rule by number to identify the sourcing method. Nothing in this rule waves the Department of Justice Legal Sufficiency Review requirement, if applicable under ORS 291.047.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.085
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0050**
**Mandatory Use Contracts and Price Agreements**

(1) Mandatory Use Contracts, means for the purposes of this rule, includes DAS and ODOT Price Agreements, service agreements, and sales agreements, which may be established for the purposes of minimizing paper work, achieving continuity of product, securing a source of supply, reducing inventory, combining requirements for volume discounts, standardization among Agencies, and reducing lead-time for ordering. A Mandatory Use Contract requires ODOT to purchase Goods or Services for an anticipated need at a predetermined price under that specific Contract, provided the Mandatory Use Contract is let by a competitive Procurement Process pursuant to the requirements of ORS 279A, 279B, and 279C.

(2) ODOT may purchase the Goods or Services from a Contractor awarded a Mandatory Use Contract without first undertaking additional competitive Solicitation.

(3) ODOT must use Mandatory Use Contracts established by DAS or ODOT unless otherwise specified in the Contract, allowed by law or these rules.

(4) Notwithstanding section (3) of this rule, ODOT is exempted from Mandatory Use Contracts for acquisition of the following, regardless of dollar amount:

(a) Goods or Services from a Local Government Agency, provided that a formal, Written agreement is entered into between the parties;

(b) Goods or Services from the federal government, pursuant to ORS 279A.180;

(c) Personal property for resale through student stores operated by public educational Contracting Agencies; and

(d) Emergency purchases declared by a Contracting Agency pursuant to ORS 279B.080.

(5) The term of the Contract, including renewals, must not exceed the maximum term stated in the original Solicitation.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279B.090
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0055**
**Sole Source Procurements**

(1) Generally. ODOT may Award a Public Contract without competition as a sole-source Procurement pursuant to the requirements of ORS 279B.075 and OAR 731-147-0035.

(2) Public Notice. If, but for ODOT's determination that it may enter into a Contract as a sole-source, ODOT would be required to select a Contractor using source selection methods set forth in either ORS 279B.055 or 279B.060, ODOT shall give public notice of the determination that the Goods or Services or class of Goods or Services are available from only one source in a manner similar to public notice of competitive sealed Bids under ORS 279B.055(4) and OAR 137-047-0300. The public notice shall describe the Goods or Services to be acquired by a sole-source Procurement, identify the prospective Contractor and include the date, time and place that protests are due. ODOT shall give such public notice at least fourteen (14) Days before Award of the Contract, unless ODOT determines that a shorter interval is in the State's best interest, and that a shorter interval will not substantially affect competition.

(3) Protest. An Affected Person may protest the determination that the Goods or Services or class of Goods or Services are available from only one source in accordance with OAR 137-047-0710.

Stat. Auth.: ORS 279A.065 & ORS 279B.075
Stats. Implemented: ORS 279B.075
Hist.: DOT 5-2005, f. & cert. ef. 8-23-05

**731-147-0060**
**Amendments for Intermediate Goods or Services Procurements**

ODOT may amend a Public Contract awarded as an intermediate Procurement in accordance with OAR 137-047-0800, but the cumulative amendments shall not increase the total Contract Price to a sum that is greater than twenty-five percent (25%) of the original Contract price, except:

(1) ODOT may amend a Public Contract awarded as an intermediate Procurement in accordance with OAR 137-047-0800 over the twenty-five percent (25%) cumulative amount but not exceeding the $150,000 threshold with written approval from the ODOT Designated Procurement Officer based upon a determination of the best interests of the State.

(2) ODOT may amend a Public Contract awarded as an intermediate Procurement in accordance with OAR 137-047-0800 over the twenty-five percent (25%) cumulative amount exceeding the $150,000 threshold with written approval from the ODOT Designated Procurement Officer and Department of Justice based upon a determination of the best interests of the State.

(3) Nothing in this rule waives the Department of Justice legal sufficiency review and approval requirement, if applicable under ORS 291.047.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279A.050, 279A.065(5), 279A.070 & 279A.140
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-148-0010**
**Application**

The Oregon Department of Transportation adopts OAR 137-048-0100 through 137-048-0320 (effective March 1, 2005), the Department of Justice Model Rules, Consultant Selection: Architectural, Engineering, Land Surveying, and Related Services Contracts including the additional provisions provided in these rules.

Stat. Auth.: ORS 279A.065
Stats. Implemented: ORS 279A.065
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-148-0020**
**Price Agreement Selection Process**

(1) Consultants for Price Agreements must be selected, and the Oregon Department of Transportation (ODOT) must obtain Architectural, Engineering and Land Surveying and Related Services by selecting a Consultant or Consultants in the following manner. When ODOT selects more than one Consultant under the Price Agreement Solicitation process under OAR 137-048-0130(1), ODOT must identify objective criteria in the Solicitation Document and the Price Agreement to be used in assigning particular Architectural, Engineering and Land Surveying and or Related Services to the most qualified consultant.

(2) Design-Build Contracts involve the provision of both design and construction services for Public Improvements under one Contract. Under most circumstances, Design-Build Contracts are Mixed Contracts with the predominate purpose of the Contract involving construction of the Public Improvement. If the predominate purpose of the Contract is to obtain Architectural, Engineering and Land Surveying and Related Services, selection may proceed under these division 148 rules and shall not be considered a Design-Build project.

Stat. Auth.: ORS 279A.065(5)(a) & 279A.070
Stats. Implemented: ORS 279C.110 & 279C.115
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

**731-149-0010**
**Application**

The Oregon Department of Transportation adopts OAR 137-049-0100 through 137-049-0910 (effective March 1, 2005), the Department of Justice Model Rules, General Provisions Related to Public Contracts for Construction Services. The adoption of the Department of Justice Model Rules by this rule does not apply to any contracts that are subject to OAR chapter 731, division 5 or division 7.

Stat. Auth: ORS 279A.065
Stats. Implemented: ORS 279A.065
Hist.: DOT 3-2005(Temp), f. 2-16-05, cert. ef. 3-1-05 thru 8-27-05; DOT 5-2005, f. & cert. ef. 8-23-05

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

**Adm. Order No.:** DMV 18-2005(Temp)
**Filed with Sec. of State:** 8-18-2005
**Certified to be Effective:** 8-18-05 thru 2-13-06
**Notice Publication Date:**
**Rules Amended:** 735-062-0190, 735-070-0020
**Subject:** OAR 735-062-0190 was adopted to comply with federal law, specifically 49 USC 5103a (Section 1012 of the USA Patriot Act of 2003) and the Federal Motor Carrier Safety Administration (FMCSA) and the Transportation Security Administration (TSA) regulations implementing this law. The federal law specifies that a person may not hold a hazardous materials endorsement on a commercial driver license (CDL) unless the driver obtains a security threat assessment from TSA. DMV implemented the requirements of the federal law by administrative rule on January 30, 2005. The 2005 Legislature clarified the state requirements by passage of House Bill 2107, Sec. 33 (2005), which required DMV to refuse to issue or renew a hazardous materials endorsement or to cancel a CDL if the driver has not completed and passes a TSA security threat assessment. The new Oregon law specifies that a person is entitled to administrative review under ORS 809.440 when the department does not issue or renew a commercial driver license with a hazardous materials endorsement or cancels a commercial driver license with a hazardous materials endorsement. Amendments to OAR 735-062-0190 and 735-070-0020 align these rules with statute and authorize DMV to provide an administrative review rather than a contested case hearing.
**Rules Coordinator:** Brenda Trump—(503) 945-5278

**735-062-0190**
**Requirements for Issuance and Retention of a Hazardous Materials Endorsement**

(1) To obtain, retain or renew a hazardous materials endorsement on an Oregon commercial driver license (CDL), a person must be qualified. To qualify for a hazardous materials endorsement a person must:

(a) Qualify for commercial driving privileges and be issued or have a valid Oregon CDL;

(b) Pass a hazardous materials endorsement knowledge test for an original endorsement or a renewal;

(c) Complete and pass a security threat assessment (security check) from the Transportation Security Administration (TSA) in accordance with 49 CFR Part 1572, including receipt by DMV of a notice from TSA which shows the person does not pose a security threat. A person must pass a TSA security check at the following times:

(A) Before DMV will issue an original hazardous materials endorsement;

(B) Four years prior to the date the CDL with a hazardous materials endorsement expires. Four years and six months prior to the expiration of a hazmat endorsement, DMV will notify the person that he or she must complete and pass a TSA security check within six months in order to retain commercial driving privileges with a hazardous materials endorsement;

(C) At the time of renewal of the CDL with a hazardous materials endorsement. Six months prior to expiration, DMV will notify the person that he or she must complete and pass a TSA security threat assessment before expiration of the CDL in order to retain commercial driving privileges with a hazardous materials endorsement; and

(D) Any other time required by DMV.

(d) Pay all required fees, which include, but may not be limited to, any applicable issuance fee and a hazardous materials knowledge test fee.

(2) To complete a TSA security check, a person must complete a security check application, submit fingerprints, provide proof of citizenship or lawful immigration status, and payment of fees as specified by TSA. To pass a TSA security check, DMV must receive a notice from TSA which shows the person does not pose a security threat.

(3) While waiting to receive the results of the security check from TSA, DMV may issue a CDL without a hazardous materials endorsement to a person required to obtain a TSA security check. A person issued a CDL without a hazardous materials endorsement is not authorized to transport hazardous materials. Upon receipt of a notice from TSA showing the person poses no security threat, DMV will issue, at no charge, a replacement CDL with a hazardous materials endorsement when the person surrenders the CDL that was issued pending the security check.

(4) A person is no longer qualified for a hazardous materials endorsement if:

(a) DMV receives a notice of threat assessment from TSA requiring immediate cancellation of the hazardous materials endorsement; or

(b) DMV receives notice from TSA indicating the person did not pass the security threat assessment.

(5) If DMV determines a person is no longer qualified for a hazardous materials endorsement, DMV must immediately cancel the person's hazardous materials endorsement. Upon cancellation of the hazardous materials endorsement, the person must:

(a) Immediately surrender to DMV the CDL showing the hazardous materials endorsement; and

(b) Pay the required fee for issuance of a replacement driver license. DMV will issue a commercial driver license without a hazardous materials endorsement if the person qualifies for commercial driving privileges.

(6) A person is no longer qualified for commercial driving privileges with a hazardous materials endorsement if when required, the person fails to complete and pass a TSA security check as described in section (2) of this rule. DMV will cancel the person's commercial driving privileges as set forth in OAR 735-070-0020.

(7) If the person does not surrender his or her CDL showing the hazardous materials endorsement within 60 days of the date of the notice of immediate or final cancellation, DMV will cancel the person's commercial driver license pursuant to ORS 809.310(2).

(8) The person may request an administrative review on the immediate cancellation of his or her hazardous materials endorsement. The issues for the administrative review are limited to whether:

(a) When required, the person completed and passed a TSA security check as described in section (3) of this rule;

(b) DMV received a notice from TSA showing the person does not qualify for a hazardous materials endorsement; and

(c) Whether the person is the same person named on the notice.

(9) When the results of the TSA security check are received, DMV will update the person's driving record to indicate the results of the security check and whether a hazardous materials endorsement was issued or denied. DMV will also notify the Commercial Drivers License Information System (CDLIS) of the results of the security check.

(10) An applicant for an Oregon CDL with a hazardous materials endorsement who presents a valid CDL with a hazardous materials endorsement issued by another state must still qualify for an original hazardous materials endorsement as set forth in this rule, including but not limited to a TSA security check.

Stat. Auth.: ORS 184.616, 184.619, 802.010 & 49 CFR Part 1572
Stats. Implemented: ORS 807.170, 807.350, 807.370 & 49 USC § 5103a
Hist.: DMV 3-2005, f. 1-20-05, cert. ef. 1-31-05; DMV 13-2005, f. 5-19-05, cert. ef. 5-31-05; DMV 18-2005(Temp), f. & cert. ef. 8-18-05 thru 2-13-06

**735-070-0020**
**Hearing Following a Cancellation**

(1) The Driver and Motor Vehicle Services Division of the Department of Transportation (DMV) will grant a contested case hearing for cancellation actions in accordance with sections (5) and (6) of this rule.

(2) A request for a hearing on the cancellation of a driver permit, driver license or identification card must comply with the requirements established in OAR 735-070-0110.

(3) When DMV receives a timely request for a hearing on the cancellation of a driver permit, driver license, or identification card, the cancellation will not go into effect pending the outcome of the hearing, except in the following situations:

(a) When DMV determines that there is a serious danger to the public health, safety, or welfare;

(b) When the cancellation is for withdrawal of parent's consent; or

(c) When the cancellation has gone into effect.

(4) For the purposes of this rule, a serious danger to the public health, safety or welfare includes, but is not limited to, the following:

(a) A false or fraudulent driver permit, driver license or identification card has been issued and it could be used to facilitate:

(A) A minor's acquisition of alcoholic beverages;

(B) The cashing of forged checks;

(C) The acquisition of property under false pretenses; or

(D) Any other unlawful activity.

(b) A driver permit or driver license is issued to a person whose driving privileges are suspended or revoked at the time the driver permit or driver license is issued. This applies to a situation where DMV would not have issued the driver permit or driver license had it known at the time that the person's driving privileges were suspended or revoked.

(c) A person determined by DMV to be an endangerment to persons or property and denied further testing through cancellation of driving privileges under ORS 807.350 and OAR 735-062-0073(5).

(5) The Office of Administrative Hearings will conduct hearings held on identification card cancellations under ORS 807.400 as contested cases in accordance with ORS 183.310 to 183.550.

(6) The Office of Administrative Hearings will conduct hearings held on driver permit or driver license cancellations under ORS 809.310 not based on a conviction as contested cases in accordance with ORS 183.310 to 183.550.

Stat. Auth.: ORS 183.415, 184.616, 814.619, 802.010 & 809.440, HB 2107, Sec. 33 (2005)
Stats. Implemented: ORS 809.310 & HB 2107, Sec. 33 (2005)
Hist.: MV 16-1987, f. 9-21-87, ef. 9-27-87; Administrative Renumbering 3-1988, Renumbered from 735-031-0067; MV 9-1989, f. & cert. ef. 2-1-89; MV 5-1992, f. & cert. ef. 4-16-92; DMV 3-2002, f. & cert. ef. 3-14-02; DMV 3-2005, f. 1-20-05, cert. ef. 1-31-05; DMV 18-2005(Temp), f. & cert. ef. 8-18-05 thru 2-13-06

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## Department of Transportation, Motor Carrier Transportation Division
## Chapter 740

**Adm. Order No.:** MCTD 4-2005(Temp)
**Filed with Sec. of State:** 8-18-2005
**Certified to be Effective:** 8-18-05 thru 2-13-06
**Notice Publication Date:**
**Rules Adopted:** 740-010-0020
**Subject:** Chapter 172, Oregon Laws 2005 (Senate Bill 595) authorizes the Director of the Oregon Department of Transportation to suspend operation of certain motor carrier statutes related to moving persons and property when the Director determines that an emergency has occurred or is imminent. Section 2 of Chapter 172, Oregon Laws 2005 (SB 595) authorizes the Director to designate by rule a line of succession for the purpose of suspending operation of motor carrier statutes in the event the Director is not available.
**Rules Coordinator:** Brenda Trump—(503) 945-5278

**740-010-0020**
**Emergency Suspension of Statutes — Delegation**

The Director of the Oregon Department of Transportation authorizes the following line of succession to temporarily suspend operation of statutes involving motor carriers as described in Chapter 172, OL 2005 (SB 595) in the event the Director is not available:

(1) Administrator of the Motor Carrier Transportation Division (MCTD);

(2) Manager of the Salem Motor Carrier Services Section of MCTD;

(3) Manager of Investigations/Safety/Federal Programs Section of MCTD;

(4) Manager of Field Motor Carrier Services Section of MCTD.

Stat. Auth.: Sec. 2, Ch. 172, OL 2005
Stats. Implemented: Sec. 2, Ch. 172, OL 2005
Hist.: MCTD 4-2005(Temp), f. & cert. ef. 8-18-05 thru 2-13-06

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## Employment Department, Child Care Division
## Chapter 414

**Adm. Order No.:** CCD 3-2005(Temp)
**Filed with Sec. of State:** 8-16-2005
**Certified to be Effective:** 8-16-05 thru 2-12-06
**Notice Publication Date:**
**Rules Amended:** 414-061-0080
**Subject:** The Employment Department, Child Care Division, is revising:

OAR 414-061-0080 to update the cost charged for an FBI records check; the cost of these record checks has been raised by the Oregon State Police.
**Rules Coordinator:** Richard L. Luthe—(503) 947-1724

**414-061-0080**
**Procedures for Conducting FBI Criminal History Checks**

(1) An FBI criminal records check will be done on a subject individual whose OSP CCH record shows multi-state offender status, who has lived in Oregon less than 18 months or when CCD has information that the individual has committed a crime in another state.

(2) The subject individual shall supply to CCD the following information:

(a) One properly completed FBI fingerprint card, with printing in the "reason fingerprinted" block which reads "ORS 181.537/NCPA/VCA Child Care";

(b) Properly completed form CCD 199, Consent for Criminal Records Check and Request for Enrollment in the Criminal History Registry; and

(c) For a subject individual who acknowledges a prior conviction, as listed in OAR 414-061-0050, an explanation of the relationship of the facts which support the conviction and all intervening circumstances. On request of CCD, the subject individual must authorize CCD to verify information provided under this rule.

(3) As part of the consent to a criminal records check, CCD may request the subject individual to consent to the use of his/her social security number in conducting the check.

(4) CCD will review the criminal records information and any additional information and will determine whether or not a subject individual may be enrolled in the Criminal History Registry.

(5) CCD will charge the subject individual $62 for an FBI records check, to be paid at the time of the request.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 657A.030(7)
Stats. Implemented: ORS 657A.030
Hist.: CCD 1-1998, f. 9-30-98, cert. ef. 10-1-98 ; CCD 2-2003, f. 12-5-03 cert. ef. 12-7-03; CCD 6-2004, f. & cert. ef 12-17-04; CCD 3-2005(Temp), f. & cert. ef. 8-16-05 thru 2-12-06

## Oregon Liquor Control Commission
## Chapter 845

**Adm. Order No.:** OLCC 5-2005
**Filed with Sec. of State:** 8-16-2005
**Certified to be Effective:** 9-1-05
**Notice Publication Date:** 5-1-05
**Rules Amended:** 845-015-0170
**Subject:** This rule describes the requirements retail sales agents must follow when accepting payment for distilled spirits in retail sales agencies (liquor stores). We amended the rule to clarify that payment must be received at the time of purchase except for distilled spirits which are delivered to Full On-Premises Sales licensed premises. The amendment will require that delivered product must be paid for by the end of the agent's business day on the same day it is delivered.
**Rules Coordinator:** Katie Hilton—(503) 872-5004

**845-015-0170**
**Payment for Distilled Spirits**

(1) Timing of Payment for Distilled Spirits Purchases. Payment for distilled spirits must be made at the time of purchase. If the purchaser is a Full On-Premises Sales licensee, and the distilled spirits being purchased are to be delivered, payment must be received at the liquor store not later than the store's close of business on the same day that the product was delivered to the licensee.

(2) A retail sales agent accepts these forms of payment:

(a) United States currency or a United States traveler's check;

(b) A cashier's check or money order;

(c) Canadian currency or a Canadian traveler's check at the current exchange rate;

(d) A licensee business check for the amount of the purchase only, properly dated, personalized and free of alterations;

(e) A personal check from a customer with a valid check guarantee card and either a valid driver's license with photo or valid DMV Identification card with photo, name, date of birth and physical description. The check must be under $200, payable to the OLCC, for the amount of purchase only, properly dated, personalized and free of alterations. The retail sales agent must write the number and expiration date of the customer's check guarantee card on the check; and

(f) At the retail sales agent's option, an approved credit or debit card transaction may be accepted from non-licensees for the amount of purchase of distilled spirits and related items.

(3) A retail sales agent must not accept a check for purchases by a licensee who has given the Commission two checks or other instruments that could not be paid upon presentation.

(4) Despite section (2) of this rule, a retail sales agent is not required to accept payment if a sale is contrary to law, if a customer lacks necessary age identification or if there is a reasonable basis to believe a customer is not lawfully presenting payment.

(5) A retail sales agent may elect to not take personal checks only if the retail sales agent accepts debit and credit cards using Commission-approved equipment.

(6) A retail sales agent must pay the Commission for an uncollected check if the retail sales agent does not comply with this rule.

Stat. Auth.: ORS 471, 471.030, 471.730(1) & (5)
Stats. Implemented: ORS 471.740 & 471.750(1)
Hist.: LCC 32-1986, f. 12-4-86, ef. 4-1-87; OLCC 10-1989, f. 10-2-89, cert. ef. 10-1-89; OLCC 2-1993(Temp), f. 6-25-93, cert. ef. 7-1-93; OLCC 4-1995, f. 5-2-95, cert. ef. 6-1-95; OLCC 16-2000, f. 11-9-00, cert. ef. 12-1-00; OLCC 2-2003, f. 1-27-03, cert. ef. 2-1-03, Renumbered from 845-015-0075; OLCC 5-2005, f. 8-16-05, cert. ef. 9-1-05

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## Oregon Public Employees Retirement System
## Chapter 459

**Adm. Order No.:** PERS 14-2005
**Filed with Sec. of State:** 8-18-2005
**Certified to be Effective:** 8-18-05
**Notice Publication Date:** 4-1-05
**Rules Amended:** 459-045-0030
**Subject:** Clarifies that Alternate Payees are entitled to benefits based on a member's eligibility rather than a member's actions or choices. The rule modifications are necessary because the existing rule provisions are unclear and contradictory and are more restrictive than the statute provides.
**Rules Coordinator:** David K. Martin—(503) 603-7713

**459-045-0030**
**General Administration**

(1) An alternate payee's award is payable to the alternate payee if the member would be eligible to receive benefits upon separation from service. The member is not required to be separated from service.

(2) A court order may restrict an alternate payee's award to be payable only when the member applies for and receives benefits.

(3) Unless prohibited by court order, an alternate payee who requests a withdrawal shall receive an additional 50 percent of the alternate payee award as of the effective date of withdrawal if:

(a) The alternate payee's effective date of withdrawal is on or after July 1, 2004, and before June 30, 2006; and

(b) As of the alternate payee's effective date of withdrawal, the member has met the requirements of OAR 459-010-0055(4), or would meet them except that he or she has not withdrawn that portion of the member account that may be withdrawn.

(4) Under no circumstance may an alternate payee withdraw less than the entire alternate payee award and payment under this section constitutes payment in full.

(5) The alternate payee may revoke the request for withdrawal if PERS receives a written request to revoke prior to the date of distribution.

(6) The separate account in the name of the alternate payee shall be credited with earnings in accordance with OAR chapter 459, division 007 as follows:

(a) To the date of distribution of the separate account; or

(b) To the date a non-vested member ceases to be a member as provided in ORS 238.095(2), whichever is earlier.

(7) An alternate payee who is awarded a separate account in the Fund in his or her own name shall not be allowed to participate in the Variable Annuity Account in the Fund, as described in ORS 238.260, regardless of whether the member participated in the Variable Annuity Account in the Fund. Once a separate account is established for the alternate payee, those funds will no longer receive variable annuity account earnings.

(8) At the time of the division and establishment of the alternate payee accord, the alternate payee account will be administered under Tier One pursuant to ORS 238.250 and 238.255 if:

(a) The member established membership in PERS or performed any period of service for a participating public employer that is credited to the six month period of employment required of an employee under ORS 238.015 prior to January 1, 1996; or

(b) The member ceased to be a member of PERS under the provisions of ORS 238.095, or 238.105, but restored part or all of the forfeited creditable service from before January 1, 1996, under the provisions of ORS 238.115 or 238.105, after January 1, 1996.

(9) At the time of the division and establishment of the alternate payee account, the alternate payee account will be administered under Tier Two pursuant to ORS 238.250 and 238.435, if the provisions of sections (8)(a) and (b) are not applicable to the member.

(10) The provisions of this rule do not apply to judge members under ORS 238.500 through 238.585.

(11) The provisions of this rule do not apply to the benefits provided under the Oregon Public Service Retirement Plan Pension Program under ORS Chapter 238A.

(12) An alternate payee who elects to begin receiving his or her award pursuant to a court order that uses the Division Methods described in OAR 459-045-0010 Sections (1) and (2), may select any retirement payment option available to the member, other than a joint and survivor annuity, but only if a court order allows the alternate payee to make any elections. The retirement payment to an alternate payee shall be:

(a) Contingent on the member's eligibility for retirement benefits, regardless of whether the member actually retires;

(b) Shall be separate and independent from the member's payment date and payment option; and

(c) Shall be actuarially computed based on the age and life expectancy of the alternate payee.

(13) The alternate payee may elect to convert the Refund Annuity Option as described in ORS 238.300 to one of the following optional forms:

(a) Option 1, as described in ORS 238.305(1);

(b) Option 4, as described in ORS 238.305(1); or

(c) The lump-sum payment option, as described in ORS 238.305(2)(a) and (b) and 238.305(3).

(14) Alternate payees are provided 60 days from the date of their first payment to change the option or designation of beneficiary, except that the designation of beneficiary under the Refund Annuity Option or Option 4 may be changed by the alternate payee at any time before the alternate payee's death.

(15) An alternate payee whose total award is less than $200 per month under Option 1, defined in ORS 238.305(1), shall receive in lieu of any and all allowances or other benefits or form of payment described in section (13) of this rule, a one time lump-sum payment equal to the actuarial value as of the effective date of the alternate payee's retirement, as is the case for a member under ORS 238.315.

(16)(a) PERS shall provide to the alternate payee a written summary of the information used in making a retirement computation. An alternate payee may contest the accuracy of the factual information used by PERS in making the computation of the retirement allowance or benefit by filing a written notice of contest with PERS not later than whichever of the following days occurs last:

(A) The 30th day after the date on which the computation and information is provided to the alternate payee under this section; or

(B) The 30th day after the date on which the retirement allowance or benefit to which the alternate payee is entitled first becomes payable.

(b) The filing of a notice of contest under this section extends the time allowed for election of an optional form of retirement allowance or benefit until the 30th day after the conclusion of the contest proceeding or review results in a change in the computation of the retirement allowance or benefit.

(c) Upon receiving a notice of contest under this section, PERS shall determine the accuracy of the contested information and make a written decision either affirming the accuracy of the information and computation based thereon or changing the computation using corrected information. PERS shall provide to the member a copy of the decision and a written explanation of any applicable statutes and rules.

(d) This section does not affect any authority of PERS, on its own initiative, to correct an incorrect computation of any retirement allowance or benefit.

(17) An alternate payee shall not receive any cost of living increase under ORS 238.360, or special ad-hoc increase that may be granted by the Legislature under 238.365 or 238.385, or any other type of increase that may be granted to PERS retirees until benefits are first paid by PERS to or on behalf of the member.

(18) An alternate payee shall not be entitled to health insurance benefits under ORS 238.410, 238.415, and 238.420 regardless of whether a court order awards these benefits to an alternate payee.

(19) An alternate payee shall not be entitled to any benefits derived from the optional purchase of police officer and fire fighter unit benefits under 238.440 regardless of whether a court order awards these benefits to an alternate payee.

(20) If an alternate payee begins receiving a payment prior to the member, the alternate payee is not entitled to any further increases in retirement credit that the member may earn or become entitled to prior to the member's actual retirement due to continued employment, earnings, or other benefits earned as a member participating in PERS.

(21) Alternate payee court awards made after a member has retired under ORS 238.300 or 238.320 shall be paid as deductions from the retired member's retirement allowance or lump-sum benefit or from the member's beneficiary's retirement allowance or lump sum payment. No alternate payee account will be established.

(22) A court order may require a member who retired under ORS 238.300 or 238.320 to change the designated beneficiary outside the timeframe allowed under ORS 238.305(5) or 238.325(2). The retirement allowance will be adjusted based on the new beneficiary's age to ensure the value of the benefits will not be greater than the allowance the member is otherwise eligible to receive.

(23) Members who retire for disability under ORS 238.320 or 238.325 are considered retired members and all the provisions of sections (12) through (21) of this rule apply to the alternate payee.

(24) Death benefits payable from an alternate payee account are as follows:

(a) If an alternate payee dies before payout or retirement, the alternate payee award is payable to the alternate payee's designated beneficiary or estate as provided by ORS 238.390 and 238.395. No employer death benefits are payable under ORS 238.395 unless the member would have been eligible for employer death benefits had the member died on the same date as the alternate payee.

(b) If an alternate payee has begun receiving retirement benefits or dies after the first payment is due, the benefits due the designated beneficiary or estate, if any, will be based on the option selected by the alternate payee.

(c) If an alternate payee dies after applying for a monthly retirement benefit but before the first of the month following the effective retirement date, the account shall be treated as if the alternate payee died before retirement and benefits will be paid under subsection (a) above.

(d) If the alternate payee is awarded a percentage of a benefit, as long as the award is payable the award will continue to be paid to the alternate payee's designated beneficiary, unless the court decree specifies otherwise.

(25) If the member predeceases the alternate payee, the benefits payable to the alternate payee are as follows:

(a) The alternate payee who has a separate account becomes eligible to withdraw his or her account in the form of a death benefit under ORS 238.390 and 238.395 (if eligible). If the alternate payee elects a death benefit under ORS 238.390 and 238.395 (if eligible), the death benefit shall be in lieu of any withdrawal, service or disability retirement or any other benefit. If the alternate payee does not elect a death benefit, the alternate payee shall be eligible to withdraw the separate account, or to leave the account in the Fund and elect to draw benefits under one of the optional retirement choices described in section (13) of this rule, any time on or after the date the member would have reached earliest retirement age.

(b) If the alternate payee is awarded a percentage of a benefit, as long as the award is payable the award shall be paid according to the decree of divorce or separation or annulment unless the court decree provides for no alternate payee death benefits from the member's account.

(26) Benefit payments to either the member or the alternate payee, or to both simultaneously, that exceed the allowable limits set forth in Section 415 of the Internal Revenue (IRC) shall be deducted from the benefit payment(s) to the member or the alternate payee, or both. Unless a final court order specifies the allocation of the deduction for benefits that exceed the limits in IRC Section 415, PERS shall pro rate the amount that exceed those limits in the same proportions that benefits were awarded to the member and the alternate payee as specified in a final court order.

(27) Distributions of benefits under OAR chapter 459, division 045 must not jeopardize the status of the programs as being part of a tax-qualified governmental plan.

Stat. Auth.: ORS 238.465 & 238.650
Stats. Implemented: ORS 238.465 & OL 2003 Ch. 276 Sec. 2
Hist.: PERS 5-1996, f. & cert. ef. 6-11-96; PERS 17-2004, f. 6-15-04 cert. ef. 7-1-04; PERS 14-2005, f.& cert. ef. 8-18-05

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**Oregon State Lottery**
**Chapter 177**

**Adm. Order No.:** LOTT 8-2005
**Filed with Sec. of State:** 9-1-2005
**Certified to be Effective:** 9-1-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 177-100-0010, 177-100-0180
**Subject:** A definition of "service" and "video lottery terminal" is being added to OAR 177-100-0010. OAR 177-100-0180 is being amended to clarify the process and requirements for obtaining approval to manufacture and service gray machines in Oregon as authorized by ORS 167.117(9)(c)(C).
**Rules Coordinator:** Mark W. Hohlt—(503) 540-1417

**177-100-0010**
**Definitions**

For purposes of division 100, the following definitions apply except as otherwise provided in OAR chapter 177, or unless the context requires otherwise:

(1) "Certification" means the inspection process used by the Lottery to approve video lottery terminals and games.

(2) "Decal" means the stamp displayed by the Lottery upon a video lottery terminal to provide notice that the terminal is authorized by the Lottery.

(3) "Display" means the visual presentation of video lottery game features shown on the screen of a video lottery terminal.

(4) "Gray machine" means a gambling device as described in ORS 167.117(9).

(5) "Manufacturer" means any individual, partnership, corporation, trust, association, joint venture, limited liability company, or other business

entity that manufactures, assembles, services, or produces video lottery terminals or gray machines in Oregon.

(6) "Service" means the activities of a manufacturer related to the maintenance, repair, testing, or quality assurance of gray machines.

(7) "Video lottery" or "Video lottery game" means a lottery conducted through video lottery terminals that are monitored by a central computer system.

(8) "Video lottery terminal" is a device operated under the authority of the Oregon State Lottery and has the meaning set forth in OAR 177-010-0003(22).

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 461.215 & 461.217
Hist.: LC 8-1991, f. & cert. ef. 11-25-91; LOTT 6-2000, f. 7-26-00, cert. ef. 8-1-00; LOTT 6-2003(Temp), f. & cert. ef. 6-5-03 thru 11-28-03; LOTT 14-2003, f. & cert. ef. 9-29-03; LOTT 5-2005(Temp), f. & cert. ef. 5-20-05 thru 11-11-05; LOTT 8-2005, f. & cert. ef. 9-1-05

**177-100-0180**
**Approval for Instate Manufacturing and Servicing of Gray Machines Shipped Out-of-State**

(1) **General Approval:** A manufacturer shall apply to the Director of the Oregon Lottery for approval to manufacture or service gray machines within Oregon.

(a) **Director's Approval:** The Director may authorize a manufacturer to manufacture or service gray machines within the state of Oregon only if the manufacturer intends to export the gray machines to another state or jurisdiction where the operation or possession of the machines is legal. The Director shall require a manufacturer to cite the law that authorizes the legal operation or possession of the machines in the state or jurisdiction, and may require additional evidence that the gray machines will be sold or otherwise provided to a person who is authorized to operate or possess the machines in that jurisdiction. The authorization includes approval to engage in ongoing research and development related to the improvement and development of video lottery terminals the manufacturer intends to manufacture.

(b) **Disclosure Requirements:** The manufacturer is subject to the same disclosure and background investigation requirements as an applicant for a major procurement. The manufacturer may be required by the Director to reimburse the Lottery for the costs of background investigations.

(c) **Inspections and Audits:** A manufacturer's premises, and all production, shipping, service, and financial records, shall be made available for routine and unannounced inspections and audits by the Assistant Director of Security. A manufacturer shall provide to the Lottery, upon request of the Assistant Director for Security, a report listing: the types and numbers of gray machines manufactured; the types and number of machines in storage; the types and number of machines serviced; the name and address of each individual or entity who purchased, leased, or otherwise was provided gray machines or who agreed or expressed an intent to purchase, lease, or otherwise acquire gray machines, or who own, operate, or otherwise possess gray machines serviced by the manufacturer; the number of shipments; destinations of all shipments; and methods of shipment, including carrier used. The information in the report shall be for a time period designated by the Assistant Director for Security. Shipment or transport of gray machines to a destination outside of Oregon also must comply with OAR 177-100-0160.

(2) **Temporary Approval:** The Director may temporarily authorize a manufacturer to manufacture or service gray machines within the state of Oregon that the manufacturer intends to export to another state or jurisdiction where the operation or possession of the machines is legal. The temporary authorization is subject to such terms, conditions, or limitations as the Director deems necessary.

(a) The manufacturer must submit the following:

(A) The information required by ORS 461.410(1);

(B) A written description of the proposed use of the gray machines;

(C) A cite for the law that authorizes the legal operation or possession of the gray machines in the state or jurisdiction where the machines will be used; and

(D) The identity of the individuals or entities who have agreed to or have expressed an intent to purchase or otherwise acquire gray machines from the manufacturer, or who own, operate, or otherwise possess gray machines serviced by the manufacturer.

(b) When the Lottery receives the above materials for temporary approval, the Lottery will conduct an abbreviated background investigation of the manufacturer. The investigation includes, but is not limited to:

(A) A computerized criminal background check of all control persons and any employee deemed necessary by the Assistant Director for Security.

(B) A credit check using the services of a commercial credit reporting company; and

(C) An inspection of the manufacturer's business premises where the gray machines will be manufactured or serviced.

(c) If the Director issues a temporary approval, it is effective for no longer than 180 days.

(3) **Cancellation of Approval:** The Director may cancel any general or temporary approval if the Director determines that the manufacturer has failed to adhere to the qualifications or conditions required for authorization of the manufacturer or otherwise poses a threat to the integrity, security, or honesty of the Lottery. Approval also may be cancelled if within a reasonable time from the date of production, the manufacturer is unable to show the machines have been purchased, leased, or otherwise acquired by a person or entity authorized to obtain or possess the machines.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4) & ORS 461
Stats. Implemented: ORS 167.117 & 167.164
Hist.: LC 7-1991(Temp), f. & cert. ef. 10-28-91; LC 8-1991, f. & cert. ef. 11-25-91; LOTT 6-2003(Temp), f. & cert. ef. 6-5-03 thru 11-28-03; LOTT 14-2003, f. & cert. ef. 9-29-03; LOTT 5-2005(Temp), f. & cert. ef. 5-20-05 thru 11-11-05; LOTT 8-2005, f. & cert. ef. 9-1-05

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**Adm. Order No.:** LOTT 9-2005(Temp)
**Filed with Sec. of State:** 9-7-2005
**Certified to be Effective:** 9-7-05 thru 3-5-06
**Notice Publication Date:**
**Rules Amended:** 177-040-0017
**Subject:** The amendment removes the requirement that an applicant for a video lottery retailer contract establish the viability of the business by operating continuously for nine months prior to entering into a Lottery retailer contract.
**Rules Coordinator:** Mark W. Hohlt—(503) 540-1417

**177-040-0017**
**Additional Business Criteria Which May Be Grounds for Denial of a Video Lottery Application**

(1) Placement of Video Lottery Terminals: Video lottery terminals shall not be placed in a business or at a premises:

(a) That has operated or will operate primarily as a grocery or convenience store. This subsection shall not apply to any existing video lottery retailer who the Director determines was not in accordance with this subsection as of October 14, 1993;

(b) That does not offer meals for on-premise consumption or alcoholic beverages for on-premise consumption as its primary business; except in those cases where the primary business, as determined in subsection (b) of this section, is recreation or entertainment where food and alcoholic beverages for on-premise consumption are offered in a dining or lounge area as an integral feature of the business. Examples include, but are not limited to, bowling centers, golf clubs, and hotels, with a dining or lounge area.

(c) Video lottery terminals shall not be placed in businesses such as laundromats, movie theaters, car dealerships, beauty salons, bed and breakfast lodging, hardware stores, dry goods stores, clothing stores, liquor stores, and other businesses not normally associated with the on-premise consumption of food and alcoholic beverages as its primary activity.

(2) **Factors Considered:** In determining the primary business, the Director may evaluate a combination of the following factors including, but not limited to: the history of the business; internal and external appearance; total square footage of the applicant's premises; the amount of space allocated for the consumption of food or alcoholic beverages; sales and other financial records; availability of seating for food and alcoholic beverage consumption; inventory; the proportion of the location's net income that results from the sale of food, beverages, goods, services and other sources of revenue; and how the business has been advertised and promoted.

(3) **Director's Determination:** The Director's determination of the retailer's primary business shall be final.

(4) **Grocery Store:** For purposes of this rule, a grocery store means a retail business at which food and foodstuffs are regularly and customarily sold in a bona fide manner for consumption off the premises, and shall include supermarkets and one-stop shopping centers which contain a grocery section in addition to offering other wares, goods and services.

(5) **Convenience Store:** For purposes of this rule, a convenience store means a retail business which offers a relatively limited line of high-volume grocery and beverage products and the majority of the products are for consumption off the premises.

Stat. Auth.: OR Const. Art. XV, Sec. 4(4)
Stats. Implemented: ORS 461

Hist.: LOTT 6-2000, f. 7-26-00, cert. ef. 8-1-00; LOTT 9-2005(Temp), f. & cert. ef. 9-7-05 thru 3-5-06

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**Oregon University System**
**Chapter 580**

**Adm. Order No.:** OSSHE 4-2005
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 8-24-05
**Notice Publication Date:** 7-1-05
**Rules Adopted:** 580-021-0029
**Subject:** This rule establishes career development leave as an OUS policy, with implementation rules under the authority of each university. The employer policy fulfills requirements of ORS 238A.025(3)(d), granting up to one calendar year of unpaid leave that does not constitute a break in service for members of the Public Employees Retirement System Chapter 238 pension plan.
**Rules Coordinator:** Marcia M. Stuart—(541) 346-5795

**580-021-0029**
**Career Development Leave**

Career development leave is available to unclassified, faculty, and classified employees of Oregon University System institutions as leave without pay, subject to the approval of the employing institution.

Stat Auth. ORS 351.070 & 238A.025
Stats. Implemented:
Hist.: OSSHE 3-2005(Temp), f. & cert. ef. 3-14-05 thru 9-6-05; OSSHE 4-2005, f. & cert. ef. 8-24-05

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**Adm. Order No.:** OSSHE 5-2005
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 8-24-05
**Notice Publication Date:** 7-1-05
**Rules Amended:** 580-050-0020, 580-050-0032
**Subject:** 580-050-0020(2) - Extends renewal of retainer agreements from one to two years.

580-050-0020(3) - Increases from $25,000 to $75,000 authority for the vice chancellor for finance and administration (VCFA) or designee to award contracts to consultants on retainer list; allows VCFA to award contracts between $75,000 and $200,000 to consultants pursuant to specified procedure; and for contracts over $200,000, permits award after competitive bidding.
**Rules Coordinator:** Marcia M. Stuart—(541) 346-5749

**580-050-0020**
**Appointment of Professional Consultants**

The Vice Chancellor for Finance and Administration or designee is authorized to select and employ architects, engineers, planners and related professional consultants (collectively called “Consultants” in this rule) energy management, construction management, facilities planning, technical services and related activities in accordance with the following standards and procedures:

(1) General Standards; Selection Factors. The purposes of this rule are to assure that Consultants are considered fairly for professional service Contracts; that those selected will be highly qualified; and to encourage excellence and cost consciousness on the part of Consultants. The following factors shall be considered in evaluating and selecting Consultants:

(a) Experience, design talent and technical competence, including an indication of the planning process expected to be used in the work;

(b) Capacity and capability to perform the work, including any specialized services within the time limitation set for the work;

(c) Past record of performance on contracts with governmental agencies and private owners with respect to such factors as cost control, quality of work, ability to meet schedules and contract administration;

(d) Availability to and familiarity with the area in which the work is located, including knowledge of design and construction techniques peculiar to the area;

(e) Proposed cost management techniques to be employed; and

(f) Ability to communicate effectively.

(2) Procurement of Consultant Services Under Retainer Agreements.

(a) At least biennially, in a trade periodical or an Oregon newspaper of general circulation, or on the Oregon University System’s procurement website, and in at least one trade periodical or newspaper geared towards minority, women and emerging small businesses, the Vice Chancellor for Finance and Administration or designee shall publish a notice stating in substance that copies of this rule may be obtained from the Office of Finance and Administration and that consultants are invited to submit qualifications to the Vice Chancellor for Finance and Administration or designee for consideration. The Vice Chancellor for Finance and Administration or designee shall also provide a copy of the above notice to the Office of Minority, Women and Emerging Small Business. A list of the names and addresses of the institution facilities planning official(s) designated by the institution president shall be provided to any consultant upon request.

(b) Following the procedures set out in section (2)(a) of this rule, the Vice Chancellor for Finance and Administration or designee will prepare a list of potential Consultants. An Institution that wishes to enter into retainer agreements may convene a committee as described in paragraph (3)(c)(C) of this rule. Such committee shall review the list prepared by the Vice Chancellor for Finance and Administration or designee and any of the Consultants who have expressed an interest and will select Consultants who appear to have the qualifications for and interest in performing professional services for the Institutions. The Institution Facilities Planning Official shall recommend to the Vice Chancellor for Finance and Administration or designee the selected Consultants.

(c) Each selected Consultant shall be invited to enter into a retainer agreement for a two-year period with the option to extend for an additional two-year term, utilizing a form of agreement approved by the Vice Chancellor for Finance and Administration. Services of the selected Consultants shall be available to all Institutions requiring such services upon request of any Institution Facilities Planning Official. The Office of Finance and Administration, on its own initiative, selects consultants for retainer agreements. The Vice Chancellor for Finance and Administration or designee may enter into interagency agreements to permit other public agencies to utilize the services of Consultants selected for retainer agreements pursuant to this subsection.

(d) Each institution facilities planning official will maintain a current roster of all consultants chosen for institutional retainer agreements by all institutions as well as a roster of retainer agreements entered into by the Office of Finance and Administration.

(e) The names of interested Consultants not selected under subsection (b) of this rule shall be maintained on a current roster and provided to the Institution Facilities Planning Official at each Institution.

(3) General Procurement of Consultant Services: The procedures to be followed when contracting for professional consulting services will depend upon a combination of factors including the total anticipated fee and whether or not the Consultant has entered into a retainer agreement pursuant to section (2) of this rule.

(a) For professional services contracts where the anticipated professional fee, including Consultant fees and reimbursable expenses and all amendments and supplements, is $75,000 or less, the Vice Chancellor for Finance and Administration or designee may authorize an appropriate Institution Facilities Planning Official to contract for such professional services with any Consultant selected in subsection (2)(a) or (2)(b) of this rule or such other Consultant as the Institution Facilities Planning Official may choose who appears to have the qualification for and interest in the proposed assignment.

(b) For professional service contracts involving an anticipated professional fee, including Consultant fees and reimbursable expenses and including amendments and supplements, between $75,001 and $200,000 or in an Emergency situation the Vice Chancellor for Finance and Administration or designee may authorize the Institution Facilities Planning Official to select a Consultant to perform the needed services using the following procedure:

(A) Select a Consultant:

(i) From those on retainer who appear to have the qualifications for and interest in the assignment; or

(ii) Select at least three Consultants not on a retainer agreement who appear to have the qualifications for and interest in the proposed assignment and notify each Consultant selected in reasonable detail of the proposed assignment and invite each Consultant to submit a Written Proposal.

(B) The Institution Facilities Planning Official shall negotiate a Contract with the selected Consultant, and if a mutually satisfactory contract cannot be agreed to, the Institution Facilities Planning Official may select another Consultant from the recommended consultants and enter into contract negotiations.

(c) For professional service contracts with an anticipated professional fee, including Consultant fees and reimbursable expenses over $200,001,

except in Emergency situations, the Institution Facilities Planning Official shall select Consultants for consideration using the following procedure:

(A) Announcement: The Institution Facilities Planning Official will give notice of intent to contract for professional services in a trade periodical, or newspaper of general circulation, or on the Institution's procurement website and in at least one trade periodical or newspaper geared towards minority, women and emerging small businesses. The notice shall include a description of the proposed project, the scope of the services required, and a description of special requirements, if any. The notice will invite qualified prospective Consultants to apply. The notice will specify where the Solicitation Document may be obtained and the Closing. The Institution Facilities Planning Official shall also provide a copy of the above notice of intent to the Office of Minority, Women and Emerging Small Business.

(B) Application: The application or Consultant's qualification must include a statement that describes the prospective Consultant's credentials, performance data and other information sufficient to establish the Consultant's qualification for the project, as well as any other information requested in the announcement.

(C) Initial Screening: The Institution Facilities Planning Official shall appoint a Consultant screening committee consisting of no fewer than two individuals to review, score, and rank the Consultants according to the solicitation criteria. The Consultant screening committee will evaluate the qualifications of all applicants and select prospective Consultants whose applications demonstrate that the selected Consultants can best fulfill the provisions of section (1) of this rule.

(D) The Final Selection Procedure:

(i) Interviews: Following screening and evaluation, the Institution Facilities Planning Official and Consultant screening committee may invite to interview, in person, finalists selected from the initial screening.

(ii) Award of Contracts: The Institution Facilities Planning Official will make the final selection based on such factors as applicant capability, experience, project approach and references; recommend the Consultant to the president or designee; and notify the selected Consultant of such selection.

(iii) An appropriate Institution Facilities Planning Official shall then negotiate a Contract with the selected Consultant. In the event a mutually satisfactory Contract cannot be agreed to, the Consultant screening committee may select for consideration and contract negotiations another Consultant from the remaining recommended Consultants.

(4) Following selection of a consultant, a report of all appointments under subsections (4)(a), (4)(b), and (4)(d) of this rule shall be made to the Board through the Vice Chancellor for Finance and Administration.

(5) The president or designee of the Institution may execute amendments, modifications or supplements to executed professional service Contracts within the scope of the original Contract and the limits prescribed in this rule.

(6) Any Consultant who has submitted a Proposal as outlined in subsections (2)(b), (3)(a), (3)(c) of this rule and claims to have been adversely affected or aggrieved by the selection of a competing Consultant, and unless a different deadline is specified in the notice of intent to contract for professional services, shall:

(a) Have seven (7) calendar days after receiving notice of selection to submit a Written protest of the selection to the Institution Facilities Planning Official. The Institution Facilities Planning Official shall not consider a selection protest submitted after the time period provided in this subsection, unless a different deadline is provided in the notice of intent to contract.

(b) The Institution Facilities Planning Official, in consultation with the Vice Chancellor for Finance and Administration or designee, shall have the authority to settle or resolve a Written protest submitted in accordance with this rule. The Institution Facilities Planning Official shall respond to the protesting Consultant within ten days of receipt of such Written protest.

(c) Judicial review of the disposition of a Written protest submitted in accordance with subsection (6)(a) of this rule may be available pursuant to the provisions of ORS 183.484.

Stat. Auth.: ORS 351.070
Stats. Implemented:
Hist.: HEB 3-1978, f. & ef. 6-5-78; HEB 8-1985, f. & ef. 12-19-85; HEB 10-1990, f. & cert. ef. 7-26-90; HEB 2-1992, f. & cert. ef. 2-12-92 (and corrected 2-21-92); HEB 6-1994, f. & cert. ef. 4-28-94; HEB 4-1995, f. & cert. ef. 8-1-95; HEB 5-1996, f. & cert. ef. 12-18-96; OSSHE 5-2004(Temp), f. & cert. ef. 6-9-04 thru 12-5-04; OSSHE 1-2005(Temp), f. 2-9-05, cert. ef. 2-10-05 thru 8-9-05; Administrative correction 8-17-05; OSSHE 5-2005, f. & cert. ef. 8-24-05

**580-050-0032**
**Contracts for Repairs and Public Improvements**

(1) The Vice Chancellor for Finance and Administration, or designee shall be the contracting officer. All Contracts for the repair of facilities or for Public Improvements shall be awarded and executed by the contracting officer unless delegated by the contracting officer.

(2) The contracting officer may delegate, through the Institution president, to a specific person at each college and university the authority to execute Contracts for the repair and improvement of facilities, provided that all applicable laws and rules are fulfilled. The Institution president may, by written agreement with the president of another Institution, subject to this rule, transfer such delegation to a person at such other Institution. A copy of each such Contract must be filed with the contracting officer or designee who may audit the project and the contracting process.

(3) The contracting officer or designee shall award Contracts valued at $25,000 or more for the repair and improvement of facilities to the lowest Bidder or best Proposer pursuant to appropriate competitive processes, including competitive bids, design/build competitions and negotiated procurements utilizing Requests for Proposals, including agreement for construction manager/general contractor. Criteria for award shall include price and any other factors as the contracting officer or designee deems appropriate, including, but not limited to, past performance of the Contractor, experience of the Contractor and the Contractor's management team on projects of similar size and scope, the Contractor's reputation for quality and timely completion of projects, the Contractor's business and project management practices, the Contractor's demonstrated commitment to affirmative action, the Contractor's willingness to agree to the Contract terms proposed by the contracting officer or designee and the Contractor's ability to post an appropriate bond. The contracting officer or designee shall maintain appropriate records of the competitive process utilized for each Contract. The president of each college and university shall determine the procedures to be used for the award of Contracts valued at less than $25,000 for the repair and improvement of facilities.

(4) The contracting officer or designee may enter into retainer agreements with Contractors using appropriate competitive procedures that take into account, at a minimum, the qualification and reputation of the Contractors, price structure, ability and willingness to respond to requests from one or more colleges and universities, location and such other factors as the contracting officer or designee shall deem appropriate. The contracting officer or designee may utilize the services of Contractors under retainer agreement for projects whose Contract Price is less than the maximum established by the Board of Higher Education in its budget or $500,000, whichever is greater.

(a) Supplements to the retainer agreement, describing the scope of the specific work and price for which it will be performed, must be executed prior to the commencement of any Work by a Contractor.

(b) Supplements having a Contract Price of $25,000 or less shall not be subject to the provisions of section (6) of this rule. However, projects may not be divided into more than one supplement to avoid the application of section (6).

(c) The contracting officer or designee shall maintain appropriate records of the competitive process used to select a Contractor from the list of Contractors with current retainer agreements in force at the time the selection is made and the supplement is issued.

(d) The contracting officer or designee should solicit prices from at least two Contractors under the retainer agreement, or document in the contracting file the reason for not doing so.

(5) The Institution president may declare an Emergency when he or she deems such a declaration appropriate. The reasons for the declaration shall be filed with the Vice Chancellor for Finance and Administration or designee and shall include justification for the use of any sole source or negotiated procurements for repairs and improvements within the scope of the Emergency declaration. Upon the declaration, the contracting officer or designee may negotiate a Contract with any qualified Contractor for repairs or improvements included in the scope of the declaration. The contracting officer or designee shall maintain appropriate records of negotiations carried out as part of the contracting process.

(6) All Public Improvement Contracts shall require Contractors to pay and Contractors shall pay, at least the rate of wage for labor determined by the Bureau of Labor and Industries to be the rate of wage for an hour's work in the same trade or occupation in the locality where such labor is performed for work performed under the Contract. The contracting officer or designee may require any Contractor to pay an amount to the Bureau of Labor and Industries to help defray costs of determining and administering

prevailing wages. The method of determining any such charge shall be described in the Solicitation Document for the project.

(7) No Contract shall be awarded to any Contractor who is not licensed to do business in the State of Oregon.

(8) The contracting officer or designee may require Offerors and Contractors to post and maintain such bonds as the contracting officer or designee decides is appropriate. Requirements related to the posting, form, maintenance, and return shall be included in solicitations and requests for bids and proposals.

(9) All Contractors shall maintain in force at all times during the period of the Contract such insurance as may be required by the contracting officer or designee.

(10) The contracting officer or designee shall ensure that retainage equal to five percent of the Contract Price is withheld from payments to any Contractor. Such retainage shall be invested by the Vice Chancellor for Finance and Administration or designee in accordance with the provisions of OAR 580-040-0007. The principal amount of such retainage and all interest or other earnings from the date of the establishment of a retainage account through the date of completion established in the Contract, less reasonable administrative costs, shall be paid to the Contractor or the Contractor's designee upon notification in writing by the contracting officer or designee that the work contemplated by the Contract has been completed satisfactorily.

(11) The contracting officer or designee shall perform all the duties of the owner on behalf of the Oregon State Board of Higher Education.

(12) The contracting officer or designee may execute change orders to Contracts as long as the scope of the contract is not altered materially by such change orders. Exceptions to this provision may be granted by the Vice Chancellor for Finance and Administration or designee.

(13) The Board of Higher Education or the Director of the Internal Audit Division may audit or investigate any Contract or retainer agreement executed under authority of this rule.

(14) The following procedures shall be used in soliciting, evaluating and rejecting or accepting Bids or Proposals for Contracts for repairs or Public Improvements:

(a) The provisions of sections (3), (4), (6), (7), (8), (10), (11), (13), (14), (22), (23), (24), and (27) of OAR 137-030-0000; sections (2) and (5) of 137-030-0010; 137-030-0012; sections (2) and (3) of 137-030-0030; sections (1), (2), and (4) of 137-030-0040; 137-030-0050 through 137-030-0085; 137-030-0100 through 137-030-0104; 137-030-0110; 137-030-0115(1); 137-030-0120; 137-030-0150; 137-030-0130; 137-040-0020; 137-040-0030; 137-040-0035; 137-040-0040; and 137-040-0045 effective January 1, 1995, shall be applicable to the bidding, awarding and administration of public contracts of the Oregon University System. (These may be found in the Oregon Attorney General's Model Public Contracting Rules Manual, January 1995);

(b) The Oregon University System reserves the right to reject any bid or proposal not in compliance with the Solicitation Documents, or with these rules, and to reject any or all Bids or Proposals upon a finding that it is in the public interest to do so;

(c) Low tie Bids are Bids that are responsive to all requirements and are identical in price, fitness, availability, and quality. Preference shall be given to the Bidder whose principal offices or headquarters are located in Oregon. If no Bidder is eligible for this preference, or if more than one Bidder is eligible for this preference, the Contract shall be awarded by drawing lots first among tied Oregon Bidders or, if there are no such Oregon Bidders, shall be awarded by drawing lots among all tied Bidders.

[Publications: Publications referenced are available from the agency.]
Stat. Auth.: ORS 351.070
Stats. Implemented:
Hist.: HEB 2-1992, f. & cert. ef. 2-12-92 (and corrected 2-21-92); HEB 1-1993, f. & cert. ef. 2-5-93; HEB 4-1995, f. & cert. ef. 8-1-95; HEB 5-1996, f. & cert. ef. 12-18-96; OSSHE 5-2004(Temp), f. & cert. ef. 6-9-04 thru 12-5-04; OSSHE 1-2005(Temp), f. 2-9-05, cert. ef. 2-10-05 thru 8-9-05; Administrative correction, 8-17-05; OSSHE 5-2005, f. & cert. ef. 8-24-05

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**Adm. Order No.:** OSSHE 6-2005(Temp)
**Filed with Sec. of State:** 8-25-2005
**Certified to be Effective:** 8-25-05 thru 2-3-06
**Notice Publication Date:**
**Rules Adopted:** 580-050-0002, 580-050-0355, 580-050-0365
**Subject:** 580-050-0002 - Provides definition of terms used throughout Division 50.
580-050-0355 - Permits negotiation when offer exceeds cost estimates.
580-050-0365 - Permits offers by facsimile and electronic means.
**Rules Coordinator:** Marcia M. Stuart—(541) 346-5749

**580-050-0002**
**Definitions**

All capitalized terms in chapter 580, division 50 have the meanings set forth below, unless otherwise defined in the chapter 580, division 50 rules.

(1) Construction Trade Services: Construction services that are not personal services on projects that are not Public Improvements.

(2) Consultants: Architects, engineers, planners, land surveyors, appraisers, managers and related professional consultants.

(3) Electronic Offer: An Offer made by an Offeror in response to an Institution's Solicitation Document posted on its procurement website.

(4) Emergency: Circumstances that were not foreseen that create a substantial risk of loss, damage, interruption of services or threat to the public health or safety that require prompt execution of a Contract to remedy the condition.

(5) Entity: A natural person capable of being legally bound, sole proprietorship, corporation, partnership, limited liability company or partnership, limited partnership, profit or nonprofit unincorporated association, business trust, two or more persons having a joint or common economic interest, or any other person with legal capacity to contract, or a government or governmental subdivision.

(6) Institution: One of the universities that is part of the Oregon University System, including the Board's Chancellor's Office.

(7) Institution Facilities Planning Official: The Vice Chancellor or, pursuant to OAR 580-050-0032(1) and (2), designee at an Institution with the authority to enter into Contracts. (8)

(8) Invitation to Bid or ITB: A Solicitation Document calling for Bids.

(9) Offer: A Bid or Proposal as applicable.

(10) Offeror: A Bidder or Proposer as applicable.

(11) Proposal: A competitive Offer submitted in response to a Request for Proposals or a request from an Institution Facilities Planning Official to respond to a proposed assignment under OAR 580-050-0020(3)(b) or (c).

(12) Public Improvement: Projects for construction, reconstruction or major renovation on real property by or for an Institution where the Contract Price exceeds $25,000, other than projects for which no funds of a public agency are directly or indirectly used except for participation that is incidental or related primarily to project design or inspection. "Public Improvement" does not include Emergency work, minor alteration, ordinary repair or maintenance necessary in order to preserve a Public Improvement or projects where the total Contract Price is less than $25,000.

(13) Request for Proposals or RFP: A Solicitation Document calling for Proposals.

(14) Request for Qualification or RFQ: A Written document that:

(a) Provides a general description of a proposed project;

(b) Indicates the type of Consultant services needed, including, if deemed necessary or appropriate, a description of the particular services needed for part or all of a proposed project or projects; and

(c) Requests each prospective Offeror to provide a Written response setting forth the Offeror's specific experience and qualifications of performing the type of services required.

(15) Signed, Sign, or Signature: Any mark, word or symbol executed or adopted by a person on behalf of an Entity evidencing an intent to be bound.

(16) Solicitation Document: An Invitation to Bid or Request for Proposals or Request for Qualifications including all documents incorporated by reference.

(17) Specification: Any description of the physical or functional characteristics, or of the nature of a supply, service or construction item, including any requirement for inspecting, testing, or preparing a supply, service, or construction item for delivery and the quantities or qualities of materials to be furnished under the Contract. Specifications generally will state the result to be obtained and may, on occasion, describe the method and manner of doing the Work to be performed.

(18) Written or Writing: Conventional paper documents, either manuscript or printed, in contrast to spoken words. It also includes electronic transmissions or Facsimile documents when required by applicable law, or to the extent permitted by the Solicitation Document or Contract.

Stat. Auth.: ORS 240 & 351.070
Stats. Implemented: ORS 240 & 351.070
Hist.: OSSHE 6-2005(Temp), f. & cert. ef. 8-25-05 thru 2-3-06

**580-050-0355**
**Negotiation When Offers Exceed Cost Estimate**

(1) If all Responsive Offers from Responsible Offerors on a competitively bid Project, including Offers received under OAR 580-050-0032(3) and (4), exceed the Institution's Cost Estimate, prior to Contract award the Institution may negotiate Value Engineering and Other Options with the Responsible Offeror submitting the lowest Responsive Bid or the best Responsive Proposal in an attempt to bring the Project within the Institution's Cost Estimate.

(2) The following definitions apply to this administrative rule:

(a) Cost Estimate: The Institution's most recent pre-Offer, good faith assessment of anticipated Contract costs, consisting either of an estimate of an architect, engineer or other qualified professional, or confidential cost calculation worksheets, where available, and otherwise consisting of formal planning or budgetary documents.

(b) Other Options: Those items generally considered appropriate for negotiation in the RFP process, relating to the details of Contract performance, but excluding any material requirements previously announced in the Solicitation Document that would likely affect the field of competition.

(c) Project: A Public Improvement or Construction Trade Services.

(d) Value Engineering: Those proposed changes to the plans, Specifications, or other Contract requirements which may be made, consistent with industry practice, under the original Contract by mutual agreement in order to take advantage of potential cost savings without impairing the essential functions or characteristics of the Public Improvement or Construction Trade Services. Cost savings include those resulting from life cycle costing, which may either increase or decrease absolute costs over varying time periods.

(3) In determining whether all Responsive Offers from Responsible Offerors exceed the Cost Estimate, only those Offers that have been formally rejected, or Offers from Offerors who have been formally Disqualified by the Institution, shall be excluded from consideration.

(4) Institutions shall not proceed with Contract award if the scope of the Project is significantly changed from the original Offer. The scope is considered to have been significantly changed if the pool of competition would likely have been affected by the change; that is, if other Offerors would have been expected by the Institution to participate in the solicitation process had the change been made during the solicitation process rather than during negotiation. This rule shall not be construed to prohibit resolicitation of trade subcontracts.

(5) Negotiations shall be initially undertaken with the lowest Responsive, Responsible Bidder or the best Responsive, Responsible Proposer. If the lowest Responsive, Responsible Bidder or the best Responsive, Responsible Proposer is not negotiating in good faith, the Institution may, at its sole discretion, negotiate Value Engineering and Other Options with the second lowest Responsive, Responsible Bidder or second best Responsive, Responsible Proposer. If that Offeror is not negotiating in good faith, the Institution may, at its sole discretion, negotiate Value Engineering and Other Options with the next lowest Responsive, Responsible Bidders (Each in order of their Bid) or the next best Responsive, Responsible Proposers (Each in order of their Proposal). Records of an Offeror used in Contract negotiations do not become public records unless they are also submitted to the Institution.

Stat. Auth.: ORS 240 & 351.070
Stats. Implemented: ORS 240 & 351.070
Hist.: OSSHE 6-2005(Temp), f. & cert. ef. 8-25-05 thru 2-3-06

**580-050-0365**
**Facsimile and Electronic Offers**

(1) Institution Authorization. An Institution may authorize Offerors to submit Facsimile or Electronic Offers when the Institution has the resources available and adequate procedures in place to handle the Offers, preserve the "sealed" requirement of competitive procurement, deliver them timely to the Opening and, if Bid or Proposal security is or will be required, provide an alternative method for receipt of the security.

(2) Provisions To Be Included in Solicitation Document. In addition to all other requirements, if the Institution authorizes a Facsimile or Electronic Offer, the Institution will include in the Solicitation Document provisions substantially similar to the following:

(a) A Facsimile or Electronic Offer, as used in this solicitation, means an Offer, modification of an Offer, or withdrawal of an Offer that is transmitted to and received by the Institution via a Facsimile machine or the worldwide web.

(b) Offerors may submit Facsimile or Electronic Offers in response to this solicitation. The entire response must arrive at the place and by the time specified in this Solicitation Document.

(c) Offerors must Sign their Facsimile or Electronic Offers.

(d) The Institution reserves the right to award the Contract solely on the Facsimile or Electronic Offer. However, upon the Institution's request the apparently successful Offeror shall promptly submit its complete original Signed Offer.

(e) If Facsimile Offers are authorized, the data and compatibility characteristics of the Institution's receiving Facsimile machine as follows:

(A) Telephone number;

(B) Compatibility characteristics, e.g. make and model number, receiving speed, and communications protocol.

(f) If Electronic Offers are authorized, the e-mail address of the Institution to be used to receive Electronic Offers.

(g) The Institution is not responsible for any failure attributable to the transmission or receipt of the Facsimile or Electronic Offer including, but not limited to the following:

(A) Receipt of garbled or incomplete documents.

(B) Availability of condition of the receiving Facsimile machine, computer or computer system.

(C) Incompatibility between the sending and receiving Facsimile machine or between the sending and receiving computers.

(D) Delay in transmission or receipt of documents.

(E) Failure of the Offeror to properly identify the Offer documents.

(F) Illegibility of Offer documents.

(G) Security and confidentiality of data.

Stat. Auth.: ORS 240 & 351.070
Stats. Implemented: ORS 240 & 351.070
Hist.: OSSHE 6-2005(Temp), f. & cert. ef. 8-25-05 thru 2-3-06

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**Oregon University System,**
**Eastern Oregon University**
**Chapter 579**

**Adm. Order No.:** EOU 5-2005
**Filed with Sec. of State:** 9-2-2005
**Certified to be Effective:** 9-2-05
**Notice Publication Date:** 8-1-05
**Rules Amended:** 579-070-0005, 579-070-0010, 579-070-0015, 579-070-0030, 579-070-0035, 579-070-0041, 579-070-0042, 579-070-0043, 579-070-0045
**Subject:** Amend Parking and Vehicular Traffic Regulations to accommodate changing needs brought on by University growth. The changes reflect current nomenclature and practices in implementing the University's parking and traffic regulations.
**Rules Coordinator:** Lara Moore—(541) 962-3773

**579-070-0005**
**Purpose**

(1) Campus parking and vehicular traffic regulations are designed to minimize congestion, maintain safety, enhance security, and maximize the use of existing parking facilities.

(2) "**The Board of Higher Education is empowered under ORS 352.360 and 351.070 to enact such regulations as it shall deem convenient or necessary to provide for the policing, control, and regulation of traffic and parking of vehicles on the property of any institution under the jurisdiction of the Board,**" and to "**prescribe and collect charges for services rendered to any person or entity.**" The fees and charges are set at levels sufficient to support fully annual operating expenses of maintaining parking facilities and to meet obligations for bonded indebtedness incurred for the acquisition of property and/or the construction of parking facilities.

(3) These regulations and fees will be reviewed annually by the Vice President of Administration, Finance, and Facilities and, if necessary, an ad hoc committee appointed for this purpose.

(4) Oregon State Police, the Union County Sheriff, and the La Grande City Police are authorized to issue citations for violations of vehicular traffic regulations occurring anywhere within approved campus boundaries. If a citation is issued by one of these enforcement agencies, the person cited should post bail or appear at the time and place stated on the citation. The college exercises no authority or responsibility over these actions.

(5) All signs and curb markings will meet established state standards. Curb Colors: Yellow — No parking; Handicapped — Blue.

(6) A vehicle is any conveyance requiring a state or city license to operate in any public area.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 11, f. & ef. 11-17-77; EOSC 3-1979, f. & ef. 6-27-79; EOSC 1-1982, f. & ef. 6-11-82; EOSC 4-1984, f. & ef. 10-25-84; EOSC 2-1986, f. & ef. 7-28-86; EOSC 4-1992, f. & cert. ef. 8-24-92; EOSC 2-1994, f. & cert. ef. 3-7-94; EOSC 5-1994, f. & cert. ef. 9-6-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0010**
**Permit Parking**

(1) Permit Parking is available to students and employees of Eastern Oregon University on a “first come, first served” basis. Permits can be purchased annually in the Cashier’s Office at Inlow Hall. The permit allows the holder to park weekdays in a permit parking area between 7 am and 5 pm (does not include designated spaces, i.e., reserved, handicap, etc). Vehicles may not remain in parking lots for more than a 24-hour period with the following exceptions: vehicles of dormitory residents and vehicles of those traveling off-campus on University business. All parking permits expire September 15. Permits must be displayed hanging from the rear-view mirror of the vehicle.

(a) The cost for a General Parking Permit:

(A) Entire school year. $75;

(B) Winter–Spring term (purchased winter term). $55;

(C) Spring term only (purchased spring term). $30;

(D) Daily Permits (purchased at Parking Kiosk). $1/day.

(b) A Designated Reserved Space may be purchased on an annual basis for $275. Designated Reserved Spaces cannot be purchased after October 31. This Fee of $275 is in addition to basic permit fee of $75. These permits are valid from September 15 through September 14 each year, Monday–Friday 7 am–5 pm only.

(c) The parking lot west of the Community Stadium is a “no fee” parking lot.

(3) The University assumes no responsibility for damage to or loss of vehicles or their contents when parked within the campus boundaries.

Stat. Auth.: ORS 351.070 & 352.360
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 11, f. & ef. 11-17-77; EOSC 3-1979, f. & ef. 6-27-79; EOSC 1-1982, f. & ef. 6-11-82; EOSC 4-1984, f. & ef. 10-25-84; EOSC 2-1986, f. & ef. 7-28-86; EOSC 2-1991, f. & cert. ef. 6-24-91; EOSC 4-1992, f. & cert. ef. 8-24-92; EOSC 2-1994, f. & cert. ef. 3-7-94 EOSC 5-1994, f. & cert. ef. 9-6-94; EOSC 2-1996, f. 8-15-96, cert. ef. 9-16-96; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0015**
**Visitor Parking**

(1) Visitor 1 Day Parking Permits may be obtained at the Permit Kiosk located at the Information Booth Parking Lot at 6th and “H” ave. These permits are valid in any general space on campus.

(2) Special Visitor Permits may be obtained in advance from individual departments on campus.

(3) Visitor parking permits for buses and vehicles bringing large groups to the campus for scheduled campus events may be obtained by mail from indivisual departments prior to the event.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 11, f. & ef. 11-17-77; EOSC 3-1979, f. & ef. 6-27-79; EOSC 1-1982, f. & ef. 6-11-82; EOSC 4-1984, f. & ef. 10-25-84; EOSC 2-1986, f. & ef. 7-28-86; EOSC 2-1991, f. & cert. ef. 6-24-91; EOSC 4-1992, f. & cert. ef. 8-24-92; EOSC 2-1994, f. & cert. ef. 3-7-94 EOSC 5-1994, f. & cert. ef. 9-6-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0030**
**State Vehicles**

State Vehicles may park in areas any General Parking space without a permit.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 11, f. & ef. 11-17-77; EOSC 3-1979, f. & ef. 6-27-79; EOSC 1-1982, f. & ef. 6-11-82; EOSC 4-1984, f. & ef. 10-25-84; EOSC 2-1986, f. & ef. 7-28-86; EOSC 4-1992, f. & cert. ef. 8-24-92; EOSC 2-1994, f. & cert. ef. 3-7-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0035**
**Citations and Fines**

(1) Citations will be issued to students employees, and visitors of Eastern Oregon University for the following violations:

(a) Parking a student- or employee-owned vehicle in a permit parking area without a parking permit — $15;

(b) Parking in a Designated Reserved Space without displaying a Reserved Permit — $50;

(c) Parking a vehicle in a fire zone — $50;

(d) Failure to display a General Parking permit — $15;

(e) Parking in a loading zone for longer than 15 minutes or when not loading or unloading bulky or heavy materials — $20;

(f) Blocking traffic within approved campus boundaries — $20;

(g) Driving, riding, or parking motor driven vehicles on sidewalks, pedestrian malls, or lawn areas or service roads — $20;

(h) Parking and/or chaining a bicycle in unauthorized areas. Bicycles are not to be parked in any entryway or general use building area — $15;

(i) Parking a vehicle in a handicap space without a current Department of Motor Vehicles permit — $100;

(j) Parking improperly (over the line, wrong way on two-way street, blocking sidewalk, etc.) — $15;

(k) Misuse or altered permit — $50.

(2) Violators are directed by means of the citation to pay a fine at the Cashier’s Office in Inlow Hall. Citation Appeal Forms may be obtained From the Cashier’s office or the Parking office at Facilities & Planning.

(3) Cost of one $15 violation may be applied toward purchase of a General Parking permit. Repeated and flagrant violations of campus parking regulations may result in immobilizing or towing and banning of the vehicle from campus.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 11, f. & ef. 11-17-77; EOSC 3-1979, f. & ef. 6-27-79; EOSC 1-1982, f. & ef. 6-11-82; EOSC 4-1984, f. & ef. 10-25-84; EOSC 2-1986, f. & ef. 7-28-86; EOSC 2-1991, f. & cert. ef. 6-24-91; EOSC 4-1992, f. & cert. ef. 8-24-92; EOSC 2-1994, f. & cert. ef. 3-7-94; EOSC 5-1994, f. & cert. ef. 9-6-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0041**
**Appeal**

(1) A person wishing to appeal a parking citation must do so in writing by preparing an “Appeal of Parking Citation” form, stating the reasons for appealing and present any verifiable facts which will substantiate the appeal. An appellant may, but is not required to, appear in person before the Committee, but must indicate the request on the Parking Citation Appeal form. Appeal forms may be picked up in the Cashier’s Office, Inlow Hall, or the Parking office at Facilities & Planning. The Parking Appeals Committee will review the appeal and its decision is final.

(2) All appeals must be submitted within 10 days from date of the citation. Appeals submitted after 10 days *will not* be considered for review. Appeals will be considered by the committee at the next regularly scheduled meeting.

(3) The following types of reasons are not acceptable grounds for appeal:

(a) Lack of knowledge of the regulations: i.e., new to campus or not read regulations;

(b) Other vehicles were also parked improperly;

(c) Disagree with or inability to pay the amount of the fine(s);

(d) Lack of space;

(e) Unread or misunderstood signs.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 5-1994, f. & cert. ef. 9-6-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0042**
**Parking Appeals Committee**

(1) The Parking Appeals Committee is established to provide an expedient method of handling appeals for parking citations issued by Eastern Oregon University personnel.

(2) The Parking Appeals Committee will consist of two unclassified staff members and two classified staff members appointed by the Vice President of Administration, Finance, and Facilities, two students appointed by the ASEOSC Committees Chairperson, one Faculty member, with the Parking Program Coordinator chairing the Committee meetings, voting only as a tie breaker. A Campus Security/Public Safety officer will serve ex-officio without vote.

(3) Each member of the Parking Appeals Committee will serve for a period of 2 years, with a maximum of two consecutive terms. Terms of office will be staggered to help insure continuity and consistency in the appeals review process.

(4) The Parking Appeals Committee will meet regularly each month.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 5-1994, f. & cert. ef. 9-6-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0043**
**Parking Appeals Committee Authority**

The Parking Appeals Committee shall have the authority to:

(1) Find the individual not guilty of the violation and dismiss the citation.

(2) Find the individual guilty of the violation and impose the appropriate fine.

(3) Find the individual guilty and issue a warning without imposing a fine.

(4) Defer the citation, meaning that the citation will be treated as a warning unless the individual receives another citation at which time the person will be charged for both.

Stat. Auth.: ORS 351.070
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 5-1994, f. & cert. ef. 9-6-94; EOU 5-2005, f. & cert. ef. 9-2-05

**579-070-0045**
**Towing/Immobilizing Vehicles**

(1) A vehicle may be towed off the campus and impounded and the owner subject to towing and storage fees in addition to designated penalties under the following circumstances:

(a) A vehicle causing imminent danger to people or University property, i.e., fire lanes, bus zones or close to fire hydrants;

(b) A vehicle having a parking permit and receiving five or more citations within a school year;

(c) A vehicle not having a parking permit and receiving three citations within a school year;

(d) A vehicle left parked or standing in an area not normally used for vehicular traffic. This includes parking on a sidewalk, or the grass.

(2) A vehicle may also be immobilized by using a mechanical device "boot" for above listed violations.

(3) Release of the vehicle will be made upon payment of the fines or by satisfactory arrangements for payment with the Accounts Receivable office.

Stat. Auth.: ORS 351
Stats. Implemented: ORS 351.070 & 352.360
Hist.: EOSC 1-1982, f. & ef. 6-11-82; EOSC 4-1984, f. & ef. 10-25-84; EOSC 2-1986, f. & ef. 7-28-86; EOU 5-2005, f. & cert. ef. 9-2-05

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## Public Utility Commission
## Chapter 860

**Adm. Order No.:** PUC 4-2005(Temp)
**Filed with Sec. of State:** 8-22-2005
**Certified to be Effective:** 9-1-05 thru 2-27-06
**Notice Publication Date:**
**Rules Adopted:** 860-021-0550, 860-034-0275
**Subject:** These rules implement Senate Bill 983, which was passed by the 2005 Oregon Legislative Assembly and signed by the Governor on June 9, 2005. The rules prohibit the termination of local exchange residential telephone service if the termination would significantly endanger a customer, or a member of the customer's household, who is at risk of domestic violence or abuse. The rules require the customer to submit to the telecommunications utility an affidavit and a copy of a court order that restrains another person from contact with the customer or member of the customer's household. The rules do not excuse the at risk customer from paying for telecommunications service; the qualifying customer is entitled by the rules to enter into a reasonable payment agreement with the utility if overdue balances exist.
**Rules Coordinator:** Diane Davis—(503) 378-4372

**860-021-0550**
**Termination of Local Exchange Residential Service for Telecommunications Customers at Significant Risk**

(1) "At significant risk" means:

(a) At risk of domestic violence, as defined in ORS 135.230;

(b) At risk of unwanted sexual contact, as defined in ORS 163.305;

(c) A person with disabilities, as defined in ORS 124.005, who is at risk of abuse, as defined in ORS 124.005(1)(a), (1)(d), or (1)(e);

(d) An elderly person, as defined in ORS 124.005, who is at risk of abuse, as defined in ORS 124.005(1)(a), (1)(d), or (1)(e); or

(e) A victim of stalking, as described in ORS 163.732.

(2) A large telecommunications utility must establish and maintain procedures for submitting and receiving affidavits under section (3) of this rule.

(3) A customer may establish that termination of local exchange residential service would significantly endanger the customer or a person in the household of the customer by providing the large telecommunications utility with:

(a) An affidavit signed by the customer stating that termination would place the customer or a person in the household of the customer at significant risk. The affidavit will include the name of the person to whom the court order applies and the relationship to the customer, and the expiration date of the order; and

(b) A copy of:

(A) An order issued under ORS 30.866, 107.700 to 107.732, 124.005 to 124.040, or 163.738 that restrains another person from contact with the customer or a person in the household of the customer at significant risk; or

(B) Any other court order that restrains another person from contact with the customer or a person in the household of the customer due to a significant risk.

(4) A customer submitting an affidavit under section (3) of this rule is not excused from paying the large telecommunications utility for any telecommunications services.

(a) Customers are required to enter into a written time-payment agreement with the large telecommunications utility within ten days after submitting the affidavit when an overdue balance exists.

(b) Terms of the time-payment agreement are those in section (5) of this rule or such other terms as the parties agree upon.

(c) The large telecommunications utility may terminate the customer's local exchange residential service if the customer refuses to enter into or fails to abide by the terms of a reasonable payment agreement.

(5) A large telecommunications utility may not disconnect local exchange residential service for nonpayment if a customer who has submitted a affidavit:

(a) Pays the greater of $10 or 25 percent of the balance owing for tariffed or price-listed services the large telecommunications utility has on file with the Commission, including:

(A) For a customer who is not eligible for Oregon Telephone Assistance Program (OTAP), the amount overdue, existing late-payment charges, any current bill, and any bill under preparation but not yet presented to the customer; or

(B) For a customer who is eligible for OTAP, the amount overdue, existing late-payment charges, any current bill, and any bill under preparation but not yet presented to the customer but excluding any toll charges or late payment charges attributable to toll charges.

(b) Enters into a time-payment agreement to bring the account into balance within 90 days of the date of the agreement; and

(c) Agrees to keep subsequent bills current.

(6) When good cause exists, the large telecommunications utility may provide, or the Commission may require, more liberal payment arrangements than those set forth in this rule after providing notice of the payment arrangements in section (5) of this rule. The large telecommunications utility must keep a written record of the reasons for such action.

(7) Nothing in this rule prevents a large telecommunications utility and a customer with an affidavit from entering into a time-payment agreement for other charges.

(8) The large telecommunications utility and the customer may agree to an alternate payment arrangement, provided the large telecommunications utility first informs the customer of the payment terms in subsection (5) of this rule.

(9) Time payments must be on a monthly basis unless otherwise agreed to by the large telecommunications utility and the customer.

(10) The large telecommunications utility may not accelerate payments under a time-payment agreement when the customer changes residences. The customer must pay tariff charges associated with the change in residence.

(11) If a customer who has submitted an affidavit fails to enter into or abide by the terms of a time-payment agreement, the large telecommunications utility may disconnect local exchange service after providing five days' notice to the customer and to the Commission's Consumer Services. The contents of the notice and manner of service must comply with OAR 860-021-0505.

Stat. Auth.: ORS 183, 756 & 759
Stats. Implemented: Ch.290, OL 2005
Hist.: PUC 4-2005(Temp), f. 8-22-05, cert. ef. 9-1-05 thru 2-27-06

**860-034-0275**
**Termination of Local Exchange Residential Service for Telecommunications Customers at Significant Risk**

(1) "At significant risk" means:

(a) At risk of domestic violence, as defined in ORS 135.230;

(b) At risk of unwanted sexual contact, as defined in ORS 163.305;

(c) A person with disabilities, as defined in ORS 124.005, who is at risk of abuse, as defined in ORS 124.005(1)(a), (1)(d), or (1)(e);

(d) An elderly person, as defined in ORS 124.005, who is at risk of abuse, as defined in ORS 124.005(1)(a), (1)(d), or (1)(e); or

(e) A victim of stalking, as described in ORS 163.732.

(2) A small telecommunications utility must establish and maintain procedures for submitting and receiving affidavits under section (3) of this rule.

(3) A customer may establish that termination of local exchange residential service would significantly endanger the customer or a person in the household of the customer by providing the small telecommunications utility with:

(a) An affidavit signed by the customer stating that termination would place the customer or a person in the household of the customer at significant risk. The affidavit will include the name of the person to whom the court order applies and the relationship to the customer, and the expiration date of the order; and

(b) A copy of:

(A) An order issued under ORS 30.866, 107.700 to 107.732, 124.005 to 124.040, or 163.738 that restrains another person from contact with the customer or a person in the household of the customer at significant risk; or

(B) Any other court order that restrains another person from contact with the customer or a person in the household of the customer due to a significant risk.

(4) A customer submitting an affidavit under section (3) of this rule is not excused from paying the small telecommunications utility for any telecommunications services.

(a) Customers are required to enter into a written time-payment agreement with the small telecommunications utility within ten days after submitting the affidavit when an overdue balance exists.

(b) Terms of the time-payment agreement are those in section (5) of this rule or such other terms as the parties agree upon.

(c) The small telecommunications utility may terminate the customer's local exchange residential service if the customer refuses to enter into or fails to abide by the terms of a reasonable payment agreement.

(5) A small telecommunications utility may not disconnect local exchange residential service for nonpayment if a customer who has submitted a valid affidavit:

(a) Pays the greater of $10 or 25 percent of the balance owing for tariffed or price-listed services the small telecommunications utility has on file with the Commission, including:

(A) For a customer who is not eligible for Oregon Telephone Assistance Program (OTAP), the amount overdue, existing late-payment charges, any current bill, and any bill under preparation but not yet presented to the customer; or

(B) For a customer who is eligible for OTAP, the amount overdue, existing late-payment charges, any current bill, and any bill under preparation but not yet presented to the customer but excluding any toll charges or late payment charges attributable to toll charges.

(b) Enters into a time-payment agreement to bring the account into balance within 90 days of the date of the agreement; and

(c) Agrees to keep subsequent bills current.

(6) When good cause exists, the small telecommunications utility may provide, or the Commission may require, more liberal payment arrangements than those set forth in this rule after providing notice of the payment arrangements in section (5) of this rule. The small telecommunications utility must keep a written record of the reasons for such action.

(7) Nothing in this rule prevents a small telecommunications utility and a customer with an affidavit from entering into a time-payment agreement for other charges.

(8) The small telecommunications utility and the customer may agree to an alternate payment arrangement, provided the small telecommunications utility first informs the customer of the payment terms in subsection (5) of this rule.

(9) Time payments must be on a monthly basis unless otherwise agreed to by the small telecommunications utility and the customer.

(10) The small telecommunications utility may not accelerate payments under a time-payment agreement when the customer changes residences. The customer must pay tariff charges associated with the change in residence.

(11) If a customer who has submitted an affidavit fails to enter into or abide by the terms of a time-payment agreement, the small telecommunications utility may disconnect local exchange service after providing five days' notice to the customer and to the Commission's Consumer Services. The contents of the notice and manner of service must comply with OAR 860-034-0260.

Stat. Auth.: ORS 183, 756 & 759
Stats. Implemented: Ch. 290, OL 2005
Hist.: PUC 4-2005(Temp), f. 8-22-05, cert. ef. 9-1-05 thru 2-27-06

**Adm. Order No.:** PUC 5-2005(Temp)
**Filed with Sec. of State:** 9-15-2005
**Certified to be Effective:** 9-15-05 thru 3-13-06
**Notice Publication Date:**
**Rules Adopted:** 860-022-0039
**Subject:** This rule begins the implementation of SB 408, which was passed by the 2005 Oregon Legislative Assembly and signed by the Governor on September 2, 2005. The bill requires public utilities to file annual tax reports and other tax information with the Commission. The bill requires the report to provide information concerning the amount of taxes paid by the public utility and the amount of taxes authorized to be collected in rates during specified time periods. Further, the bill requires the Commission to review the report and determine if the amount of taxes assumed in rates differed by at least $100,000 from the amount of taxes paid by the public utility to units of government. SB 408 directs the Commission, upon finding that difference in amounts, to require the public utility to implement a rate schedule with an automatic adjustment clause accounting for the difference. This rule establishes the filing requirements for the first tax report due October 15, 2005. These issues, and others relating to the details of the potential automatic adjustment clause, will be further reviewed in the permanent rulemaking, AR 499.
**Rules Coordinator:** Diane Davis—(503) 378-4372

**860-022-0039**
**Annual Tax Reports and Automatic Adjustment Clauses Relating to Public Utility Taxes**

(1) This rule applies to any regulated investor-owned utility, or successor in interest, that provided electric or natural gas service to an average of 50,000 or more customers in Oregon in 2003.

(2) As used in this rule:

(a) "Affiliated group" means an affiliated group of corporations of which the public utility is a member and that files a consolidated federal income tax return.

(b) "Deferred taxes" means the total deferred tax expense of regulated operations as reported in the appropriate FERC deferred tax expense accounts that relate to the year being reported.

(c) "Income" means taxable income.

(d) "Properly attributed" means the product determined by multiplying the following two values:

(A) The total amount of taxes paid by the public utility or affiliated group to units of government; and

(B) The ratio of the tax liability of Oregon regulated operations of the public utility to the total tax liability from all affiliates of the public utility or the affiliated group with a positive tax liability.

(e) "Regulated operations of the utility" means those activities of a public utility that are subject to rate regulation by the Commission.

(f) "Tax" means a federal, state or local tax or fee that is imposed on or measured by income and that is paid to a unit of government, but does not include a franchise fee or privilege tax.

(g) "Taxes authorized to be collected in rates" means the product determined by multiplying the following three values, calculated excluding the revenues and costs related to sales for resale and purchased gas for natural gas utilities:

(A) The revenues the public utility collects from ratepayers in Oregon, adjusted for any rate adjustment imposed under this rule;

(B) The ratio of the net revenues from regulated operations of the public utility to gross revenues from regulated operations of the public utility, as determined by the Commission in establishing rates; and

(C) The effective tax rate used by the Commission in establishing rates, calculated as the ratio of total taxes to pre-tax income.

(h) "Taxes paid" means net amounts received by units of government from the public utility or from the affiliated group and properly attributed to regulated operations of the public utility, adjusted as follows:

(A) Increased by the amount of tax savings realized as a result of charitable contribution deductions allowed because of the charitable contributions made by the public utility;

(B) Increased by the amount of tax savings realized as a result of tax credits associated with investment by the public utility in the regulated operations of the public utility, to the extent the expenditures giving rise to the tax credits and tax savings resulting from the tax credits have not been taken into account by the Commission in the public utility's last general ratemaking proceeding; and

(C) Adjusted by deferred taxes related to the regulated operations of the public utility.

(i) "Units of government" mean federal, state and local taxing authorities.

(3) By October 15, 2005, each public utility will file a tax report with the Commission. The tax report will contain the following information for each of the three preceding fiscal years:

(a) The amount of taxes paid to units of government by the public utility or its affiliated group, without regard to the tax year for which the taxes were paid;

(b) The amount in section (3)(a) of this rule that is properly attributed to Oregon regulated operations of the public utility;

(c) The amount of tax liability of Oregon regulated operations of the public utility calculated on a stand-alone basis using Oregon results of operations;

(d) The amount of taxes authorized to be collected in rates for Oregon regulated operations of the public utility; and

(e) An explanation of the method by which the above amounts were calculated and all supporting workpapers and documents supporting the calculations.

(4) Each public utility will provide any information the Commission requires to make the determination in section (6) of this rule.

(5) The Commission may disclose, or any intervenor may obtain and disclose, the amount by which the amount of taxes that units of government received from the public utility or from the affiliated group differed from the amount of costs for taxes collected, directly or indirectly, as part of rates paid by customers, including whether the difference is positive or negative. An intervenor may not disclose any further information unless the Commission allows the disclosure. The Commission will not authorize disclosure of any information that is exempt from disclosure under the Public Records Law ORS 192.410 – 192.505.

(6) Within 180 days following the filing of the public utility's tax report, the Commission will determine whether the taxes authorized to be collected in rates for any of the three preceding fiscal years differed by $100,000 or more from the amount of taxes paid to units of government that are properly attributed to the Oregon regulated operations of the public utility.

(7) If the Commission makes a finding of a difference of $100,000 or more in section (6) of this rule, the Commission will require the public utility to make a compliance filing establishing an automatic adjustment clause tariff to be effective within 60 days of the finding.

Stat. Auth.: ORS Ch. 183, 756, 757 & 759
Stats. Implemented: ORS 756.040 & 756.060
Hist.: PUC 5-2005(Temp), f. & cert. ef. 9-15-05 thru 3-13-06

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**Teacher Standards and Practices Commission**
**Chapter 584**

**Adm. Order No.:** TSPC 6-2005(Temp)
**Filed with Sec. of State:** 8-16-2005
**Certified to be Effective:** 8-16-05 thru 1-30-06
**Notice Publication Date:**
**Rules Amended:** 584-036-0055, 584-038-0004, 584-040-0005, 584-100-0046
**Rules Suspended:** 584-017-0110
**Subject: Amend:** OAR 584-036-0055 *Fees, Forfeiture, and Expedited Service*: Amends the administrative rule governing fees and incorporates the following fee increases due to finger printing cost increases with the Oregon State Police. Amends current finger print fees from $42 to $62. Amends charter school registration fees from $50 to $75, fingerprint fees inclusive.

OAR 584-038-0004 *Adding Endorsements to a Basic or Standard License*: Allows TSPC to add middle-level endorsements onto Basic and Standard Teaching Licenses to assist educators to meet the federal definitions of "highly qualified teacher" under the federal No Child Left Behind Act.

OAR 584-040-0005 *Standard Teaching License Requirements*: Amends definition of acceptable Master's degree to make consistent with acceptable master's degree allowed for Initial and Continuing Teaching licenses.

OAR 584-100-0046 *Preliminary Teaching License*: Amends when candidates are eligible to receive Preliminary Teaching Licenses. Previously they were limited to new hires into federal No Child Left Behind Act Title I funded positions. Amendments expand the access to the license to all teachers who otherwise qualify as being highly qualified, but do not immediately qualify for the Initial Teaching License.

**Suspend:** OAR 584-017-0110 *Early Childhood Authorization*: Should have been repealed when OAR 584-017-0115 was adopted in January, 2005. It was an oversight not to repeal at that time.
**Rules Coordinator:** Victoria Chamberlain—(503) 378-6813

**584-017-0110**
**Early Childhood Authorization (Valid for Teaching from Age Three through Grade Four)**

The unit assures that candidates for the Early Childhood Authorization demonstrate knowledge, skills, and competencies in an early childhood setting.

(1) Candidates document understanding and apply knowledge of developmental psychology and learning appropriate to students age three through grade four within the cultural and community contexts of the teacher education institution and cooperating school districts.

(2) Candidates articulate and apply a philosophy of education which is appropriate to the students in early childhood education and which assures that students learn to think critically and integrate subject matter across disciplines.

(3) Candidates document broad knowledge of the subject matter, curriculum, and methods needed to enable students to meet state and district standards by passing the Multiple Subjects Assessment for Teachers (MSAT).

(4) Candidates will demonstrate knowledge and application of the following reading competencies:

(a) Phonemic awareness;
(b) Phonics and decoding;
(c) Fluency;
(d) Vocabulary;
(e) Comprehension;
(f) Written expressions;
(g) Formal and informal assessment.
(h) Methods of teaching reading to English language learners

(5) Candidates complete student teaching or internship with students age three through grade four. A practicum may substitute for student teaching if this is an additional authorization on an Initial or Continuing Teaching License.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 2-1998, f. 2-4-98, cert. ef. 1-15-99; TSPC 7-1998, f. 9-28-98, cert. ef. 1-15-99; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 4-2002, f. & cert. ef. 5-21-02; TSPC 6-2002, f. & cert. ef. 10-23-02; Suspended by TSPC 6-2005(Temp), f. & cert. ef. 8-16-05 thru 1-30-06

**584-036-0055**
**Fees, Forfeiture, and Expedited Service**

(1) All fees are assessed for evaluation of the application and are not refundable.

(2) The Commission issues the appropriate license at no additional cost if the applicant qualifies for it within 90 days following evaluation of the application. After 90 days, the applicant may attempt to satisfy the same requirements without paying another fee but must file a new application form. After one year, the applicant must pay another fee, file a new application, and satisfy all license requirements in effect at the time of filing.

(3) The fee for evaluating an application for a license based upon completion of an Oregon approved program is $75.

(4) The fee for evaluating an application for a license not based upon completion of an Oregon approved program is $90.

(5) The fee for evaluating an application for renewal of a license is $75.

(6) The fee for each duplicate license is $10.

(7) The fee for evaluating an application to add one or more endorsements or authorization levels to a currently valid license is $75. No additional fee is required to add an endorsement in conjunction with an application for renewal or reinstatement of a license.

(8) The fee to evaluate an application for reinstatement of an expired license is $75 plus a late application fee of $15 for each month or portion of a month that the license has been expired to a maximum of $150 total.

(9) The fee for evaluating an application for reinstatement of a suspended license is $75.

(10) The fee for evaluating an application for reinstatement of a revoked license is $150 in addition to the $75 application fee.

(11) Forfeiture for a check which the applicant's bank will not honor is $25, unrelated to any evaluation fees. The total amount due shall be paid in cash or credit at the Commission's office or by a Money Order.

(12) There is no fee for evaluating licensure applications submitted on behalf of teachers participating in exchange programs or on Congressional appointment from foreign countries.

(13) The fee for alternative assessment in lieu of the test of educational specialty is $200.

(14) An employer and an applicant may jointly request expedited service by submitting a license application, which must include the C-1 and C-3 forms, accompanied by the regular application fee and an additional service fee of $100.

(a) Qualified applicants will be authorized to perform all duties of the position upon receipt of the emergency licensed issued by the Commission. This emergency license and future licensure is conditional upon determination that all requirements for the license have been met.

(b) The Commission may limit the number of applications from an employing district to a maximum of 100 in any two-day period.

(15) The fee for registration of a charter school teacher is $75 which includes the fee for required criminal records and fingerprinting costs.

(16) The fee for renewal of a charter school registration is $25.

(17) The fee for a criminal records check including fingerprinting is $62.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.200, 342.400 & 342.985
Hist.: TS 15, f. 12-20-76, ef. 1-1-77; TS 17, f. 12-19-77, ef. 1-1-78; TS 2-1979, f. 8-21-79, ef. 1-1-80; TS 1-1982, f. & ef. 1-5-82; TS 3-1983, f. & ef. 5-16-83; TS 4-1983, f. 5-17-83, ef. 7-1-83; TS 6-1984, f. 12-27-84, ef. 1-15-85; TS 4-1985, f. 10-4-85, ef. 1-1-86; TS 7-1986, f. 10-15-86, ef. 1-15-87; TS 5-1988, f. 10-6-88, cert. ef. 1-15-89; TS 7-1989, f. & cert. ef. 12-13-89; TS 1-1992, f. & cert. ef. 1-15-92; TS 4-1994, f. 7-19-94, cert. ef. 10-15-94; TS 5-1994, f. 9-29-95, cert. ef. 10-15-94; TS 4-1997, f. 9-25-97, cert. ef. 10-4-97; TSPC 4-1999, f. & cert. ef. 8-2-99; TSPC 2-2000, f. & cert. ef. 5-15-00; TSPC 1-2003, f. & cert. ef. 1-13-03; TSPC 6-2004, f. & cert. ef. 8-25-04; TSPC 6-2005(Temp), f. & cert. ef. 8-16-05 thru 1-30-06

**584-038-0004**
**Adding Endorsements to a Basic or Standard License**

(1) An endorsement will be added on a basic or standard license upon documentation of a passing score as currently specified by the commission on a designated test of subject mastery, together with completion of one of the following practical experiences: (For Basic or Standard Elementary License practicum exceptions, see subsection (4) below.)

(a) A practicum of two semester hours or three quarter hours, which except as specified below may or may not be part of a longer preparation that includes content or methods courses in the specialty, in an institution approved to prepare teachers for that endorsement; or

(b) Verification of teaching experience on either an optional assignment of ten hours or less or an approved conditional assignment permit as allowed by OAR 584-060-0081 if teaching in Oregon; or

(c) Verification of one year of half-time or more teaching experience in the endorsement; or

(d) Completion of an approved program in the new specialty area.

(2) Alternately, the applicant may qualify for a new endorsement through completion of academic requirements, together with completion of either of the following practical experiences:

(a) Verification of five years of experience teaching the new specialty on a license valid for the assignment. However, all ESOL, ESOL/bilingual experience must be completed outside of Oregon on a license valid for the assignment.

(b) Verification of teaching experience on either an optional assignment of ten hours or less or an approved conditional assignment permit as allowed by OAR 584-060-0081 if teaching in Oregon.

(3) Middle-School Endorsements: Middle-School Endorsements may be added to a Basic or Standard Teaching License under the conditions specified in subsection (1) above with passage of any of the middle-school Commission approved tests in Language Arts, Social Studies or Science. The endorsement will be limited to teaching those subjects in grades 5 through 9 only. [See, OAR 584-036-0015 for rules on assignments.]

(4) Endorsements on Elementary Licenses: A subject-matter endorsement may be added to a Basic or Standard Elementary License in the core academic areas of Language Arts; Social Studies; and Science by passage of a Commission-approved test in the subject-matter area only. An additional practicum is not required.

(5) In addition to the requirements described in subsection (1)(a) above, an approved institutional program including content and methods courses is always required as preparation for added endorsement in elementary education, special education, communication disorders, hearing impairment, or visual impairment.

(6) Approved course preparation is required for adding endorsement in subjects for which no subject mastery test is available.

(7) Subjects in which the commission does not offer endorsement may be taught by anyone whose basic or standard license authorizes teaching at the grade level of the course.

(8) Academic requirements for basic endorsement are detailed in sections of OAR 584-038 below, and academic requirements for standard endorsement are detailed in OAR 584-040. Also, professional-technical endorsements to basic, standard, and pre-1965 licenses are discussed in OAR 584-042-0009.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.200
Hist.: TSPC 4-1999, f. & cert. ef. 8-2-99; TSPC 6-2005(Temp), f. & cert. ef. 8-16-05 thru 1-30-06

**584-040-0005**
**Standard Teaching License Requirements**

(1) Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted a Standard Teaching License.

(2) The Standard Teaching License is issued for five years and is renewable repeatedly under conditions specified below. It is valid for regular teaching at one or more designated authorization levels in one or more designated specialties and for substitute teaching at any level in any specialty.

(3) The applicant must provide verification of successful teaching experience in Oregon schools while holding a Basic Teaching License or a Five-Year Regular License valid for the assignment in one of the following ways:

(a) Three years of one-half time or more experience is required; or

(b) For persons holding a Basic Teaching License prior to January 1, 1990, two years of experience or three years of one-half time or more experience, whichever is less.

(4) The applicant must provide evidence of one of the following:

(a) Completion of an approved Standard Teaching License program which culminates with forty-five quarter hours of upper-division or graduate study beyond the bachelor's degree and includes the following:

(A) Verification of completion of the professional preparation described in OAR 584-040-0008 unless the application is for a Standard Teaching License with a standard special education endorsement, in which case the professional preparation in OAR 584-040-0008 is not required; and

(B) Evidence of completion of the academic preparation for one of the standard endorsements outlined in OAR 584-040-0010 through 584-040-0300 in a field in which the basic endorsement is held, or completion of two of the basic subject matter endorsements outlined in OAR 584-038-0010 through 584-038-0280. Fifteen of the quarter hours that are required for the endorsement(s) must be at graduate level; or

(b) Completion of a master's or higher degree in the arts and sciences, or an advanced degree in the professions from a regionally accredited institution in the United States or the foreign equivalent of such a degree approved by the Commission;

(c) Completion of an inservice program offered by an approved teacher education program granting credit for the experience, culminating in either a master's degree or 45 quarter hours of upper-division or graduate study beyond the bachelor's degree.

(5) An applicant who does not complete the requirements of (4)(a)(ii) above, will not be given a Standard Endorsement, but would retain any Basic Endorsement that the applicant holds.

(6) The applicant must have a passing score on a test of knowledge of U.S. and Oregon civil rights laws at the conclusion of a course or workshop approved by the commission.

(7) The applicant must verify recent education experience in one of the following ways during the three-year period immediately preceding application:

(a) Completion of an approved teacher education program; or

(b) Beginning and completion in a public school or regionally accredited private school in a U.S. jurisdiction of at least one academic year as a full-time licensed educator or two consecutive years as a half-time licensed educator on any license appropriate for the assignment, or equivalent experience as in a state or federal school; or

(c) Receipt of 6 semester hours or 9 quarter hours of academic credit, germane to teaching licensure, from a regionally accredited college or university; or

(d) Completion of one hundred eighty days of teaching in Oregon schools on a teaching license valid for the assignment; or

(e) Compliance with provisions of OAR 584-048-0020; or

(f) A combination of such experience and credit may be submitted in satisfaction of this requirement in which one quarter hour of preparation equals 20 days of successful experience.

(8) The Standard Teaching License may be renewed under the provisions of 584-048-0035 together with completion of the professional development requirements as described in 584-090-0005.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.200
Hist.: TS 15, f. 12-20-76, ef. 1-1-77; TS 17, f. 12-19-77, ef. 1-1-78; TS 1-1982, f. & ef. 1-5-82; TS 3-1983, f. & ef. 5-16-83; TS 4-1983, f. 5-17-83, ef. 7-1-83; TS 6-1984, f. 12-27-84, ef. 1-15-85; TS 4-1985, f. 10-4-85, ef. 1-1-86; TS 7-1986, f. 10-15-86, ef. 1-15-87; TS 1-1987, f. & ef. 3-3-87; TS 1-1988, f. 1-14-88, cert. ef. 1-15-88; TS 3-1988, f. & cert. ef. 4-7-88; TS 6-1989, f. & cert. ef. 10-6-89; TS 7-1989, f. & cert. ef. 12-13-89; TS 1-1992, f. & cert. ef. 1-15-92; TS 4-1994, f. 7-19-94, cert. ef. 10-15-94; TSPC 6-2002, f. & cert. ef. 10-23-02; TSPC 1-2004(Temp), f. & cert. ef. 3-17-04 thru 9-12-04; TSPC 6-2004, f. & cert. ef. 8-25-04; TSPC 6-2005(Temp), f. & cert. ef. 8-16-05 thru 1-30-06

**584-100-0046**
**Preliminary Teaching License**

(1) Upon filing a correct and complete application in form and manner prescribed by the Commission, a qualified applicant shall be granted a Preliminary Teaching License for up to one-year.

(2) To be eligible for a Preliminary Teaching License, the applicant must meet the following requirements:

(a) Hold a bachelor's degree;

(b) Document completion of a teacher education program in any state;

(c) Demonstrate knowledge of applicable civil rights laws by completing the required civil rights affidavit;

(d) Demonstrate subject matter competency as defined in OAR 584-100-0006(14);

(e) Furnish fingerprints in the manner prescribed by the Commission; and

(f) If do not hold a current first aid card, must obtain an approved first aid card within 90 days of receiving the license.

(3) At the expiration of one-year, in order to remain highly qualified, educators holding a Preliminary Teaching License must meet all remaining requirements for the Initial Teaching License.

(4) The Preliminary Teaching License is valid for one year only, and cannot be renewed or extended.

(5) The Preliminary Teaching License is not eligible for district conditional assignment permits.

(6) Eligible applicants will also receive a three-year unrestricted Transitional Teaching License pursuant to ORS 584-060-0161.

Stat. Auth: ORS 342
Stats. Implemented: ORS 342.125
Hist.: TSPC 2-2004, f. & cert. ef. 3-17-04; TSPC 5-2005(Temp), f. & cert. ef. 7-1-05 thru 12-28-05; TSPC 6-2005(Temp), f. & cert. ef. 8-16-05 thru 1-30-06

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**Adm. Order No.:** TSPC 7-2005
**Filed with Sec. of State:** 8-24-2005
**Certified to be Effective:** 8-24-05
**Notice Publication Date:** 11-1-04, 7-1-05
**Rules Adopted:** 584-060-0052, 584-060-0062, 584-070-0132
**Rules Amended:** 584-001-0005, 584-010-0010, 584-017-0130, 584-017-0140, 584-017-0170, 584-036-0015, 584-060-0012, 584-060-0013, 584-060-0051, 584-060-0071
**Rules Repealed:** 584-019-0045, 584-060-0061
**Subject: Adopt:** 584-060-0052: *Adding Authorization Levels to Existing Initial and Continuing Teaching Licenses* – Creates new rule from language that was formerly included in OAR 584-060-0051. Language aligns with 584-017-0170 which governs rules for preparation programs.

584-060-0062: *Adding Endorsements to Initial or Continuing Teaching Licenses* – Creates new rule to clarify provisions for adding endorsements onto Initial or Continuing Teaching Licenses. Rewrites previous rule to insert title paragraphs and clarify language. Reconciles language with rules for Basic and Standards Teaching Licenses. Adds new language for adding a middle-level endorsement. Clarifies when a program is required.

584-070-0132: *Emergency School Counselor License* – Adopts emergency license for School Counselors.

**Amend:** 584-001-0005: *Model Rules of Procedure* – Updates and cites current Attorney General rules of procedures for the agency.

584-010-0010: Approval of Education Programs for Teachers, Administrators, and Personnel Service Specialists – Clarifies rules in effect at the time of the site visit apply to site visit; clarifies when interim visit may occur; updates term between visits from five to seven years.

584-017-0130: *Middle Level Authorization* – Updates optional tests that may be taken to add new middle-level endorsement to licenses; clarifies practicum experience allowed to add the authorization.

584-017-0140: *High School Authorizations* – Renumbers for consistency with other rules in Division 17; adds cites for reference into the rule.

584-017-0170: *Adding Endorsements to Initial or Continuing Teaching Licenses* – Clarifies rule and reconciles with Division 60 rules.

584-036-0015: *Basic and Standard Teaching Licenses with Authorizations and Endorsements* – Permanently adopts temporary rule amendments. Reformatted rule, clarified language, cleaned up inconsistencies.

584-060-0012: *Initial I Teaching License Requirements* – Changes term of Initial Teaching License from five to three years, renames the license the Initial I license and clarifies eligibility for the Initial II license.

584-060-0013: *Initial II Teaching License Requirements* – Clarifies rules for obtaining Initial Teaching License II; clarifies requirements for post-baccalaureate programs resulting in Initial I licensure.

584-060-0051: *Teaching Authorization Levels* – Rewrites language to improve clarity, reconciles with Division 17 language.

584-060-0071: *Endorsements Requiring Multiple Authorization Levels* – Renumbers paragraphs for reading clarify, updates language related to special education areas.

**Repeal:** 584-019-0045: F*iling Petition for Reconsideration or Rehearing is Condition of Judicial Review of Final Orders of TSPC in Contested Cases* –Repeal unnecessary rule, procedure covered in ORS Chapter 183.

584-060-0061: *Endorsement of Specialties* – Rule rewritten in OAR 584-060-0062, updated and clarified.

**Rules Coordinator:** Victoria Chamberlain—(503) 378-6813

**584-001-0005**
**Model Rules of Procedure**

The Attorney General's Hearing Officer Panel Rules of Procedure, OAR 137-003-0501 to 137-003-0700 effective in December 1999, and the Collaborative Dispute Resolution Rules, OAR 137-005-0020 to 137-005-0050, effective in October 2001, and Model Rules of Procedure, OAR 137-001-0005 to 137-001-0080, effective in December 2003 are by this reference adopted as the rules of procedure for the Teacher Standards and Practices Commission and shall be controlling except as otherwise required by statute or rule.

[ED. NOTE: The full text of the Attorney General's Model Rules of Procedure is available from the office of the Attorney General or Teacher Standards and Practices Commission.]
Stat. Auth.: ORS 183
Stats. Implemented: ORS 183.341
Hist.: TS 1, f. 7-31-73, ef. 7-15-73; TS 6, f. 11-21-73, ef. 12-25-73; TS 13, f. 12-20-76, ef. 1-1-77; Renumbered from 584-021-0100; TS 5-1978, f. & ef. 11-1-78; TS 4-1980, f. & ef. 7-29-80; TS 2-1982, f. & ef. 4-16-82; TS 7-1983, f. & ef. 12-14-83; TS 8-1986, f. 12-19-86, ef. 1-15-87; TS 3-1988, f. & cert. ef. 4-7-88; TS 4-1991, f. & cert. ef. 3-12-91; TS 9-1994, f. & cert. ef. 11-21-94; TSPC 1-2000(Temp), f. & cert. ef. 1-18-00 thru 7-11-00; TSPC 2-2000, f. & cert. ef. 5-15-00; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-010-0010**
**Approval of Education Programs for Teachers, Administrators, and Personnel Service Specialists**

(1) Commission rules for program approval apply to all educator licensure programs. The rules in effect at the time of a unit site visit shall be the rules upon which the unit is evaluated.

(2) Institutions offering programs with alternate time schedules shall submit information equivalent to that required by applicable sections of OAR 584-010-0010 to 584-010-0140 indicating plans at comparable stages of trainee development.

(3) Institutions providing off-campus programs administered by the institution with instruction provided at sites other than the main campus including programs taught on weekends and/or nights delivered through technology in another city will be evaluated as part of the institution's professional education unit.

(4) Unless otherwise stipulated, Commission approval of a program shall expire on August 31 of the final year of the approved period. It is the responsibility of the institution to apply for renewal or a Commission-approved extension in advance of the expiration of the program approval period.

(5) Commission program approval is granted following evaluation of program objectives, philosophy, and content and following an onsite assessment by a visiting committee.

(6) In addition to annual reports, periodic reports may be required from the institution upon evidence that the program, institution or unit has undergone major modifications as defined in OAR 584-005-0005(33). An interim visit may only occur after the institution has had an opportunity to present evidence the program has not undergone unapproved major modifications and only after a full vote of the Commission.

(7) Institutions receive program approval for a period of five or seven years. At the end of the approved period, or any lesser period as designated by the Commission, the Commission will re-evaluate the program through the onsite assessment process and in accordance with the rule adopted in division 10 and 17 of these administrative rules.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.147
Hist.: TS 14, f. 12-20-76, ef. 1-1-77; TS 16, f. 12-19-77, ef. 1-1-78; TS 5-1980, f. & ef. 9-11-80; TS 5-1986, f. 7-31-86, ef. 9-1-87; TS 1-1991, f. & cert. ef. 1-2-91; TS 1-1992, f. & cert. ef. 1-15-92; TS 7-1992, f. 12-17-92, cert. ef. 1-15-93; TS 5-1993, f. & cert. ef. 10-7-93; TSPC 1-1998, f. & cert. ef. 2-4-98; TSPC 3-2005(Temp), f. & cert. ef. 4-15-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-017-0130**
**Middle Level Authorization**

The unit assures that candidates for a Middle Level authorization demonstrate knowledge, skills, and competencies in the middle level setting.

(1) Candidates document understanding and apply knowledge of developmental psychology and learning, appropriate to students in middle level education within the cultural and community context of the teacher education institution and cooperating school districts.

(2) Candidates articulate and apply a philosophy of education which is appropriate to the students in middle level education and which ensures that students learn to think critically and integrate subject matter across disciplines.

(3) Candidates document broad knowledge of the subject matter, curriculum and methods needed to enable students to meet state and district standards by passing the required Commission-approved multiple subjects examination.

(4) Candidates document in-depth knowledge of one subject matter or specialty endorsement appropriate to middle level teaching assignments by one or more of the following:

(a) Completing a college major in the subject matter or specialty endorsement;

(b) Passing the required Commission-approved test or tests, in the subject or specialty, including Basic Math;

(c) Passing the optional Commission-approved test in middle school Language Arts, Math, Social Studies or Science;

(d) Presenting evidence satisfactory to the Commission of specialized education.

(5) Candidates who have also passed the required Commission-approved multiple subjects examination may add subject-matter endorsements to the Initial Teaching License with middle-level authorizations by:

(a) Passing the high school level subject-mastery test, including Basic math. These endorsements authorize the candidate to teach the subjects through grade 12 so long as the candidate also holds the high school authorization; or

(b) Passing the middle school optional Commission-approved test in Language Arts, Social Studies or Science. These endorsements are only valid to teach the subject up through grade 9 in an elementary, middle or junior high school regardless if the candidate holds a high school authorization.

(6) Candidates who have not passed the commission-approved multiple subjects examination, but hold middle-level authorizations in art; English for Speakers of Other Languages (ESOL); bilingual education/ESOL; music, physical education, adaptive physical education; reading or special education may add an endorsement by:

(a) Passing the Commission-approved test or tests, including the middle school tests in Language Arts, Social Studies or Science in the subject-matter endorsement; and

(b) Completing one of the following practical experiences in grades 5–9:

(A) A practicum of 2 semester hours or 3 quarter hours, which except as specified below may or may not be part of a longer preparation that includes content or methods courses in the subject area, in an institution approved to prepare teachers for that endorsement;

(B) Verification of one year of experience teaching the new subject-area at least one hour each day or the equivalent on either an optional assignment of ten hours or less or on an approved conditional assignment permit (CAP) as allowed by OAR 584-060-0081; or

(C) Five years of experience teaching the subject area in a public school or regionally accredited private school within a U.S. jurisdiction on a license appropriate for the assignment before holding any Oregon license.

(7) Candidates complete student teaching or internship with students in grades 5–9 in an elementary, middle, or junior high school. A practicum may substitute for student teaching if this is an additional authorization on an Initial or Continuing Teaching License.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 2-1998, f. 2-4-98, cert. ef. 1-15-99; TSPC 6-1998, f. & cert. ef. 7-13-98; TSPC 7-1998, f. 9-28-98, cert. ef. 1-15-99; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 4-2002, f. & cert. ef. 5-21-02; TSPC 6-2002, f. & cert. ef. 10-23-02; TSPC 4-2005(Temp), f. & cert. ef 5-6-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-017-0140**
**High School Authorizations**

The unit assures that candidates for a High School Authorization demonstrate knowledge, skills, and competencies in a high school setting.

(1) Candidates document understanding and apply knowledge of developmental psychology and learning, appropriate to students in grades 7–12 within the cultural and community context of the teacher education institution and cooperating school districts.

(2) Candidates articulate and apply a philosophy of education which is appropriate to the students in grades 7–12 and which ensures that students learn to think critically and integrate subject matter across disciplines.

(3) Candidates document in-depth knowledge of one subject matter or specialty area, curriculum, and methods needed to enable students to meet state and district standards by passing the required Commission-approved test or tests in the specific subject area(s).

(4) Candidates holding middle-level endorsements in language arts, social studies or science, pursuant to OAR 584-017-0130(5) are not eligible to teach these subjects on the high school authorization.

(5) Candidates complete student teaching or internship with students in grades 7–12. A practicum may substitute for student teaching if this is an additional authorization on an Initial or Continuing Teaching License. (See, OAR 584-017-0175 for adding an authorization level.)

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 2-1998, f. 2-4-98, cert. ef. 1-15-99; TSPC 7-1998, f. 9-28-98, cert. ef. 1-15-99; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 4-2005(Temp), f. & cert. ef 5-6-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-017-0170**
**Adding Endorsements to Initial or Continuing Teaching Licenses**

The unit makes provisions for adding subject matter and specialty area endorsements to Initial and Continuing Teaching Licenses consistent with the provisions of OAR 584-060-0062.

(1) The unit shall have an approved program for every endorsement it recommends to TSPC. The endorsement will be added to the license upon the submission of a C-2 form documenting the candidate's completion of the program's requirements.

(2) It is at the unit's discretion to accept practicum experience from approved conditional assignments with districts as part of their recommendation to the commission for a candidate's endorsement.

(3) Endorsement programs will be reviewed under the standards in effect as of the effective date of this rule:

(a) For endorsements where no program is required, evidence of passage of the required Commission approved test or tests and documentation of the required practicum experience; or

(b) For endorsements where a program is required by the Commission, evidence that the program conforms to the standards that are currently in effect for that program at the time the program is submitted for approval.

[ED. NOTE: Forms referenced are available from the agency.]
Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120, 342.147 & 342.165
Hist.: TSPC 2-1998, f. 2-4-98, cert. ef. 1-15-99; TSPC 7-1999, f. & cert. ef. 10-8-99; TSPC 6-2002, f. & cert. ef. 10-23-02; TSPC 1-2003, f. & cert. ef. 1-13-03; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-036-0015**
**Basic and Standard Teaching Licenses with Authorizations and Endorsements**

(1) A Basic Teaching License is issued to an applicant who meets the requirements set forth in OAR 584-038-0005.

(a) It is valid for three years and may be renewed under conditions set forth in division 048.

(b) The endorsements are valid only for departmental assignments in elementary, middle, or junior high schools through grade nine if requirements leading to standard licensure are not met. To retain authorization for teaching in a high school, holders of subject matter endorsements must meet renewal requirements leading to standard licensure (See, division 40 for further information).

(2) A Standard Teaching License is issued to an applicant who meets the requirements set forth in OAR 584-040-0005. The Standard Teaching License is valid for five years and may be renewed. A Standard Teaching License is valid for the same assignments as a Basic Teaching License with similar authorizations and endorsements. In addition, the Standard Teaching License authorizes assignments in grades five through twelve or in preprimary through grade twelve for which a renewed Basic Teaching License may not provide authorization. These authorizations and endorsements are explained in the following sections.

(3) Grade level authorizations are stated on a Basic or Standard Teaching License as follows:

(a) Preprimary through nine;

(b) Preprimary through twelve;

(c) Grades five through nine in an elementary, middle, or junior high school; or

(d) Grades five through twelve.

(4) Assignments: Assignments which are permitted on Basic and Standard Teaching Licenses are stated as endorsements as follows:

(a) Elementary: An elementary subject matter endorsement issued after January 14, 1987 is valid for the self-contained classroom and for departmental assignments in preprimary through grade nine of an elementary, middle, or junior high school except assignments of .51 percent or more in:

(A) Art;

(B) Educational media;

(C) Foreign language;

(D) Health;

(E) Home economics;

(F) Technology education;

(G) Mathematics;

(H) Music;

(I) Physical education; and

(J) Reading.

(b) An elementary endorsement issued on or before January 14, 1987, is valid for departmental assignments in mathematics in preprimary through grade nine of an elementary, middle, or junior high school regardless of the percentage of the mathematics assignment.

(c) The elementary endorsement is also valid for assignments in the high school in which the holder is teaching elementary basic skills as it relates to more than one of the following high school subject areas:

(A) Language arts;

(B) Social studies;

(C) Mathematics; or

(D) Reading.

(d) An elementary endorsement issued after January 15, 2001 in assignments of .51 FTE or more in English for Speakers of Other Languages requires the ESOL endorsement.

(e) Middle School endorsements: Middle school endorsements in language arts, social studies or science may be added to a Basic or Standard teaching license. These endorsements are valid to teach the subject in grades 5 through 9 in an elementary, middle or junior high school only.

(f) Subject matter endorsements valid in preprimary through 12: The following subject matter endorsements are valid for teaching in the subject area in grades preprimary through grade twelve:

(A) Art;

(B) ESOL;

(C) Foreign language;

(D) Health;

(E) Home economics;

(F) Technology education;

(G) Library or educational media;

(H) Mathematics;

(I) Music;

(J) Physical education; or

(K) Reading.

(5) Special Education Assignments: The appropriate special education endorsement is required for a special education assignment in a state-reimbursed or state-approved program. Special education endorsements are valid in preprimary through grade twelve, but are limited to teaching in the special education endorsement area only.

(a) The Handicapped Learner I and II endorsements are valid for teaching handicapped learners and severely handicapped learners (including multi-handicapped), except hearing impaired, speech impaired, and visually impaired, which require the specific endorsement.

(b) The Severely Handicapped Learner endorsement is valid for teaching those defined in OAR 584-036-0005.

(6) Basic special education license must qualify for standard: Upon expiration of the second Basic Teaching License, the holder of a special education endorsement must qualify for a Standard Teaching License with a standard special education endorsement. The severely handicapped learner endorsement is an exception to this rule; it may be renewed without completion of a Standard Teaching License. (See OAR 584-048-0030 regarding renewal of the severely handicapped learner endorsement.)

(7) Professional technical endorsements: A professional technical endorsement is valid for teaching in professional technical programs approved by the Oregon Department of Education and as noted on the license. Any professional technical endorsement is valid for assignments in diversified occupations or as work experience coordinators.

(8) Assignments in areas where the Commission does not issue an endorsement: Any Oregon teaching license is valid for assignment in areas in which the Commission has no endorsements, including but not limited to:

(a) Computer education;

(b) Personal finance; or

(c) Outdoor education.

(9) Coaching assignments: Any Oregon teaching license is also valid for assignment as an athletic coach.

(10) Assignments in "subjects" contained within an endorsement: Assignments in subjects which are a component of a broader endorsement (such as history, which is subsumed in the social studies endorsement) necessitate the broader endorsement.

(a) Resource room, special teacher assignments: Teachers whose titles are broad (such as resource center, enrichment, learning center, or special teacher, etc.) shall hold the subject matter and grade level endorsements that are most compatible with the curriculum being taught.

(b) Teachers On Special Assignments (TOSA): Any Oregon teaching license is valid for an assignment involving leadership responsibilities, such as planning and development of curriculum, organization and maintenance of professional growth programs for licensed personnel, or improvement of instructional practices, if evaluation of licensed personnel is not required by the position.

(c) Counseling assignments: Any Oregon basic or standard teaching license is valid for .49 or less time as a counselor at the grade levels valid for the teaching license.

(d) Drivers education assignments: A teacher holding a Basic, Standard, or Five-Year Regular Teaching License and the appropriate Oregon motor vehicle operator's license may serve as a driver education instructor for the classroom portion of the course. An instructor who provides the behind-the-wheel portion of the course shall meet requirements established by the Oregon Department of Transportation.

(e) Alternative Education: Any Oregon teaching license is valid to teach any subject or grade level in a public alternative education program. A teaching license is not required to teach in a private alternative education program.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120-200, 342.400 & 342.985

Hist.: TS 15, f. 12-20-76, ef. 1-1-77; TS 17, f. 12-19-77, ef. 1-1-78; TS 2-1979, f. 8-21-79, ef. 1-1-80; TS 2-1981(Temp), f. & ef. 8-17-81; TS 1-1982, f. & ef. 1-5-82; TS 6-1982, f. & ef. 12-9-82; TS 3-1983, f. & ef. 5-16-83; TS 6-1984, f. 12-27-84, ef. 1-15-85; TS 7-1986, f. 10-15-86, ef. 1-15-87; TS 1-1987, f. & ef. 3-3-87; TS 1-1988, f. 1-14-88, cert. ef. 1-15-88; TS 3-1988, f. & cert. ef. 4-7-88; TS 2-1989, f. & cert. ef. 2-16-89; TS 3-1989, f. & cert. ef. 7-31-89; TS 5-1989(Temp), f. & cert. ef. 10-6-89; TS 7-1989, f. & cert. ef. 12-13-89; TS 2-1990, f. 6-1-90, cert. ef. 6-14-90; TS 1-1992, f. & cert. ef. 1-15-92; TS 4-1992, f. & cert. ef. 10-1-92; TS 6-1997, f. 9-25-97, cert. ef. 1-15-01; TSPC 5-2001, f. & cert. ef. 12-13-01; TSPC 4-2005(Temp), f. & cert. ef 5-6-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-060-0012**
**Initial I Teaching License Requirements**

(1) Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted an Initial I Teaching License for three years.

(2) The Initial I Teaching License is valid for regular teaching at one or more designated authorization levels in one or more designated specialties and for substitute teaching at any level in any specialty. (See 584-060-0052 for Authorization Levels.)

(3) To be eligible for an Initial I Teaching License, an applicant must:

(a) Possess the personal qualifications for licensure including attainment of at least eighteen years of age and possessing good moral character and mental and physical health necessary for employment as an educator; and

(b) Hold a bachelor's degree or higher from a regionally accredited institution in the United States, or the foreign equivalent of such degree approved by the commission. A master's degree or a doctoral degree from a regionally accredited institution in the United States validates a non-regionally accredited bachelor's degree for licensure; and

(c) Complete an initial teacher education program approved by the commission in Oregon, or complete a state-approved teacher preparation program in any U.S. jurisdiction, or complete a foreign program evaluated as satisfactory by an Oregon institution approved to offer the corresponding program; and

(d) Receive a passing score as currently specified by the commission on each of one or more tests of subject mastery for license endorsement or authorization; and

(A) Any subject-matter test, except the basic skills tests, may be waived if the applicant demonstrates special academic preparation satisfactory to the commission together with five years of experience teaching the specific subject matter on a license valid for the assignment in a public school or regionally accredited private school in a U.S. jurisdiction before holding any Oregon license. The five years of experience must be acquired entirely outside of the state of Oregon and must be obtained while holding an out-of-state license valid for the assignment.

(B) Some applicants may be eligible for alternative assessment for waiver of the subject-matter tests only. (See OAR 584-052-0030 to 0033 regarding Alternative Assessment guidelines and regulations.)

(e) Receive a passing score as currently specified by the commission on a test of basic verbal and computational skills; (See 584-060-0002(7) for definition of Basic Skills Tests.)

(f) Receive a passing score on a test of knowledge of U.S. and Oregon civil rights laws at the conclusion of a course or workshop approved by the commission; and

(g) Furnish fingerprints in the manner prescribed by the commission. (See OAR 584-036-0062 for Criminal Records Check Requirement.)

(h) Obtain a first aid card pursuant to ORS 342.126.

(i) Complete a recent experience during the three-year period immediately preceding application. (See OAR 584-005-0005(54) for definition of Recent Experience.)

(4) Applicants who have completed programs from states other than Oregon will be required to submit a C-2 form from the institution granting program completion, in addition to transcripts, verifying completion of the teacher education program. A license from another state valid for unrestricted full time teaching may be accepted in lieu of a C-2. A teaching license issued by the U.S. Department of Defense will be considered as a license from another state. Completion of alternative routes teaching programs through school districts or other avenues are subject to Executive Director approval.

(5) The Initial I Teaching License may be renewed two times for three years upon showing progress toward completion of the renewal requirements as described in OAR 584-060-0013 during the life of the Initial I Teaching License under the following conditions:

(a) The progress must meet or exceed the equivalent of 3 semester hours or 4.5 quarter hours of graduate coursework germane to the license or directly germane to public school employment.

(b) The educator must qualify for an Initial II Teaching License upon expiration of ten years following the date the first Initial I Teaching License was issued. A one year unconditional extension may be obtained if the educator is unable to meet all requirements within the nine year period. (See, OAR 584-060-0013 Initial II Teaching License.)

(6) The Executive Director may grant an extension to the Initial I Teaching License for a term determined by the director, if and only if extraordinary circumstances can be demonstrated that the teacher was unable to complete the requirements for the Initial II Teaching License during the life of the Initial I Teaching License.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.165 & 342.136
Hist.: TSPC 1-2005, f. & cert. ef. 1-21-05; TSPC 5-2005(Temp), f. & cert. ef. 7-1-05 thru 12-28-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-060-0013**
**Initial II Teaching License Requirements**

(1) Upon filing a correct and complete application in form and manner prescribed by the commission, a qualified applicant shall be granted an Initial II Teaching License for three years.

(2) To be eligible for an Initial II Teaching License, and if the Initial I Teaching License was granted on the basis of a completed teacher preparation program culminating in a bachelor's degree, the applicant must:

(a) Complete a master's degree or higher in the arts and sciences or an advanced degree in the professions from a regionally accredited institution in the United States, or the foreign equivalent of such degree approved by the commission, together with an equally accredited bachelor's degree; or

(b) In lieu of a master's degree, a candidate must complete graduate level coursework germane to the license or directly germane to public school employment as follows:

(A) At least ten semester hours or fifteen quarter hours in subject-matter coursework; and

(B) At least ten semester hours or fifteen quarter hours in graduate-level education-related coursework; and

(C) At least ten semester hours or fifteen quarter hours in graduate-level electives.

(3) To be eligible for an Initial II Teaching License, and if the Initial I Teaching License was granted on the basis of a post-baccalaureate completed teacher preparation program whether the program culminates in a master's degree, the applicant must complete one of the following (a)–(c):

(a) Six semester hours or nine quarter hours of graduate level academic credit from a regionally accredited college or university, or the graduate level credit must:

(A) Be completed after the Initial I Teaching License has first been issued; and

(B) Be germane to the teaching license or directly germane to public school employment; and

(C) May include pedagogy, or content related to an existing endorsement or authorization, or content related to a new endorsement or authorization. (Completion of this required coursework does not guarantee completion of commission approved endorsement requirements offered by any Oregon college or university)

(b) A commission-approved school district program determined to be equivalent to (a) above; or

(c) Any commission-approved professional assessment.

(d) In all cases, the combination of a post-baccalaureate program and the additional hours required by this subsection must be equivalent to a master's degree or 45 quarter hours or 30 semester hours.

(4) The Initial II Teaching License may be renewed repeatedly for three years upon completion of:

(a) All the requirements in either (3) or (4) above; and

(b) Any one of the following educational experiences as a licensed educator on a license appropriate for the assignment:

(A) One academic year full-time; or

(B) Two academic years half-time or more; or

(C) One hundred and eighty (180) days as a substitute; or

(D) Completion of 6 semester hours or 9 quarter hours of preparation completed in an approved institution during the life of the current teaching license; or

(E) A combination of (A)–(D) above may be submitted in satisfaction of this requirement in which one quarter hour of preparation equals 20 days of successful experience;

(F) Meeting any of the special provisions for renewal contained in OAR 584-048-0015 or 584-048-0020; and

(c) A professional development plan in accordance with OAR 584-090.

(5) A teacher may choose to become eligible for the Continuing Teaching License in lieu of obtaining the Initial II Teaching License. (See OAR 584-060-0022.)

(6) Teachers issued Initial Teaching Licenses prior to July 1, 2005 must meet the requirements of this rule prior to the expiration of ten (10) years from the date the first Initial Teaching License was issued. The additional year granted to licensees holding an Initial Teaching License prior to October 13, 2003, will be included in the ten year calculation for meeting the requirements of this rule.

(7) This rule applies to all Initial Teaching Licenses issued after December 1998.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.165 & 342.136
Hist.: TSPC 1-2005, f. & cert. ef. 1-21-05; TSPC 5-2005(Temp), f. & cert. ef. 7-1-05 thru 12-28-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-060-0051**
**Teaching Authorization Levels**

(1) Teachers must prepare for one or more authorization levels at the early childhood, elementary, middle or high school levels in addition to satisfying the Objectives for Initial Teaching License in OAR 584-017-0100.

(2) Demonstrated competency at these developmental levels indicates the teacher knows, understands and can apply developmental psychology and learning theory appropriate to student age and grade within cultural and community contexts, and can apply an articulated philosophy of education capable of ensuring that students at a particular authorization level will learn to think critically and integrate knowledge across disciplines.

(3) A first Transitional or Initial Teaching License is authorized for levels on the basis of professional education, experience, previous licensure, and specialized academic course work.

(4) Early Childhood Education (ECE) Authorization: The early childhood education (ECE) authorization level requires completion of an approved program including passing the commission-approved multiple subjects examination (MSE) together with completion of a practicum experience with students in preprimary through grade four (4) in a school designated as a pre-primary school, a primary school, or an elementary school. (See, OAR 584-017-0110 for ECE authorization competencies and OAR 584-017-0175 for adding an authorization level to a license.)

(a) The ECE authorization level is valid for any multiple subjects teaching assignment, except assignments in subsection (b) below, in preprimary through grade four (4) in a school designated as a preprimary school, a primary school, or an elementary school.

(b) The ECE authorization level is not valid for assignments requiring specialization endorsement such as art, music, ESOL, ESOL/bilingual, physical education, adaptive physical education, or special education under OAR 584-060-0071.

(5) Elementary (ELEM) Authorization: The Elementary (ELEM) authorization level requires completion of an approved program including passing the commission-approved multiple subjects examination (MSE) together with completion of a practicum experience with students in one or more grades between grades three (3) through eight (8) in an elementary classroom or in a self-contained 5th or 6th grade classroom in a middle school. (See, OAR 584-017-0120 for ELEM authorization competencies and OAR 584-017-0175 for adding an authorization level to a license.)

(a) The ELEM authorization level is valid for any multiple subjects teaching assignment, except assignments in subsection (b) below, in grades three (3) through eight (8) in a school designated as an elementary school with the Oregon Department of Education; or in a self-contained 5th or 6th grade classroom in a middle school.

(b) The ELEM authorization level is not valid for assignments requiring specialization endorsement such as art, music, ESOL, ESOL/bilingual, physical education, adaptive physical education, or special education under OAR 584-060-0071.

(6) The Middle-Level (ML) Authorization: The Middle-Level (ML) authorization level requires completion of an approved program including passing the commission-approved multiple subjects examination (MSE) together with completion of a practicum experience with students in one or more grades between grades five (5) through eight (8). Additionally, the ML authorization requires in-depth knowledge of one subject-matter or specialty endorsement appropriate to middle-level teaching assignments. (See, OAR 584-017-0130 for further ML authorization requirements; OAR 584-060-0062 for ML endorsements; and OAR 584-017-0175 for adding an authorization level to a license.)

(a) The ML authorization is valid for any multiple subjects teaching assignment, except assignments in subsection (b) below, in grades five (5) through eight (8) of a school designated as an elementary, middle, or junior high school.

(b) The ML authorization level is not valid for assignments requiring specialization endorsement such as art, music, ESOL, ESOL/bilingual, physical education, adaptive physical education, or special education under OAR 584-060-0071.

(7) The high school authorization level requires completion of an approved program and qualification for at least one subject-matter endorsement appropriate to secondary schools by passing the required Commission-approved test or tests of subject mastery in the endorsement area, together with completion of a practicum experience with students in one or more grades between grades nine (9) through twelve (12). The high school (HS) authorization is valid for teaching one or more integrated or departmentalized subjects, with which the license must be endorsed, in grades seven (7) through twelve (12) of a school designated as a high school. (See OAR 584-017-0140 for HS authorization requirements; OAR 584-060-0062 for HS endorsements; and OAR 584-017-0175 for adding an authorization level to a license.)

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120-143, 342.153, 342.165 & 342.223-232
Hist.: TSPC 4-1999, f. & cert. ef. 8-2-99; TSPC 4-2002, f. & cert. ef. 5-21-02; TSPC 6-2002, f. & cert. ef. 10-23-02; TSPC 2-2005, f. & cert. ef. 4-15-05; TSPC 4-2005(Temp), f. & cert. ef 5-6-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-060-0052**
**Adding Authorization Levels to Existing Initial and Continuing Teaching Licenses**

(1) A candidate seeking to add the next contiguous authorization level to an existing Initial or Continuing Teaching License will complete the following:

(a) At least six quarter hours or four semester hours of preparation in child or adolescent development, whichever is appropriate for the level being completed. The program will include methods of instruction in the appropriate subjects at the requested authorization level and may include taking additional subject-matter tests to qualify for the authorization level; and

(b) One of the following practicum experiences, which must include preparation of one work sample to document teaching effectiveness at the new authorization level:

(A) A practicum of two semester hours or three quarter hours; or

(B) Verification of a successful teaching experience for at least one year of at least half-time on an approved conditional assignment permit pursuant to OAR 584-060-0081, if approved by the authorization program.

(2) A candidates may add an authorization level that is not contiguous to an existing Initial or Continuing Teaching License if:

(a) The candidates successfully completes an approved program at that level; and

(b) The completed program includes the required practicum experience and completion of a work sample to document teaching effectiveness at the new authorization level.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.143, 342.153, 342.165 & 342.223 - 342.232
Hist.: TSPC 3-2005(Temp), f. & cert. ef. 4-15-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-060-0062**
**Adding Endorsements to Initial or Continuing Teaching Licenses**

(1) Subject-Matter Competency: A new endorsement will be added to a new or existing Initial or Continuing Teaching License upon documentation of one of the following: (For Middle-Level Endorsement exceptions see subsection (3) below.)

(a) For endorsements where subject-matter mastery tests are required by the commission: Documentation of a passing score on all Commission-approved tests required for the endorsement; or

(b) For endorsements where the commission has not approved subject-matter mastery tests in Drama, Japanese, Latin, Russian and Adaptive Physical Education:

(A) Completion of a program or demonstrated completion of required coursework; or

(B) A nonprovisional out-of-state license in the subject-area.

(c) For out-of-state applicants upon first licensure in Oregon: Proof of licensure and five years experience teaching the endorsed subject on an out-of-state non provisional license may allow for waiver of subject-matter tests in the endorsement area. (See, Section (2)(c) below for further information on the required experience.)

(2) Practicum Requirements: In addition to the requirements in subsection (1) above, one of the following practical experiences must be completed:

(a) A practicum of 2 semester hours or 3 quarter hours, which except as specified below may or may not be part of a longer preparation that includes content or methods courses in the subject area, in an institution approved to prepare teachers for that endorsement;

(b) Verification of one year of experience teaching the new subject-area at least one hour each day or the equivalent on either an optional assignment of ten hours or less or an approved conditional assignment permit (CAP) as allowed by OAR 584-060-0081.

(c) For out-of-state licensed applicants only: Five years of experience teaching the subject area in a public school or regionally accredited private school within a U.S. jurisdiction on a license appropriate for the assignment before holding any Oregon license. Other licensed teaching experience deemed to be equivalent to five years of teaching in the manner described above must be specifically approved by the Executive Director.

(3) Specified Middle-Level Subject-Matter Endorsements: Teachers holding an Initial or Continuing Teaching License with a middle-level authorization are not required to complete an additional subject-related practicum to add the endorsements specified in this subsection. To add a middle-level endorsement to a middle-level authorized license, only the Commission-approved subject-matter high school or middle-level test or tests are required in any of the following areas:

(a) Language Arts;

(b) Social Studies;

(c) Science; or

(d) Math.

(4) Some endorsement areas may require the completion of a new authorization level prior to being added to the license. The applicant should obtain a check sheet of requirements from TSPC prior to pursing adding a new endorsement to an existing license.

(5) When Programs are Required: An approved institutional program including content and methods courses is always required as preparation for added endorsement in the following areas:

(a) Special education, including Early Intervention;

(b) Communication disorders;

(c) Hearing impairment;

(d) Visual impairment;

(e) Reading; or

(f) Subjects for which no subject mastery test has been required by the commission for endorsement including but not limited to: Drama, Japanese, Latin, Russian and Adaptive Physical Education.

(6) Specialty Endorsements: Specialty endorsements such as art, music, ESOL, ESOL/bilingual, physical education, adaptive physical education, reading, special education and educational media specialists require multiple-authorizations and may involve additional coursework. (See, OAR 584-060-0071.)

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.143, 342.153, 342.165 & 342.223 - 342.232
Hist.: TSPC 3-2005(Temp), f. & cert. ef. 4-15-05 thru 9-30-05; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-060-0071**
**Endorsements Requiring Multiple Authorization Levels**

(1) There are several specialties in which endorsement of a teaching license must apply to more than one level of authorization. Multiple-subject endorsement is not required at any level for these specialties, meaning that a subject mastery test is required, but the Multiple Subjects Examination (MSE) is not. However, passage of the MSE alone, will not qualify an applicant for addition of the multiple subjects endorsement on licenses endorsed in specialty areas provided for under this rule.

(2)(a) Teachers of the following specialty areas must qualify, through approved academic preparation in the desired authorization levels and through supervised work experience or student teaching, for authorization at any of the following two levels: early childhood and elementary; or elementary and middle-level; or middle-level and high school:

(A) Art;

(B) Bilingual education with English for speakers of other languages (ESOL);

(C) ESOL;

(D) Music;

(E) Physical education;

(F) Adaptive physical education;

(G) Reading; and

(H) Special education.

(b) Candidates completing a practica experience at either early childhood or elementary and at either middle or high school level shall qualify for authorization for pre-primary through grade twelve.

(c) Teachers of special education must complete preparation in the full continuum of disabilities: mild, moderate, and severe.

(3) Educational media specialists must qualify, through approved academic preparation and through supervised work experience or student teaching, for authorization at all four levels: early childhood, elementary, middle-level, and high school.

(4)(a) Endorsements in the following areas must qualify, through approved academic preparation and through supervised work experience or student teaching, for authorization at all four levels: early childhood, elementary, middle-level, and high school:

(A) Communication disorders;

(B) Hearing impairments; or

(C) Visual impairments.

(b) Teachers for the visually impaired must demonstrate proficiency in reading and writing Braille by obtaining a certificate of competency from the National Library Service for the Blind and Physically Handicapped or an equivalent certificate currently approved by the commission.

(c) Teachers for students with communication disorders may obtain authorization at all four levels by earning a certificate of clinical competence from the American Speech and Hearing Association or successor approved by the commission.

Stat. Auth.: ORS 342
Stats. Implemented: ORS 342.120 - 342.143, 342.153, 342.165 & 342.223 - 342.232
Hist.: TSPC 4-1999, f. & cert. ef. 8-2-99; TSPC 6-2002, f. & cert. ef. 10-23-02; TSPC 3-2003, f. & cert. ef. 5-15-03; TSPC 7-2005, f. & cert. ef. 8-24-05

**584-070-0132**
**Emergency School Counselor License**

(1) An Emergency School Counselor License may be issued when a school district demonstrates extenuating circumstances that merit the issuance of the license in order to protect the district's programs or students.

(2) The Emergency School Counselor License shall be issued solely at the discretion of the Executive Director for any length of time deemed necessary to protect the district's programs or students. The Executive Director may consider efforts the educator has made in meeting school counselor licensure requirements.

(3) An Emergency School Counselor License generally will not exceed one year unless the educator or the district has presented unusual extenuating circumstances.

(4) The Emergency School Counselor License is not subject to the 120 days allowed for licensure renewal purposes under ORS 342.127(4).

Stat. Auth.: ORS 342.125
Stats. Implemented: ORS 342.120 - 342.143, 342.153, 342.165 & 342.223 - 342.342
Hist.: TSPC 7-2005, f. & cert. ef. 8-24-05

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| 123-065-3500 | 2-25-05 | Amend | 4-1-05 |
| 123-065-3530 | 2-25-05 | Amend | 4-1-05 |
| 123-065-3545 | 2-25-05 | Adopt | 4-1-05 |
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| 125-246-0355 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0360 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0400 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0410 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0420 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0430 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0440 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0450 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0460 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0470 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0500 | 3-1-05 | Adopt | 1-1-05 |
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| 125-246-0560 | 3-1-05 | Adopt | 1-1-05 |
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| 125-246-0560 | 6-6-05 | Amend | 7-1-05 |
| 125-246-0560 | 8-3-05 | Amend | 9-1-05 |
| 125-246-0570 | 3-1-05 | Adopt | 1-1-05 |
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| 125-246-0575 | 8-3-05 | Amend | 9-1-05 |
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| 125-246-0625 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0630 | 3-1-05 | Adopt | 1-1-05 |
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| 125-246-0710 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0720 | 3-1-05 | Adopt | 1-1-05 |
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| 125-246-0800 | 3-1-05 | Adopt | 1-1-05 |
| 125-246-0900 | 3-1-05 | Adopt | 1-1-05 |
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| 125-247-0420 | 3-1-05 | Adopt | 1-1-05 |
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| 125-247-0440 | 3-1-05 | Adopt | 1-1-05 |
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| 125-247-0460 | 3-1-05 | Adopt | 1-1-05 |
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| 125-247-0660 | 3-1-05 | Adopt | 1-1-05 |
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| 125-247-0710 | 3-1-05 | Adopt | 1-1-05 |
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| 125-247-0730 | 3-1-05 | Adopt | 1-1-05 |
| 125-247-0740 | 3-1-05 | Adopt | 1-1-05 |
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| 333-116-0170(T) | 12-1-04 | Repeal | 1-1-05 |
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| 333-116-0180(T) | 12-1-04 | Repeal | 1-1-05 |
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| 333-505-0007 | 2-4-05 | Amend | 3-1-05 |
| 333-535-0025 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0061 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0080 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0085 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0090 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0100 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0110 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0115 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0120 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0260 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0270 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0300 | 8-15-05 | Amend | 9-1-05 |
| 333-535-0310 | 8-15-05 | Amend | 9-1-05 |
| 333-700-0130 | 8-15-05 | Amend | 9-1-05 |
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| 334-001-0012 | 7-1-05 | Amend | 8-1-05 |
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| 334-010-0050 | 2-23-05 | Amend | 4-1-05 |
| 335-005-0025 | 9-13-05 | Amend | 10-1-05 |
| 335-060-0010 | 9-13-05 | Amend | 10-1-05 |
| 335-060-0060 | 9-13-05 | Amend | 10-1-05 |
| 335-070-0040 | 9-13-05 | Amend | 10-1-05 |
| 335-070-0060 | 9-13-05 | Amend | 10-1-05 |
| 335-070-0080 | 9-13-05 | Amend | 10-1-05 |
| 335-070-0085 | 9-13-05 | Amend | 10-1-05 |
| 335-095-0020 | 9-13-05 | Repeal | 10-1-05 |
| 335-095-0055 | 9-13-05 | Adopt | 10-1-05 |
| 339-010-0005 | 8-11-05 | Amend | 9-1-05 |
| 339-010-0016 | 8-11-05 | Adopt | 9-1-05 |
| 339-010-0050 | 8-11-05 | Amend | 9-1-05 |
| 339-020-0010 | 8-11-05 | Amend | 9-1-05 |
| 339-020-0020 | 8-11-05 | Amend | 9-1-05 |
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| 339-020-0040 | 8-11-05 | Repeal | 9-1-05 |
| 339-020-0050 | 8-11-05 | Repeal | 9-1-05 |
| 339-020-0060 | 8-11-05 | Repeal | 9-1-05 |
| 339-020-0070 | 8-11-05 | Repeal | 9-1-05 |
| 339-020-0100 | 8-11-05 | Amend | 9-1-05 |
| 340-012-0026 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0027 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0028 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0030 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0040 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0041 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0042 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0045 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0046 | 6-1-05 | Repeal | 6-1-05 |
| 340-012-0047 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0048 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0049 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0050 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0052 | 6-1-05 | Repeal | 6-1-05 |
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| 340-012-0055 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0060 | 3-1-05 | Amend | 3-1-05 |
| 340-012-0065 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0066 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0067 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0068 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0071 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0072 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0073 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0074 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0079 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0081 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0082 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0083 | 6-1-05 | Amend | 6-1-05 |
| 340-012-0090 | 6-1-05 | Am. & Ren. | 6-1-05 |
| 340-012-0097 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0130 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0145 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0150 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0160 | 6-1-05 | Adopt | 6-1-05 |
| 340-012-0162 | 6-1-05 | Adopt | 6-1-05 |
| 340-016-0055 | 11-19-04 | Amend | 1-1-05 |
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| 340-045-0075 | 7-1-05 | Amend | 8-1-05 |
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| 340-071-0115 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0116 | 3-1-05 | Am. & Ren. | 2-1-05 |
| 340-071-0117 | 3-1-05 | Am. & Ren. | 2-1-05 |
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| 340-071-0130 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0131 | 3-1-05 | Adopt | 2-1-05 |
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| 340-071-0155 | 3-1-05 | Amend | 2-1-05 |
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| 340-071-0162 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0165 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0170 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0175 | 3-1-05 | Amend | 2-1-05 |
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| 340-071-0335 | 3-1-05 | Amend | 2-1-05 |
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| 340-071-0450 | 3-1-05 | Repeal | 2-1-05 |
| 340-071-0460 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0500 | 3-1-05 | Amend | 2-1-05 |
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| 340-071-0600 | 3-1-05 | Amend | 2-1-05 |
| 340-071-0650 | 3-1-05 | Adopt | 2-1-05 |
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| 340-073-0026 | 3-1-05 | Amend | 2-1-05 |
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| 340-073-0050 | 3-1-05 | Amend | 2-1-05 |
| 340-073-0055 | 3-1-05 | Amend | 2-1-05 |
| 340-073-0056 | 3-1-05 | Amend | 2-1-05 |
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| 340-073-0065 | 3-1-05 | Amend | 2-1-05 |
| 340-073-0070 | 3-1-05 | Amend | 2-1-05 |
| 340-073-0075 | 3-1-05 | Amend | 2-1-05 |
| 340-073-0080 | 3-1-05 | Amend | 2-1-05 |
| 340-073-0085 | 3-1-05 | Amend | 2-1-05 |
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| 340-090-0045 | 7-14-05 | Amend | 8-1-05 |
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| 340-102-0065 | 7-14-05 | Amend | 8-1-05 |
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| 340-141-0140 | 7-14-05 | Amend | 8-1-05 |
| 340-142-0005 | 7-14-05 | Amend | 8-1-05 |
| 340-142-0130 | 7-14-05 | Amend | 8-1-05 |
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| 340-162-0150 | 7-14-05 | Amend | 8-1-05 |
| 340-177-0095 | 7-14-05 | Amend | 8-1-05 |
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| 340-200-0040 | 12-15-04 | Amend | 1-1-05 |
| 340-200-0040 | 1-4-05 | Amend | 2-1-05 |
| 340-200-0040 | 2-10-05 | Amend | 3-1-05 |
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| 340-200-0040 | 7-12-05 | Amend | 8-1-05 |
| 340-200-0040 | 9-9-05 | Amend | 10-1-05 |
| 340-204-0010 | 1-4-05 | Amend | 2-1-05 |
| 340-204-0030 | 1-4-05 | Amend | 2-1-05 |
| 340-204-0030 | 9-9-05 | Amend | 10-1-05 |
| 340-204-0040 | 1-4-05 | Amend | 2-1-05 |
| 340-204-0040 | 9-9-05 | Amend | 10-1-05 |
| 340-204-0090 | 12-15-04 | Amend | 1-1-05 |
| 340-218-0080 | 2-10-05 | Amend | 3-1-05 |
| 340-220-0030 | 7-11-05 | Amend | 8-1-05 |
| 340-220-0040 | 7-11-05 | Amend | 8-1-05 |
| 340-220-0050 | 7-11-05 | Amend | 8-1-05 |
| 340-224-0060 | 1-4-05 | Amend | 2-1-05 |
| 340-224-0060 | 9-9-05 | Amend | 10-1-05 |
| 340-224-0070 | 1-4-05 | Amend | 2-1-05 |
| 340-225-0020 | 1-4-05 | Amend | 2-1-05 |
| 340-225-0020 | 9-9-05 | Amend | 10-1-05 |
| 340-225-0045 | 1-4-05 | Amend | 2-1-05 |
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| 340-230-0410 | 2-10-05 | Amend | 3-1-05 |
| 340-238-0040 | 2-10-05 | Amend | 3-1-05 |
| 340-238-0060 | 2-10-05 | Amend | 3-1-05 |
| 340-240-0030 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0100 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0110 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0120 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0130 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0140 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0150 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0180 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0190 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0200 | 1-4-05 | Repeal | 2-1-05 |
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| 340-240-0220 | 1-4-05 | Amend | 2-1-05 |
| 340-240-0230 | 1-4-05 | Amend | 2-1-05 |
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| 340-256-0340 | 7-12-05 | Amend | 8-1-05 |
| 340-256-0350 | 7-12-05 | Amend | 8-1-05 |
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| 350-081-0086 | 7-1-05 | Adopt | 7-1-05 |
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| 350-081-0570 | 7-1-05 | Adopt | 7-1-05 |
| 350-081-0580 | 7-1-05 | Adopt | 7-1-05 |
| 350-081-0590 | 7-1-05 | Adopt | 7-1-05 |
| 350-081-0600 | 7-1-05 | Adopt | 7-1-05 |
| 350-081-0610 | 7-1-05 | Adopt | 7-1-05 |
| 350-081-0620 | 7-1-05 | Adopt | 7-1-05 |
| 350-081-0630 | 7-1-05 | Adopt | 7-1-05 |
| 410-003-0000 | 8-27-05 | Repeal | 10-1-05 |
| 410-003-0001 | 8-27-05 | Repeal | 10-1-05 |
| 410-003-0002 | 8-27-05 | Repeal | 10-1-05 |
| 410-003-0003 | 8-27-05 | Repeal | 10-1-05 |
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| 410-007-0210 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0220 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0230 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0240 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0250 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0260 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0270 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0280 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0290 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0300 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0310 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0320 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0330 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0340 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0370 | 3-29-05 | Amend | 5-1-05 |
| 410-007-0380 | 3-29-05 | Amend | 5-1-05 |
| 410-050-0401 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0411 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0421 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0431 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0441 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0451 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0461 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0471 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0481 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0491 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0501 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0511 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0521 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0531 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0541 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0551 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0561 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0571 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0581 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0591 | 2-1-05 | Adopt | 3-1-05 |
| 410-050-0700 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0710 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0720 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0730 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0740 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0750 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0760 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0770 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0780 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0790 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0800 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0810 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0820 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0830 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0840 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0850 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0860 | 12-3-04 | Amend(T) | 1-1-05 |
| 410-050-0860 | 5-7-05 | Adopt | 5-1-05 |
| 410-050-0860 | 5-10-05 | Amend(T) | 6-1-05 |
| 410-050-0860 | 7-11-05 | Amend | 8-1-05 |
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| 410-050-0861 | 5-10-05 | Adopt(T) | 6-1-05 |
| 410-050-0861 | 7-11-05 | Adopt | 8-1-05 |
| 410-050-0861(T) | 7-11-05 | Repeal | 8-1-05 |
| 410-050-0870 | 5-7-05 | Adopt | 5-1-05 |
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| 410-120-0000 | 10-1-05 | Amend | 10-1-05 |
| 410-120-0025 | 10-1-05 | Adopt | 10-1-05 |
| 410-120-0250 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1140 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1160 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1180 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1195 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1200 | 4-1-05 | Amend | 4-1-05 |
| 410-120-1200 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1210 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1230 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1260 | 4-1-05 | Amend | 4-1-05 |
| 410-120-1260 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1280 | 4-1-05 | Amend | 4-1-05 |
| 410-120-1280 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1290 | 10-1-05 | Repeal | 10-1-05 |
| 410-120-1295 | 2-9-05 | Amend(T) | 3-1-05 |
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| 410-120-1320 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1340 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1350 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1360 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1380 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1385 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1390 | 10-1-05 | Amend | 10-1-05 |
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| 410-120-1580 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1600 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1640 | 10-1-05 | Repeal | 10-1-05 |
| 410-120-1660 | 10-1-05 | Repeal | 10-1-05 |
| 410-120-1680 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1685 | 10-1-05 | Repeal | 10-1-05 |
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| 410-120-1855 | 10-1-05 | Adopt | 10-1-05 |
| 410-120-1860 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1865 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1870 | 10-1-05 | Amend | 10-1-05 |
| 410-120-1875 | 10-1-05 | Amend | 10-1-05 |
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| 410-121-0150 | 4-1-05 | Amend | 4-1-05 |
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| 410-121-0157 | 4-1-05 | Amend(T) | 4-1-05 |
| 410-121-0157 | 6-6-05 | Amend | 7-1-05 |
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| 410-121-0157(T) | 6-6-05 | Repeal | 7-1-05 |
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| 410-121-0185 | 4-1-05 | Amend | 4-1-05 |
| 410-121-0190 | 4-1-05 | Amend | 4-1-05 |
| 410-121-0300 | 12-10-04 | Amend(T) | 1-1-05 |
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| 410-121-0300 | 4-1-05 | Amend(T) | 5-1-05 |
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| 410-122-0020 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0020 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0040 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0055 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0080 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0184 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0186 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0190 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0190 | 10-1-05 | Amend | 10-1-05 |
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| 410-122-0202 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0202 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0202 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0203 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0204 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0204 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0205 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0207 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0208 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0208 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0209 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0210 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0320 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0325 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0340 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0340 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0365 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0375 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0400 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0420 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0475 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0500 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0560 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0560 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0580 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0590 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0590 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0625 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0630 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0630 | 10-1-05 | Amend | 10-1-05 |
| 410-122-0660 | 4-1-05 | Amend | 4-1-05 |
| 410-122-0720 | 1-1-05 | Amend | 2-1-05 |
| 410-122-0720 | 10-1-05 | Amend | 10-1-05 |
| 410-123-1040 | 8-1-05 | Amend | 9-1-05 |
| 410-123-1085 | 4-1-05 | Amend | 4-1-05 |
| 410-123-1240 | 8-1-05 | Amend | 9-1-05 |
| 410-123-1260 | 4-1-05 | Amend | 4-1-05 |
| 410-123-1670 | 4-1-05 | Amend | 4-1-05 |
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| 410-130-0200 | 4-1-05 | Amend | 4-1-05 |
| 410-130-0220 | 4-1-05 | Amend | 4-1-05 |
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| 410-130-0585 | 10-1-05 | Amend | 10-1-05 |
| 410-130-0587 | 4-1-05 | Amend | 4-1-05 |
| 410-130-0587 | 10-1-05 | Amend | 10-1-05 |
| 410-130-0610 | 4-1-05 | Adopt | 4-1-05 |
| 410-130-0680 | 4-1-05 | Amend | 4-1-05 |
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| 410-141-0080 | 5-1-05 | Amend | 6-1-05 |
| 410-141-0080 | 10-1-05 | Amend | 10-1-05 |
| 410-141-0110 | 5-1-05 | Amend | 6-1-05 |
| 410-141-0120 | 5-1-05 | Amend | 6-1-05 |
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| 410-141-0400 | 5-1-05 | Amend | 6-1-05 |
| 410-141-0405 | 5-1-05 | Amend | 6-1-05 |
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| 410-141-0440 | 5-1-05 | Amend | 6-1-05 |
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| 411-031-0020 | 7-1-05 | Amend | 8-1-05 |
| 411-031-0040 | 1-1-05 | Amend(T) | 2-1-05 |
| 411-031-0040 | 7-1-05 | Amend | 8-1-05 |
| 411-031-0050 | 1-1-05 | Amend(T) | 2-1-05 |
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| 411-034-0010 | 12-1-04 | Amend | 1-1-05 |
| 411-034-0020 | 12-1-04 | Amend | 1-1-05 |
| 411-034-0020 | 7-1-05 | Amend | 8-1-05 |
| 411-034-0030 | 12-1-04 | Amend | 1-1-05 |
| 411-034-0030 | 7-1-05 | Amend | 8-1-05 |
| 411-034-0035 | 12-1-04 | Adopt | 1-1-05 |
| 411-034-0040 | 12-1-04 | Adopt | 1-1-05 |
| 411-034-0050 | 12-1-04 | Amend | 1-1-05 |
| 411-034-0055 | 12-1-04 | Adopt | 1-1-05 |
| 411-034-0055 | 7-1-05 | Amend | 8-1-05 |
| 411-034-0070 | 12-1-04 | Amend | 1-1-05 |
| 411-034-0070 | 7-1-05 | Amend | 8-1-05 |
| 411-034-0090 | 12-1-04 | Amend | 1-1-05 |
| 411-045-0000 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0010 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0020 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0030 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0040 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0050 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0060 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0070 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0080 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0090 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0100 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0110 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0120 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0130 | 1-4-05 | Amend | 2-1-05 |
| 411-045-0140 | 1-4-05 | Amend | 2-1-05 |
| 411-048-0000 | 8-1-05 | Amend | 9-1-05 |
| 411-048-0130 | 8-1-05 | Amend | 9-1-05 |
| 411-070-0033 | 4-19-05 | Adopt | 6-1-05 |
| 411-070-0359 | 12-28-04 | Amend | 2-1-05 |
| 411-070-0428 | 12-28-04 | Amend | 2-1-05 |
| 411-070-0440 | 12-28-04 | Repeal | 2-1-05 |
| 411-070-0442 | 12-28-04 | Adopt | 2-1-05 |
| 411-070-0446 | 12-28-04 | Repeal | 2-1-05 |
| 411-070-0465 | 12-28-04 | Amend | 2-1-05 |
| 411-335-0010 | 1-1-05 | Adopt | 1-1-05 |
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| 411-335-0040 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0050 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0060 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0070 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0080 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0090 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0100 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0110 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0120 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0130 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0140 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0150 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0160 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0170 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0180 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0190 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0200 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0210 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0220 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0230 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0240 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0250 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0260 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0270 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0280 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0290 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0300 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0310 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0320 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0330 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0340 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0350 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0360 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0370 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0380 | 1-1-05 | Adopt | 1-1-05 |
| 411-335-0390 | 1-1-05 | Adopt | 1-1-05 |
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| 411-340-0030 | 6-23-05 | Amend | 8-1-05 |
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| 411-340-0050 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0060 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0080 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0090 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0110 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0120 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0130 | 1-1-05 | Amend(T) | 2-1-05 |
| 411-340-0130 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0140 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0150 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0160 | 6-23-05 | Amend | 8-1-05 |
| 411-340-0170 | 6-23-05 | Amend | 8-1-05 |
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| 411-360-0030 | 2-1-05 | Adopt | 2-1-05 |
| 411-360-0040 | 2-1-05 | Adopt | 2-1-05 |
| 411-360-0050 | 2-1-05 | Adopt | 2-1-05 |
| 411-360-0060 | 2-1-05 | Adopt | 2-1-05 |
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| 411-360-0300 | 2-1-05 | Adopt | 2-1-05 |
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| 413-010-0715 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0716 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0717 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0718 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0720 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0721 | 2-1-05 | Amend | 3-1-05 |
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| 413-010-0723 | 2-1-05 | Amend | 3-1-05 |
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| 413-010-0735 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0738 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0740 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0743 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0745 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0746 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0748 | 2-1-05 | Amend | 3-1-05 |
| 413-010-0750 | 2-1-05 | Amend | 3-1-05 |
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| 413-015-0210 | 2-1-05 | Amend | 3-1-05 |
| 413-015-0215 | 2-1-05 | Amend | 3-1-05 |
| 413-015-0305 | 2-1-05 | Amend | 3-1-05 |
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| 413-015-0505 | 9-15-05 | Amend(T) | 10-1-05 |
| 413-015-0510 | 9-15-05 | Amend(T) | 10-1-05 |
| 413-015-0511 | 2-1-05 | Amend | 3-1-05 |
| 413-015-0511 | 9-15-05 | Amend(T) | 10-1-05 |
| 413-015-0512 | 9-15-05 | Amend(T) | 10-1-05 |
| 413-015-0513 | 9-15-05 | Amend(T) | 10-1-05 |
| 413-015-0514 | 9-15-05 | Amend(T) | 10-1-05 |
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| 413-015-1000 | 4-1-05 | Amend | 5-1-05 |
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| 413-015-1105 | 1-28-05 | Adopt(T) | 3-1-05 |
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| 413-015-1110 | 1-28-05 | Adopt(T) | 3-1-05 |
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| 413-015-1115 | 1-28-05 | Adopt(T) | 3-1-05 |
| 413-015-1115 | 7-28-05 | Adopt | 9-1-05 |
| 413-015-1120 | 1-28-05 | Adopt(T) | 3-1-05 |
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| 413-030-0150 | 6-1-05 | Repeal | 7-1-05 |
| 413-030-0155 | 6-1-05 | Repeal | 7-1-05 |
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| 413-050-0120 | 9-12-05 | Suspend | 10-1-05 |
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| 413-050-0140 | 9-12-05 | Suspend | 10-1-05 |
| 413-050-0500 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0510 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0515 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0525 | 1-1-05 | Repeal | 2-1-05 |
| 413-050-0530 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0535 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0540 | 1-1-05 | Repeal | 2-1-05 |
| 413-050-0545 | 1-1-05 | Repeal | 2-1-05 |
| 413-050-0550 | 1-1-05 | Repeal | 2-1-05 |
| 413-050-0555 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0560 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0565 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0570 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0575 | 1-1-05 | Amend | 2-1-05 |
| 413-050-0580 | 1-1-05 | Repeal | 2-1-05 |
| 413-050-0585 | 1-1-05 | Amend | 2-1-05 |
| 413-055-0100 | 1-1-05 | Amend | 2-1-05 |
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| 413-055-0140 | 1-1-05 | Amend | 2-1-05 |
| 413-055-0145 | 1-1-05 | Amend | 2-1-05 |
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| 413-055-0155 | 1-1-05 | Repeal | 2-1-05 |
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| 413-080-0130 | 9-1-05 | Suspend | 10-1-05 |
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| 414-061-0080 | 8-16-05 | Amend(T) | 10-1-05 |
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| 414-061-0110 | 11-16-04 | Amend | 1-1-05 |
| 414-205-0170 | 11-16-04 | Amend | 1-1-05 |
| 414-205-0170 | 4-29-05 | Amend | 6-1-05 |
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| 416-250-0060 | 1-11-05 | Amend | 2-1-05 |
| 416-250-0070 | 1-11-05 | Amend | 2-1-05 |
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| 416-250-0090 | 1-11-05 | Amend | 2-1-05 |
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| 416-315-0010 | 6-13-05 | Adopt | 7-1-05 |
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| 416-340-0020 | 3-25-05 | Amend | 5-1-05 |
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| 416-340-0040 | 3-25-05 | Amend | 5-1-05 |
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| 416-380-0040 | 8-12-05 | Repeal | 9-1-05 |
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| 436-110-0310 | 7-1-05 | Amend | 7-1-05 |
| 436-110-0320 | 7-1-05 | Amend | 7-1-05 |
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| 436-110-0327 | 7-1-05 | Adopt | 7-1-05 |
| 436-110-0330 | 7-1-05 | Amend | 7-1-05 |
| 436-110-0335 | 7-1-05 | Amend | 7-1-05 |
| 436-110-0336 | 7-1-05 | Adopt | 7-1-05 |
| 436-110-0337 | 7-1-05 | Adopt | 7-1-05 |
| 436-110-0345 | 7-1-05 | Amend | 7-1-05 |
| 436-110-0346 | 7-1-05 | Adopt | 7-1-05 |
| 436-110-0347 | 7-1-05 | Adopt | 7-1-05 |
| 436-110-0350 | 7-1-05 | Amend | 7-1-05 |
| 436-110-0351 | 7-1-05 | Adopt | 7-1-05 |
| 436-110-0352 | 7-1-05 | Adopt | 7-1-05 |
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| 436-120-0340 | 7-1-05 | Amend | 7-1-05 |
| 436-120-0350 | 7-1-05 | Amend | 7-1-05 |
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| 436-120-0400 | 7-1-05 | Amend | 7-1-05 |
| 436-120-0410 | 7-1-05 | Amend | 7-1-05 |
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| 461-155-0235 | 2-18-05 | Amend | 4-1-05 |
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| 461-155-0270 | 1-1-05 | Amend | 2-1-05 |
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| 603-001-0170 | 6-30-05 | Adopt | 8-1-05 |
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| 603-011-0630 | 2-17-05 | Amend | 4-1-05 |
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| 635-041-0074(T) | 7-25-05 | Suspend | 9-1-05 |
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| 812-002-0275 | 8-24-05 | Adopt | 10-1-05 |
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| 812-002-0620 | 8-24-05 | Amend | 10-1-05 |
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| 812-003-0140 | 10-1-05 | Amend | 10-1-05 |
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| 836-043-0009 | 8-1-05 | Amend | 7-1-05 |
| 836-043-0017 | 8-1-05 | Amend | 7-1-05 |
| 836-043-0086 | 8-1-05 | Amend | 7-1-05 |
| 836-050-0010 | 8-1-05 | Amend | 7-1-05 |
| 836-050-0230 | 8-1-05 | Amend | 7-1-05 |
| 836-050-0240 | 8-1-05 | Amend | 7-1-05 |
| 836-051-0010 | 8-1-05 | Amend | 7-1-05 |
| 836-051-0020 | 8-1-05 | Amend | 7-1-05 |
| 836-051-0540 | 8-1-05 | Amend | 7-1-05 |
| 836-051-0550 | 8-1-05 | Amend | 7-1-05 |
| 836-051-0570 | 8-1-05 | Amend | 7-1-05 |
| 836-051-0590 | 8-1-05 | Amend | 7-1-05 |
| 836-052-0114 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0119 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0124 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0129 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0133 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0134 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0136 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0138 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0139 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0142 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0145 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0151 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0156 | 8-1-05 | Amend | 7-1-05 |
| 836-052-0160 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0165 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0165 | 8-1-05 | Amend | 7-1-05 |
| 836-052-0175 | 8-1-05 | Amend | 7-1-05 |
| 836-052-0180 | 7-26-05 | Amend | 9-1-05 |
| 836-052-0180 | 8-1-05 | Amend | 7-1-05 |
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| 836-052-0515 | 3-1-05 | Repeal | 4-1-05 |
| 836-052-0516 | 3-1-05 | Adopt | 4-1-05 |
| 836-052-0520 | 3-1-05 | Repeal | 4-1-05 |
| 836-052-0525 | 3-1-05 | Repeal | 4-1-05 |
| 836-052-0526 | 3-1-05 | Adopt | 4-1-05 |
| 836-052-0530 | 3-1-05 | Am. & Ren. | 4-1-05 |
| 836-052-0535 | 3-1-05 | Am. & Ren. | 4-1-05 |
| 836-052-0536 | 3-1-05 | Adopt | 4-1-05 |
| 836-052-0540 | 3-1-05 | Repeal | 4-1-05 |
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| 836-062-0005 | 8-1-05 | Amend | 7-1-05 |
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| 836-071-0127 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0148 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0150 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0160 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0180 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0190 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0195 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0210 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0215 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0220 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0225 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0230 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0235 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0242 | 8-1-05 | Amend | 7-1-05 |
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| 836-071-0263 | 8-1-05 | Adopt(T) | 7-1-05 |
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| 836-071-0291 | 8-1-05 | Am. & Ren. | 7-1-05 |
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| 836-071-0321 | 8-1-05 | Adopt | 7-1-05 |
| 836-071-0323 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0326 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0328 | 8-1-05 | Adopt | 7-1-05 |
| 836-071-0331 | 8-1-05 | Amend | 7-1-05 |
| 836-071-0336 | 8-1-05 | Amend | 7-1-05 |
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| 836-075-0070 | 8-1-05 | Amend | 7-1-05 |
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| 836-080-0014 | 8-1-05 | Amend | 7-1-05 |
| 836-080-0022 | 8-1-05 | Amend | 7-1-05 |
| 836-080-0029 | 8-1-05 | Amend | 7-1-05 |
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| 836-080-0043 | 8-1-05 | Amend | 7-1-05 |
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| 836-080-0610 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0615 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0620 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0625 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0630 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0635 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0640 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0645 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0650 | 4-1-05 | Adopt | 5-1-05 |
| 836-080-0655 | 4-1-05 | Adopt | 5-1-05 |
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| 837-012-0650 | 6-7-05 | Amend | 7-1-05 |
| 837-012-0655 | 6-7-05 | Amend | 7-1-05 |
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| 837-012-0670 | 6-7-05 | Amend | 7-1-05 |
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| 839-021-0355 | 1-3-05 | Amend | 2-1-05 |
| 839-025-0700 | 4-1-05 | Amend | 5-1-05 |
| 839-025-0750 | 4-18-05 | Amend | 5-1-05 |
| 839-025-0750 | 5-2-05 | Amend | 6-1-05 |
| 839-025-0750 | 6-1-05 | Amend | 7-1-05 |
| 839-025-0750 | 6-21-05 | Amend | 8-1-05 |
| 839-025-0750 | 7-1-05 | Amend | 8-1-05 |
| 839-025-0750 | 7-22-05 | Amend | 9-1-05 |
| 839-025-0750 | 8-10-05 | Amend | 9-1-05 |
| 839-025-0750 | 8-29-05 | Amend | 10-1-05 |
| 839-050-0050 | 2-11-05 | Amend | 3-1-05 |
| 839-050-0220 | 2-11-05 | Amend | 3-1-05 |
| 839-050-0360 | 2-11-05 | Amend | 3-1-05 |
| 845-001-0008 | 5-1-05 | Amend | 6-1-05 |
| 845-003-0670 | 5-1-05 | Amend | 6-1-05 |
| 845-004-0020 | 5-1-05 | Amend | 6-1-05 |
| 845-004-0101 | 1-1-05 | Amend | 1-1-05 |
| 845-005-0303 | 5-1-05 | Amend | 6-1-05 |
| 845-005-0312 | 1-1-05 | Amend | 2-1-05 |
| 845-005-0314 | 5-1-05 | Amend | 6-1-05 |
| 845-006-0434 | 5-1-05 | Amend | 6-1-05 |
| 845-006-0475 | 5-1-05 | Amend | 6-1-05 |
| 845-009-0010 | 7-1-05 | Amend | 7-1-05 |
| 845-009-0015 | 7-1-05 | Amend | 7-1-05 |
| 845-009-0135 | 5-1-05 | Amend | 6-1-05 |
| 845-009-0200 | 1-1-05 | Amend | 2-1-05 |
| 845-010-0905 | 12-1-04 | Amend | 1-1-05 |
| 845-010-0915 | 12-1-04 | Amend | 1-1-05 |
| 845-015-0143 | 6-1-05 | Amend | 7-1-05 |
| 845-015-0170 | 9-1-05 | Amend | 10-1-05 |
| 845-015-0175 | 1-1-05 | Amend | 2-1-05 |
| 847-005-0005 | 7-20-05 | Amend | 9-1-05 |
| 847-010-0100 | 7-20-05 | Adopt | 9-1-05 |
| 847-015-0025 | 1-27-05 | Amend | 3-1-05 |
| 847-020-0130 | 7-20-05 | Amend | 9-1-05 |
| 847-020-0160 | 7-20-05 | Amend | 9-1-05 |
| 847-020-0170 | 7-20-05 | Amend | 9-1-05 |
| 847-035-0030 | 1-27-05 | Amend | 3-1-05 |
| 847-035-0030 | 4-21-05 | Amend | 6-1-05 |
| 847-035-0030 | 7-20-05 | Amend | 9-1-05 |
| 847-050-0037 | 4-21-05 | Amend | 6-1-05 |
| 847-050-0041 | 1-27-05 | Amend | 3-1-05 |
| 847-080-0018 | 7-20-05 | Amend | 9-1-05 |
| 848-001-0000 | 12-29-04 | Amend | 2-1-05 |
| 848-001-0005 | 12-29-04 | Amend | 2-1-05 |
| 848-005-0010 | 4-8-05 | Amend | 5-1-05 |
| 848-005-0030 | 12-29-04 | Adopt | 2-1-05 |
| 848-010-0010 | 12-29-04 | Amend | 2-1-05 |
| 848-010-0015 | 12-29-04 | Amend | 2-1-05 |
| 848-010-0020 | 12-29-04 | Amend | 2-1-05 |
| 848-010-0026 | 12-29-04 | Amend | 2-1-05 |
| 848-010-0033 | 12-29-04 | Adopt | 2-1-05 |
| 848-010-0035 | 12-29-04 | Amend | 2-1-05 |
| 848-010-0044 | 12-29-04 | Adopt | 2-1-05 |
| 848-010-0045 | 12-29-04 | Repeal | 2-1-05 |
| 848-010-0050 | 12-29-04 | Repeal | 2-1-05 |
| 848-010-0060 | 12-29-04 | Repeal | 2-1-05 |
| 848-010-0070 | 12-29-04 | Repeal | 2-1-05 |
| 848-010-0080 | 12-29-04 | Repeal | 2-1-05 |
| 848-010-0090 | 12-29-04 | Repeal | 2-1-05 |
| 848-010-0105 | 12-29-04 | Renumber | 2-1-05 |
| 848-010-0110 | 12-29-04 | Am. & Ren. | 2-1-05 |
| 848-010-0115 | 12-29-04 | Renumber | 2-1-05 |
| 848-010-0120 | 12-29-04 | Am. & Ren. | 2-1-05 |
| 848-010-0125 | 12-29-04 | Repeal | 2-1-05 |
| 848-015-0010 | 12-29-04 | Adopt | 2-1-05 |
| 848-015-0020 | 12-29-04 | Adopt | 2-1-05 |
| 848-015-0030 | 12-29-04 | Adopt | 2-1-05 |
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| 848-020-0010 | 12-29-04 | Amend | 2-1-05 |
| 848-020-0020 | 12-29-04 | Repeal | 2-1-05 |
| 848-020-0030 | 12-29-04 | Amend | 2-1-05 |
| 848-020-0040 | 12-29-04 | Amend | 2-1-05 |
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| 848-040-0105 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0110 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0115 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0120 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0125 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0130 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0135 | 12-29-04 | Adopt | 2-1-05 |
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| 848-040-0155 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0160 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0165 | 12-29-04 | Adopt | 2-1-05 |
| 848-040-0170 | 12-29-04 | Adopt | 2-1-05 |
| 848-045-0010 | 12-29-04 | Adopt | 2-1-05 |
| 848-045-0020 | 12-29-04 | Adopt | 2-1-05 |
| 848-050-0000 | 12-29-04 | Repeal | 2-1-05 |
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| 848-050-0020 | 12-29-04 | Repeal | 2-1-05 |
| 848-050-0030 | 12-29-04 | Repeal | 2-1-05 |
| 848-050-0100 | 12-29-04 | Adopt | 2-1-05 |
| 848-050-0110 | 12-29-04 | Adopt | 2-1-05 |
| 848-050-0120 | 12-29-04 | Adopt | 2-1-05 |
| 850-010-0190 | 4-13-05 | Amend | 5-1-05 |
| 850-010-0212 | 8-15-05 | Amend | 9-1-05 |
| 850-010-0220 | 2-4-05 | Amend | 3-1-05 |
| 850-010-0225 | 2-4-05 | Amend | 3-1-05 |
| 850-010-0225 | 6-10-05 | Amend | 7-1-05 |
| 850-020-0000 | 2-4-05 | Amend | 3-1-05 |
| 850-020-0005 | 2-4-05 | Amend | 3-1-05 |
| 850-020-0010 | 2-4-05 | Repeal | 3-1-05 |
| 850-020-0015 | 2-4-05 | Repeal | 3-1-05 |
| 850-020-0020 | 2-4-05 | Amend | 3-1-05 |
| 850-020-0025 | 2-4-05 | Amend | 3-1-05 |
| 850-020-0030 | 2-4-05 | Amend | 3-1-05 |
| 851-050-0002 | 2-17-05 | Amend | 4-1-05 |
| 851-050-0131 | 11-30-04 | Amend | 1-1-05 |
| 851-050-0131 | 2-17-05 | Amend | 4-1-05 |
| 851-050-0131 | 4-26-05 | Amend | 6-1-05 |
| 851-050-0131 | 6-30-05 | Amend | 8-1-05 |
| 851-052-0030 | 6-30-05 | Amend | 8-1-05 |
| 851-062-0055 | 6-30-05 | Amend | 8-1-05 |
| 852-005-0005 | 7-1-05 | Amend | 8-1-05 |
| 852-005-0010 | 2-23-05 | Amend | 4-1-05 |
| 852-010-0015 | 2-23-05 | Amend | 4-1-05 |
| 852-010-0020 | 2-23-05 | Amend | 4-1-05 |
| 852-010-0023 | 2-23-05 | Amend | 4-1-05 |
| 852-010-0027 | 2-23-05 | Amend | 4-1-05 |
| 852-010-0080 | 7-1-05 | Amend | 8-1-05 |
| 852-020-0035 | 4-8-05 | Adopt | 5-1-05 |
| 852-050-0006 | 7-1-05 | Amend | 8-1-05 |
| 852-050-0018 | 2-23-05 | Amend | 4-1-05 |
| 852-050-0021 | 4-8-05 | Adopt | 5-1-05 |
| 852-070-0030 | 2-23-05 | Amend | 4-1-05 |
| 852-080-0040 | 4-8-05 | Amend | 5-1-05 |
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| 855-041-0060 | 4-14-05 | Amend | 5-1-05 |
| 855-041-0208 | 6-28-05 | Adopt(T) | 8-1-05 |
| 855-041-0600 | 3-1-05 | Adopt | 3-1-05 |
| 855-041-0610 | 3-1-05 | Adopt | 3-1-05 |
| 855-041-0620 | 3-1-05 | Adopt | 3-1-05 |
| 855-050-0037 | 5-14-05 | Adopt | 5-1-05 |
| 855-050-0038 | 5-14-05 | Adopt | 5-1-05 |
| 855-050-0039 | 5-14-05 | Adopt | 5-1-05 |
| 855-050-0041 | 5-14-05 | Adopt | 5-1-05 |
| 855-050-0042 | 5-14-05 | Adopt | 5-1-05 |
| 855-050-0043 | 5-14-05 | Adopt | 5-1-05 |
| 855-110-0007 | 3-1-05 | Amend | 3-1-05 |
| 855-110-0010 | 3-1-05 | Amend | 3-1-05 |
| 860-011-0001 | 12-30-04 | Amend | 2-1-05 |
| 860-011-0010 | 12-30-04 | Amend | 2-1-05 |
| 860-011-0011 | 12-30-04 | Adopt | 2-1-05 |
| 860-011-0012 | 12-30-04 | Adopt | 2-1-05 |
| 860-011-0015 | 12-30-04 | Amend | 2-1-05 |
| 860-011-0020 | 12-30-04 | Repeal | 2-1-05 |
| 860-011-0022 | 12-30-04 | Am. & Ren. | 2-1-05 |
| 860-011-0023 | 12-30-04 | Repeal | 2-1-05 |
| 860-011-0024 | 12-30-04 | Repeal | 2-1-05 |
| 860-011-0025 | 12-30-04 | Repeal | 2-1-05 |
| 860-011-0030 | 12-30-04 | Repeal | 2-1-05 |
| 860-011-0035 | 12-30-04 | Amend | 2-1-05 |
| 860-011-0080 | 12-30-04 | Amend | 2-1-05 |
| 860-012-0007 | 12-1-04 | Amend | 1-1-05 |
| 860-012-0015 | 12-28-04 | Amend | 2-1-05 |
| 860-013-0021 | 12-30-04 | Am. & Ren. | 2-1-05 |
| 860-013-0036 | 12-30-04 | Adopt | 2-1-05 |
| 860-013-0037 | 12-30-04 | Adopt | 2-1-05 |
| 860-013-0040 | 12-30-04 | Repeal | 2-1-05 |
| 860-013-0060 | 12-30-04 | Amend | 2-1-05 |
| 860-013-0065 | 12-30-04 | Amend | 2-1-05 |
| 860-013-0070 | 12-30-04 | Amend | 2-1-05 |
| 860-013-0071 | 12-30-04 | Amend | 2-1-05 |
| 860-013-0075 | 12-30-04 | Amend | 2-1-05 |
| 860-014-0005 | 12-30-04 | Amend | 2-1-05 |
| 860-014-0010 | 12-30-04 | Amend | 2-1-05 |
| 860-014-0023 | 12-30-04 | Amend | 2-1-05 |
| 860-014-0060 | 12-30-04 | Amend | 2-1-05 |
| 860-014-0065 | 12-30-04 | Amend | 2-1-05 |
| 860-014-0070 | 12-30-04 | Amend | 2-1-05 |
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| 860-021-0021 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0034 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0034 | 12-30-04 | Amend | 2-1-05 |
| 860-021-0036 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0036 | 12-30-04 | Amend | 2-1-05 |
| 860-021-0037 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0037 | 12-30-04 | Amend | 2-1-05 |
| 860-021-0125 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0130 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0200 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0205 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0206 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0210 | 12-1-04 | Amend | 1-1-05 |
| 860-021-0420 | 12-1-04 | Amend | 1-1-05 |
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| 860-022-0005 | 12-30-04 | Amend | 2-1-05 |
| 860-022-0015 | 12-30-04 | Amend | 2-1-05 |
| 860-022-0020 | 12-30-04 | Amend | 2-1-05 |
| 860-022-0038 | 12-30-04 | Amend | 2-1-05 |
| 860-022-0039 | 9-15-05 | Adopt(T) | 10-1-05 |
| 860-024-0020 | 6-3-05 | Amend | 7-1-05 |
| 860-024-0021 | 6-3-05 | Amend | 7-1-05 |
| 860-032-0095 | 12-1-04 | Amend | 1-1-05 |
| 860-032-0095 | 12-30-04 | Amend | 2-1-05 |
| 860-032-0097 | 12-1-04 | Amend | 1-1-05 |
| 860-032-0097 | 12-30-04 | Amend | 2-1-05 |
| 860-032-0610 | 12-30-04 | Amend | 2-1-05 |
| 860-033-0005 | 12-1-04 | Amend | 1-1-05 |
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| 860-033-0006 | 12-30-04 | Amend | 2-1-05 |
| 860-033-0007 | 12-1-04 | Adopt | 1-1-05 |
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| 860-033-0009 | 12-1-04 | Adopt | 1-1-05 |
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| 860-033-0030 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0045 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0050 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0505 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0530 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0535 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0536 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0537 | 12-1-04 | Amend | 1-1-05 |
| 860-033-0540 | 12-1-04 | Amend | 1-1-05 |
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| 860-034-0030 | 12-1-04 | Amend | 1-1-05 |
| 860-034-0090 | 12-1-04 | Amend | 1-1-05 |
| 860-034-0095 | 12-1-04 | Amend | 1-1-05 |
| 860-034-0095 | 12-30-04 | Amend | 2-1-05 |
| 860-034-0097 | 12-1-04 | Amend | 1-1-05 |
| 860-034-0097 | 12-30-04 | Amend | 2-1-05 |
| 860-034-0110 | 12-1-04 | Amend | 1-1-05 |
| 860-034-0140 | 12-1-04 | Amend | 1-1-05 |
| 860-034-0160 | 12-1-04 | Amend | 1-1-05 |
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| 860-034-0600 | 12-30-04 | Amend | 2-1-05 |
| 860-036-0035 | 12-1-04 | Amend | 1-1-05 |
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| 860-036-0075 | 12-1-04 | Amend | 1-1-05 |
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| 860-036-0095 | 12-30-04 | Amend | 2-1-05 |
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| 860-036-0097 | 12-30-04 | Amend | 2-1-05 |
| 860-036-0115 | 12-1-04 | Amend | 1-1-05 |
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| 860-036-0615 | 12-30-04 | Amend | 2-1-05 |
| 860-036-0625 | 12-30-04 | Amend | 2-1-05 |
| 860-036-0645 | 12-30-04 | Amend | 2-1-05 |
| 860-037-0030 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0035 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0045 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0070 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0095 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0095 | 12-30-04 | Amend | 2-1-05 |
| 860-037-0097 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0097 | 12-30-04 | Amend | 2-1-05 |
| 860-037-0110 | 12-1-04 | Amend | 1-1-05 |
| 860-037-0410 | 12-30-04 | Amend | 2-1-05 |
| 860-037-0420 | 12-30-04 | Amend | 2-1-05 |
| 860-037-0430 | 12-30-04 | Amend | 2-1-05 |
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